# CABINET MEMBER FOR ADULT SOCIAL CARE

**Venue:** **Town Hall, Moorgate Street, Rotherham. S60 2TH**

**Date:** **Monday, 17th February, 2014**

**Time:** **10.00 a.m.**

## A G E N D A

1. To determine if the matters are to be considered under the categories suggested in accordance with Part 1 (as amended March 2006) of Schedule 12A to the Local Government Act 1972.

2. To determine any item which the Chairman is of the opinion should be considered later in the agenda as a matter of urgency.

3. Apologies for Absence.

4. Declarations of Interest

5. Minutes of previous meeting (Pages 1 - 7)

6. Health and Wellbeing Board (Pages 8 - 17)

7. Adult Services Revenue Budget Monitoring (Pages 18 - 23)

8. Debt Management and Recovery Policy for Adult Social Care Debt (Pages 24 - 51)

9. Winterbourne View Joint Improvement Programme (Pages 52 - 72)

10. Training Adult Social Care Workforce (Pages 73 - 76)

11. Domestic Abuse Scrutiny Review (Pages 77 - 113)

12. Update Response to Scrutiny Review re Continuing Healthcare (Pages 114 - 121)

13. Exclusion of the Press and Public
    Resolved:- That, under Section 100A(4) of the Local Government Act 1972, the press and public be excluded from the meeting for the following item of business on the grounds that it involves the likely disclosure of exempt

information as defined in Paragraph 3 of Part 1 of Schedule 12A to the Local Government Act, 1972 (as amended March, 2006) (involves information relating to finance and business affairs).

14. Rothercare Dispersed Alarms - Tender (Pages 122 - 124)

15. Date of Next Meeting
    - Monday, 17th March, 2014 at 10.00 a.m.

# CABINET MEMBER FOR ADULT SOCIAL CARE
## Monday, 20th January, 2014

Present:- Councillor Doyle (in the Chair); Councillors Gosling and P. A. Russell.

## H57. DECLARATIONS OF INTEREST

Councillor P. A. Russell declared a personal interest in Minute No. 69 (Review of Non-Residential Service Charges).

## H58. MINUTES OF PREVIOUS MEETING

Consideration was given to the minutes of the meeting held on 9th December, 2013.

Resolved:- That the minutes of the meeting held on 9th December, 2013, be approved as a correct record.

## H59. HEALTH AND WELLBEING BOARD

The minutes of the meeting of the Health and Wellbeing Board held on 18th December, 2013, were noted.

## H60. ROTHERHAM LEARNING DISABILITY PARTNERSHIP BOARD

The noted of a meeting of the Rotherham Learning Disability Partnership Board held on 6th December, 2013, were submitted for information.

## H61. RESIDENTIAL AND NURSING CARE QUALITY AND ACTIVITY MONITORING

Consideration was given to a report presented by Jacqui Clark, Operational Commissioner, which provided an update on the annual report on residential care activity for the period 1st July to 30th September, 2013.

The report provided information on occupancy levels and quality monitoring outcomes for 2013/14 for services delivered by independent and in-house residential and nursing care homes.

Members requested further information, to be submitted to the net meeting, relating to providers' supervision of medication administered to persons in their care.

Discussion took place on the arrangements for meetings with representatives of the Care Quality Commission.

Resolved:- (1) That the report be noted.

(2) That the report be included on the agenda for the next meeting of the Contracting for Care Forum.

## H62. COMMUNITY AND HOME CARE ACTIVITY AND QUALITY MONITORING

Consideration was given to a report presented by Jacqui Clark, Operational Commissioner, which provided information on Community and Home Care Service activity and quality for the period 1st July to 30th September, 2013.

The report provided information on activity levels and quality monitoring outcomes for 2013/14 for services delivered by the Community and Home Care Services Framework.

Further information was provided on the framework activity, monitoring of quality, including concerns, defaults and embargos and an overview of concerns.

Discussion ensued on the review of the medication policy in line with a jointly commissioned service (with the Rotherham Clinical Commissioning Group).

Members noted that the current Community and Home Care Services contractual agreement ends on 31 March 2015 and has an option to be extended until 31 March 2016. The preparatory commissioning work will begin early in the 2014/2015 financial year and progress reports submitted to Elected Members.

Resolved:- (1) That the report be noted.

(2) That the report be included on the agenda for the next meeting of the Contracting for Care Forum.

## H63. ADULT SERVICES REVENUE BUDGET MONITORING

Consideration was given to a report presented by Mark Scarrott, Finance Manager (Neighbourhoods and Adult Services), which provided a financial forecast for the Adult Services Department within the Neighbourhoods and Adult Services Directorate to the end of March, 2014, based on actual income and expenditure to the end of November, 2013.

It was reported that the forecast for the financial year 2013/14 was an overspend of £1.205 millions, against an approved net revenue budget of £72.809 millions. The main budget pressures related to slippage on a number of budget savings targets including Continuing Health Care funding and implementing the review of In-house Residential Care.

The latest year end forecast showed a number of underlying budget

pressures which were being offset by a number of forecast underspends:-

Adults General
- A slight underspend based on estimated charges including training

Older People
- A forecast overspend on In-House Residential Care due to delays on implementation of budget savings target and recurrent budget pressure on Residential Care income
- Recurrent budget pressures in Direct Payments, however, client numbers had reduced since April together with a reduction in the average cost of packages
- Underspend on In House Transport due to forecast additional income
- Forecast underspend on Enabling Care and Sitting Service, Community Mental Health, Carers' Services and planned delays on the recruitment to vacant posts within Assessment and Care Management and Community Support plus additional income from Health
- Overspend on independent sector Home Care due to an increase in demand since April
- Overspend on independent residential and nursing care due to an additional 73 clients receiving a service than forecast. Additional income from property charges was reducing the overall overspend
- Forecast savings on in-house day care due to vacant posts and moratorium on non-pay budgets
- Overall underspend on Rothercare due to slippage in Service Review including options for replacement of alarms together with additional income
- Overall minor underspends in other non-pay budgets due to moratorium on non-essential spend

Learning Disabilities
- Slight underspend on independent sector Residential Care budgets due to a reduction in placements. Work was ongoing regarding Continuing Health Care applications and an internal review of all high cost placements
- Forecast overspend on Day Care due to a delay on the implementation of Day Care Review including increase in fees and charges plus recurrent budget pressure on external transport
- Overspend in independent sector Home Care due to increase in demand and slippage in meeting budget savings
- High cost placements in independent Day Care resulting in a forecast overspend, however, the pressure was reduced due to additional Continuing Health Care funding and 1 client moving out of the area
- High cost Community Support placements resulting in forecast overspend
- Delay in developing Supported Living Schemes plus additional funding from Health resulting in a forecast underspend
- Efficiency savings on Service Level Agreements for Advice and

Information and Client Support Services
- Lower than expected increase in demand for Direct Payments
- Additional staffing costs and essential repairs within In-House Residential Care offset by planned delays in recruiting to vacant posts within Assessment and Care Management

Mental Health
- Projected overspend on Residential Care budget due to a slippage on budget savings target plan to move clients into Community Support Services offset by an underspend in Community Support budget
- Budget press on Direct Payments but additional income recovery was reducing the overall pressure on budget
- Overspends on employees' budgets due to lower than staff turnover, additional overtime and agency cover

Physical and Sensory Disabilities
- Continued pressure on Independent Sector Domiciliary Care due to a continued increase in demand for service
- Further increase in demand for Direct Payments
- Underspend on Community Support as clients moved to Direct Payments
- Forecast underspend on Residential and Nursing Care due to planned slippage in developing alternatives to respite provision
- Reduction in contract with independent sector Day Care provider
- Underspend on equipment and minor adaptations budgets
- Forecast efficiency savings on contracts with Voluntary Sector providers and higher than forecast staff turnover

Safeguarding
- Overspend due to lower than expected staff turnover and use of agency support

Supporting People
- Efficiency savings on subsidy contracts had already been identified against budget

Total expenditure on Agency staff for Adult Services to the end of November, 2013, was £254,082 (no off contract expenditure) compared with actual expenditure of £219,672 (no off contract expenditure) for the same period last year. The main areas of spend were within Assessment and Care Management Teams, Residential Care and Safeguarding to cover front line vacancies and sickness. There had been no expenditure on consultancy to date.

There had been £273,473 spent up to the end of November, 2013, on non-contractual overtime for Adult Services compared with expenditure of £254,303 for the same period last year.

Careful scrutiny of expenditure and income and close budget monitoring

remained essential to ensure equity of Service provision for adults across the Borough within existing budgets particularly where the demand and spend was difficult to predict in a volatile social care market. A potential risk was the future number and cost of transitional placements from Children's Services into Learning Disability Services together with any future reductions in Continuing Health Care funding.

Regional benchmarking within the Yorkshire and Humberside region for the final quarter of 2012/13, showed that Rotherham remained below average on spend per head in respect of Continuing Health Care.

Resolved:- That the latest financial projection against budget for 2013/14, as now submitted, be noted.

## H64. EXCLUSION OF THE PRESS AND PUBLIC

Resolved:- That, under Section 100A(4) of the Local Government Act 1972, the press and public be excluded from the meeting for the following items of business on the grounds that they involve the likely disclosure of exempt information as defined in Paragraph 3 of Part 1 of Schedule 12A to the Local Government Act 1972 (as amended March 2006) (information relating to the financial or business affairs of any particular person (including the Council)).

## H65. TRAINING OF ADULT SOCIAL CARE WORKFORCE

Consideration of this item was deferred until the next meeting.

(Although this item had originally been included within the open section of this meeting's agenda, Members agreed that it should be moved to the private section of the agenda and considered as an exempt item in accordance with Paragraph 3 of Part I of Schedule 12A to the Local Government Act 1972)

## H66. SETTING IN HOUSE RESIDENTIAL ACCOMMODATION CHARGES 2014-15

Consideration was given to a report presented by Mark Scarrott, Finance Manager (Neighbourhoods and Adult Services) proposing an increase in charges for self-funding residents in In-house Residential Care Homes for 2014/15.

In accordance with its statutory duty, the Council was required to set a maximum charge for residential accommodation it provided in Local Authority homes. It was proposed that the maximum charge for all Local Authority residential care homes be increased by 2.7% in line with the increase in welfare benefits.

In accordance with established practice, all charges were based on estimated cost and occupancy levels so that residents could be advised of

the revised charges as near to the date they became effective as possible.

Resolved:- That increase in the charge for In-house Residential Care Homes, as set out in the report now submitted, be approved with effect from 1 April, 2014.

## H67. FEE SETTING 2014-15 INDEPENDENT SECTOR RESIDENTIAL AND NURSING CARE FOR PEOPLE OVER 65 YEARS

Consideration was given to a report presented by Mark Scarrott, Finance Manager (Neighbourhoods and Adult Services) concerning proposals to increase the fees to the Independent Sector Residential and Nursing Care Providers (People Over 65 Years) for the financial year 2014/15.

There had been open consultation with the Older Persons' Care Home sector around fee setting for 2014/15 and the options available.

The residential care market in Rotherham faced significant financial pressures. The Council was committed to supporting and stabilising provision in order to deliver care and support to the town's most vulnerable older residents.

Resolved:- That a fee increase for Residential and Nursing Care Homes for People Over 65 Years be approved of 1.62% for 2014/15, as set out in the report submitted.

## H68. FEE SETTING 2014-15 COMMUNITY AND HOME CARE SERVICES - INDEPENDENT SECTOR DOMICILIARY CARE

Consideration was given to a report, presented by Mark Scarrott, Finance Manager (Neighbourhoods and Adult Services), proposing an increase in fees to Independent Sector Community and Home Care Services (Domiciliary Care) for 2014/15.

During the financial year 2012/13, the Council had paid the CHCS Framework providers at the tendered value. Providers were invited to submit a competitive hourly rate without any restriction imposed by the Council, unlike other local authorities which invite tenderers to submit applications under or on a capped rate. An inflationary uplift awarded for care purchased in 2013/14 was at 1.57%. The current hourly rates paid to providers remain well below the rates paid two years ago.

Reference was made to the implications of the payment of a living wage to Community and Home care Services employees.

Resolved:- That an inflationary uplift of 1.44% be approved for services commissioned through the Community and Home Care Services (Domiciliary Care) Framework for the financial year 2014/15.

## H69. REVIEW OF NON-RESIDENTIAL SERVICE CHARGES

Consideration was given to a report, presented by Mark Scarrott, Finance Manager (Neighbourhoods and Adult Services), containing proposals for increasing charges for non-residential services for 2014/15.

Charges were reviewed as part of the Council's budget setting exercise for 2013/14 and subsequently increased in line with inflation at 2.5%. The Council could not charge more than the cost of the service, including overheads.

The submitted report included five options for making increases to the charges.

Resolved:- (1) That the report be received and its contents noted.

(2) That option 4, as detailed in the report submitted, be approved and implemented with effect from 1 April 2014, whereby the Domiciliary Care maximum charge is increased to the level of the residential care fee and there is also an increase to the hourly rate by CPI inflation at 2.7%.

(3) That a further report be submitted to a future meeting of the Cabinet Member and Advisers for Adult Social Care in respect of charges for the community alarm service provided by Rothercare.

(Councillor P. A. Russell declared a personal interest in the above item)

**HEALTH AND WELLBEING BOARD**
**22nd January, 2014**

**Present:-**

| | |
|---|---|
| Councillor Ken Wyatt | Cabinet Member, Health and Wellbeing **(in the Chair)** |
| Chris Bain | RDaSH |
| Louise Barnett | Rotherham Foundation Trust |
| Karl Battersby | Strategic Director, Environment and Development Services |
| Tom Cray | Strategic Director, Neighbourhoods and Adult Services |
| Councillor John Doyle | Cabinet Member, Adult Social Care |
| Chris Edwards | Chief Commissioning Officer, Rotherham CCG |
| Jason Harwin | South Yorkshire Police |
| Julie Kitlowski | Rotherham CCG |
| Councillor Paul Lakin | Cabinet Member, Children, Young People and Families Services |
| Dr. David Polkinghorn | Rotherham CCG |
| Joyce Thacker | Strategic Director, Children, Young People and Families |
| Janet Wheatley | Voluntary Action Rotherham |

**Also in attendance:-**

| | |
|---|---|
| Robin Carlisle | Rotherham CCG |
| Kate Green | Policy Officer, RMBC |
| Melanie Hall | Healthwatch Rotherham (rep. Naveen Judah) |
| Pete Hudson | Chief Finance Manager, RMBC |
| Shona McFarlane | Director of Health and Wellbeing, RMBC |
| Phil Morris | Rotherham Local Safeguarding board |
| Joanna Saunders | Department of Public Health (rep. Dr. Radford) |
| Chrissy Wright | Strategic Commissioning Manager, RMBC |

Apologies for absence were submitted by Brian Hughes, Naveen Judah, Martin Kimber and Tracy Holmes.

**S64. MINUTES OF PREVIOUS MEETING AND MATTERS ARISING**

Resolved:- That the minutes be approved as a true record.

Arising from Minute No. S59 (Flu Vaccination Programme), Joanna Saunders reported that there was no further national information. There was a national meeting convened for the following week from which feedback would be received.

Arising from Minute No. 61 (Joint Strategic Needs Assessment), Chrissy Wright gave clarification of the website address. A report would be submitted in due course on uptake.

Janet Wheatley reported that a consultation event was to take place on 27th January at the Unity centre for the voluntary and community sector.

## S65. COMMUNICATIONS

The following were reported:-

(1) Attendance at a meeting of specialist commissioners by Councillor Dalton.

(2) NHS England's Commissioning intentions had been received and would be circulated.

(3) Rotherham was 1 of 6 areas in the country that had successfully secured funding from the local area CCG and the Police and Crime Commissioners for a pilot initiative for mental health patients in custody. There had been some recruitment of staff and there would be mental health practitioners working alongside the Police and Council employees to identify those with possible mental health issues. An update would be submitted in due course.

(4) "Ramp up the Red" – a national Heart Town initiative – would run though the month of February.

## S66. RMBC BUDGET - MEETING THE CHALLENGE

Pete Hudson, Chief Finance Manager, gave the following powerpoint presentation:-

The Financial Challenge
- The scale of financial challenges/risks facing local government was set to continue at least until 2017 (possibly a decade)
- From 2013/14 there had been increased financial risk transferred to local councils through the Local Government Finance and Welfare Reform challenges and restrictions on finances e.g. Council Tax Referenda
- Sustainable medium/long term financial planning was now even more critical

What this meant for Rotherham
- 2010/11 £5M (emergency budget)
- 2011/12 £30M
- 2012/13 £20M
- 2013/14 £20M
- 2014/15 £23M
- 2015/16 £23M (estimate)

Old Budget Principles
- Previous budget principles services the Council well in the past, however, in the context of the Government's Finance and Welfare Reform changes, a new approach was essential to meet future financial challenges:-
  Support Services pared to a minimum

Staff headcount reduced by over 1,000 and management posts reduced by 19%
Lean Council
No longer 'salami slice' services

New Budget Principles
The Council's budget had been developed to:-
- Focus on the things most important to local people
- Help people to help themselves wherever possible
- Provide early support to prevent needs becoming more serious
- Shift scarce resources to areas of greatest need including targeting services and rationing services to a greater extent than at present

What this meant for Rotherham
- Need to create an Investment Fund to focus on delivering Business Growth
- Not doing everything, providing fewer services directly and supporting more people needing help through forging partnerships with other public sector stakeholders, communities, businesses and citizens to help them to do more for themselves
- Using the limited and shrinking resources to tackle the biggest problems for the most needy, focussing on the 11 most deprived areas, accepting some would need to get less or less frequently
- Achieving the best quality, safest, most reliable outcome via the most affordable service delivery method
- Direct provision of service only where the Council was the cheapest/best quality solution to meet the critical needs of its citizens

Rotherham's 2014/15 Budget Challenge
Initial Funding Gap in Medium Term Financial Strategy
£19.1M
- June Spending Round adjustments
  +1.0M
- July Technical Consultation adjustments
  £0.4M

Additional Pressures
- New Government announcements
  +0.7M
  (reduced Housing Benefit grant/reduced Education Support Grant)
- Pensions Triennial Revaluation
  +1.5M
- Undelivered savings target 2013/14
  +0.3M

Revised Funding Gap
£23.0M

Meeting the Challenge: Savings Proposals 2014/15

- Directorate Savings Proposals
  £15.6M
- Central Savings Proposals
  £5.3M
- Revisions to Planning Assumptions
  £2.1M
- Total
  £23.0M

It was noted that the budget proposals were to be considered by Cabinet 5th March, 2014.

Discussion ensued on the presentation with the following comments made:-

- Important for all parties to share their budget proposals to enable collaborative working and achieve maximum impact for the funding available – also to ensure partners did not make budget cuts in the same areas
- Once the full list of all the saving proposals had been compiled Impact Assessments would be worked up to accompany the report to Cabinet to enable Members to be aware of the effect of the savings

Pete was thanked for his presentation.

**S67. RMBC COMMISSIONING INTENTIONS FOR ADULTS AND CHILDREN'S SERVICES**

Chrissy Wright, Strategic Commissioning Manager, gave the following powerpoint presentation:-

The Big Things – Adult Social Care and CYPS
- Early Intervention and Prevention
- Dependence to Independence
- Joint Commissioning and Integration
- Achieving Financial Efficiencies

Alignment with Health and Wellbeing Strategic Priorities
- Priority 1 – Prevention and Early Intervention
- Priority 2 – Expectations and Aspirations
- Priority 3 – Dependence to Independence
- Priority 4 – Healthy Lifestyles
- Priority 5 – Long Term Conditions
- Priority 6 – Poverty

Adult Social Care – Priority Activities
- Early Intervention and Prevention
  Growth of Connect to Support
- Dependence to Independence

Disinvest in residential care placements and invest in community-based services
- Joint Commissioning and Integration
  Better Care Fund identify current joint work and opportunities for a pooled budget with alignment with RCCG
- Achieving Financial Efficiencies
  Delivering the identified savings in the budget matrix

CYPS Social Care – Priority Activities
- Early Intervention and Prevention
  Partnership with Public health on breast feeding and smoking cessation in pregnancy
- Dependence to Independence
  Deliver Support and Aspiration SEND reforms
- Joint Commissioning and Integration
  Building transition into the Better Care Fund programme
- Achieving Financial Efficiencies
  Deliver the strategic transformation intentions e.g. reconfiguration of Children's Centres

Discussion ensued on the presentation with the following comments made:-

- Children's Centres had been a flagship for the previous Government, however, the current Government had not provided funding for them. Due to the critical financial challenges faced by the Council, there was only funding for 1 more year
- Given the support for the 11 most deprived areas, many of which had Children's Centres and were a model of good practice, it was felt that closing them would be disastrous
- Just working in the 11 most deprived areas would not achieve the aims/aspirations across the board

Chrissy was thanked for her presentation.

## S68. ROTHERHAM CCG PLAN 2014/2015

Robin Carlisle, Deputy Chief Officer, Rotherham CCG, presented the CCG's 5 year commissioning plan for endorsement prior to submission to NHS England on 14th February, 2014.

The plan had been developed in discussion with member GP practices, other Rotherham commissioners (RMBC and NHS England) and providers of health services in Rotherham (including TRFT and RDASH) and circulated to stakeholders. Comments received and the requirements of the planning guidance "Everyone Counts" had been incorporated into the draft.

Comments by Board members would be welcomed particularly on the following:-

- 5 year vision
- Plan on a page
- QIPP (Quality, Innovation, Productivity and Prevention) both Provider and System Wide

There was still work required by the February deadline with regard to financial implications, levels of ambition for outcome measures and Rotherham's approach to the Better Care Fund.

Discussion ensued on the document with the following comments made:-

- Important for all Service providers to understand/know the detail of what the implications were for their particular services and the chance to be involved
- Need to sure all the plans being submitted to the various bodies all aligned and did not forget the transformational time required to make the plans happen

Resolved:- (1) That any comments on the plan be submitted to the CCG as a matter of urgency to enable the plan to be submitted to NHS England by the 14th February, 2014, deadline.

(2) That the Council and NHS England, as co-commissioners, confirm that the plan was complementary with their own commissioning plans.

(3) That TRFT and RDASH, as substantial providers of health services within Rotherham, confirm that the financial, activity and strategic vision in the plan triangulated with their 5 year organisational plans.

**S69. BETTER CARE FUND**

Tom Cray, Strategic Director Neighbourhoods and Adult Services, gave the following powerpoint presentation;-

Task Group Terms of Reference
- To work members of the Health and Wellbeing Board to understand and interpret the requirements of the Better Care Fund
- To develop a local jointly agreed vision for integration
- To develop a plan to be signed off by the Health and Wellbeing Board and submitted to NHS England by 14th February
- To do any necessary further work to ensure the plan was adopted and being monitored by April, 2014

We Are Here:-
- The Health and Wellbeing Board has developed good relationships across the new health and care landscape
- Already agreed the joint priorities through the Health and Wellbeing Strategy informed by the JSNA

- The Health and Wellbeing Board have made a commitment to integration through the local Strategy
- Clear links to what needs to be delivered as part of the Better Care Fund
- Better Care Fund Plan would help deliver the Health and Wellbeing Strategy

Definition of Integration

- Adopt the nationally recognised definition of Integration:
  "I can plan my care with people who work together to understand me and my carer(s), allowing me control, and bringing together services to achieve the outcomes important to me" ('National Voices')

Vision

- Overarching vision of Health and Wellbeing Board: To improve health and reduce health inequalities across the whole of Rotherham
- The Better Care Fund would contribute to 4 of the strategic outcomes of the Health and Wellbeing Strategy:
  - Prevention and Early Intervention – Rotherham people will get help early to stay health and increase their independence
  - Expectations and Aspirations – all Rotherham people will have high aspirations for their health and wellbeing and expect good quality services in their community
  - Dependence to Independence – Rotherham people and families will increasingly identify their own needs and choose solutions that are best suited to their personal circumstances
  - Long-term Conditions – Rotherham people will be able to manage long-term conditions so that they are able to enjoy the best quality of life

Measuring Success

- Develop 'I statements' as a common narrative to help us
  - Keep the voice of Rotherham people at the heart
  - Understand what integration feels like for service users/patients/carers
- Based on what people tell us – way of 'making it real'
- Influencing change through people's experiences
- Adopt this as a principle with aim to implement at a later date (drawing on lessons learned from national consultation)

Criteria for Selection of One Local Measure
Must have:-

- A clear, demonstrable link with the Joint Health and Wellbeing Strategy
- Data which was robust and reliable with no major data quality issues (e.g. not subject to small numbers – see "statistical significance" in next section)
- An established, reliable (ideally published) source
- Timely data available, in line with requirements for pay for

performance – this meant that baseline data must be available in 2013-14 and that the data must be collected more frequently than annually
- A numerator and a meaningful denominator available to allow the metric to be produced as a meaningful proportion or a rate
- A challenging locally set plan for achievement
- A metric which created the right incentives

Local Measure (choose 1 from 9 or select own)
- NHS Outcome Framework
  - Proportion of people feeling supported to manage their (long term) condition
  - Diagnosis rate for people with Dementia
  - Proportion of patients with fragility fractures recovering to their previous levels of mobility/walking ability at 120 days
- Adult Social Care Outcomes Framework
  - Social care related quality of life
  - Carer reported quality of life
  - Proportion of adults in contact with secondary, mental health services living independently, with or without support
- Public Health Outcomes Framework
  - Proportion of adult social care users who have as much social contacts as they would like
  - Proportion of adults classified as inactive
  - Injuries due to falls in people aged 65 or over (Persons)

Does the Local Measure meet the Better Care Fund Criteria?

Local Measure – suggested option
- NHS Outcome Framework
  - Possible new local measure
    Health Related Quality of Life for people with long term conditions, Indicator E.A.2 from the "Everyone Counts"
  - Proportion of people feeling supported to manage their (long term) condition

Next Steps
- To have a clear commitment from all partners to provide data and information as and when required
- To agree the local measure for pay-for-performance element
- Joint offer working group (LA/CCG/NHSE) to ensure we are meeting all national conditions
- Consultation with user/patients/providers
- Next Task Group meeting 31st January to look at:-
  - What is currently commissioned that does not improve Better Care Fund measures
  - What needs to be commissioned to meet the Better Care Fund measures and estimated costs
  - First draft of Better Care Fund Plan

Discussion ensued with the following points raised/clarified:-

- The task group comprised of Martin Kimber, Chris Edwards, Julie Kitlowski, Councillor John Doyle, John Radford and Tom Cray
- It was not new money but the funding currently allocated to the Local Authority and the CCG for Services provided to patients and the citizens of Rotherham
- A regional event had shown that Rotherham had made similar levels of progress as others with regard to the submission
- Challenge was to ascertain which Services met the outcomes and then how to prioritise to meet the Services currently commissioned

Tom was thanked for his presentation.

## S70. JOINT PROTOCOL BETWEEN HEALTH AND WELLBEING BOARD AND CHILDREN'S SAFEGUARDING BOARD

Phil Morris, Rotherham Local Safeguarding Children Board (RLSB), submitted a proposed Protocol which outlined and confirmed the functions and responsibilities of Rotherham's key strategic partnerships i.e. the RLSB, the Children, Young People and Families Partnership (CYPFSP) and the Health and Wellbeing Board. It also set out the relationship between them, providing clarity and ensuring that the needs of children and young people in the Borough were identified and addressed at a strategic level:-

- The CYPFSP will formally report to the HWBB on the progress update against the relevant priorities (in line with the Health and Wellbeing Strategy) of both the CYPFSP and the key milestones and targets within the Children and Young People's Commissioning Plan

- The RLSCB will submit its Annual Report of the Health and Wellbeing Board

- The Health and Wellbeing Board will ensure that:
  The Joint Strategic Needs Assessment takes account of key areas for vulnerable children identified via the RLSCB Annual Report and the CYPFSP key priorities. The Director of Public Health had specific responsibility for this

- The Health and Wellbeing Board may also request that the CYPFSP and/or the RLSCB to consider issues for development, action or scrutiny

Resolved:- That the Protocol be approved and be put into operation with immediate effect.

## S71. DATE OF NEXT MEETING

Resolved:- That a Special meeting of the Health and Wellbeing Board be held on Tuesday, 11th February, 2014, commencing at 9.30 a.m. in the Rotherham Town Hall.

**ROTHERHAM BOROUGH COUNCIL – REPORT TO MEMBERS**

| | | |
|---|---|---|
| **1** | **Meeting:** | **Cabinet Member for Adult Social Care** |
| **2** | **Date:** | **Monday 17th February 2014** |
| **3** | **Title:** | **Adult Services Revenue Budget Monitoring Report 2013/14** |
| **4** | **Directorate :** | **Neighbourhoods and Adult Social Services** |

## 5 Summary

This Budget Monitoring Report provides a financial forecast for the Adult Services Department within the Neighbourhoods and Adult Services Directorate to the end of March 2014 based on actual income and expenditure for the period ending December 2013.

The latest forecast for the financial year 2013/14 is an overall overspend of £1.083m, against an approved net revenue budget of £72.809m, a further reduction in the overspend of £121k since the last report. However, compensatory forecast underspends within the remaining NAS Directorate is reducing the overall forecast overspend to £379k. The main budget pressure areas relate to the delayed implementation of a number of budget savings including continuing health care funding and the review of in-house residential care.
Management actions continue to be developed by budget managers to bring the forecast overspend in line with the approved cash limited budget.

## 6 Recommendations

**That the Cabinet Member receives and notes the latest financial projection against budget for 2013/14.**

## 7 Proposals and Details

### 7.1 The Current Position

The approved net revenue budget for Adult Services for 2013/14 is £72.809m. The approved budget included additional funding for demographic and some existing budget pressures (£0.949m) together with a number of savings (£7.186m) identified through the 2013/14 budget setting process.

7.1.1 The table below summarises the latest forecast outturn against approved budgets:-

| Nov Variation | Division of Service | Net Budget | Forecast Outturn | Variation | Variation |
|---|---|---|---|---|---|
| £000 | | £000 | £000 | £000 | % |
| -67 | Adults General | 1,783 | 1,717 | -66 | -3.70 |
| +885 | Older People | 29,455 | 30,215 | +760 | +2.58 |
| +265 | Learning Disabilities | 23,527 | 23,776 | +249 | +1.06 |
| -239 | Mental Health | 5,004 | 4,796 | -208 | -4.16 |
| +433 | Physical & Sensory Disabilities | 5,270 | 5,689 | +419 | +7.95 |
| +14 | Safeguarding | 729 | 744 | +15 | +2.06 |
| -86 | Supporting People | 7,041 | 6,955 | -86 | -1.22 |
| | | | | | |
| **+1,205** | **Total Adult Services** | **72,809** | **73,892** | **+1,083** | **+1.49** |

7.1.2 The latest year end forecast shows there are a number of underlying budget pressures mainly in respect of an increase in demand for Direct Payments across all client groups plus pressures on external transport provision within Learning Disability services, increased demand in year for independent sector residential and home care and delayed implementation on budget savings within in house residential care and additional continuing health care contributions. These pressures are being reduced by a number of forecast non recurrent under spends and management actions to enable spend to be contained within the approved budget by the end of the financial year.

The main variations against approved budget for each service area can be summarised as follows:

**Adults General (-£66k)**

This area includes the cross cutting budgets (Workforce planning and training, and corporate charges) are forecasting an overall under spend based on estimated charges including savings on training budgets.

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**Older People (+£760k)**

- Overspend on In-House Residential Care due to delays on implementation of budget savings target due to extended consultation (+£311k) and recurrent budget pressure on residential care income (+£51k).
- Recurrent budget pressure in Direct Payments over budget (+£581k). However, client numbers have reduced (-23) since April together with a reduction in the average cost of packages.
- Under spend on In House Transport (-£40k) due to forecast additional income.
- Forecast under spend on Enabling Care and sitting service (-£280k) based on current level of service. However, there is an over spend on Independent sector home care (+£668k), which has experienced an increase in demand since April (+27 clients).
- An over spend on independent residential and nursing care (+£780k) due to an additional 73 clients receiving a service than forecast. Additional income from property charges is reducing the overall overspend.
- Forecast under spend in respect of Community Mental Health budgets due to planned delay's in developing dementia services in order to reduce the overall Directorate overspend (-£249k).
- Under spend on carers services due to vacancies and reduced take up in carers breaks (-£183k).
- Planned delay's on recruitment to vacant posts within Assessment & Care Management and Community Support plus additional income from Health (-£615k).
- Forecast saving on in-house day care (-£88k) due to vacant posts and the moratorium on non-pay budgets.
- Overall under spend on Rothercare (-£132k) due to slippage in service review including options for replacement of alarms together with additional income.
- Other minor under spends in other non pay budgets due to the moratorium on non-essential spend (-£44k).

**Learning Disabilities (+£249k)**

- Independent sector residential care budgets now forecasting a slight underspend due to a reduction in placements (-£35k). Work is ongoing regarding CHC applications and an internal review of all high cost placements.
- Forecast overspend on Day Care (+£177k) due to a delay on the implementation of day care review including increase in fees and charges, plus recurrent budget pressure on the provision of external transport.

- Overspend in independent sector home care (+£94k) due to increase in demand for the service.
- High cost placements in independent day care is resulting in a forecast overspend of +£85k. Pressure reduced due to additional CHC funding and one client moving out of the area.
- High cost community support placements is resulting in a forecast overspend of £37k.
- A delay in developing Supported Living schemes plus additional funding from health is resulting in a forecast under spend (-£15k).
- Efficiency savings on SLA's for advice and information and client support services (-£63k).
- Lower than expected increase in demand for direct payments (-£25k).
- Additional staffing costs and essential repairs with In house Residential care offset by planned delays in recruiting to vacant posts within Assessment & Care Management (-£6k).

**Mental Health (-£208k)**

- Projected over spend on residential care budget (+£77k) due to slippage on budget savings target plan to move clients into community support services. This pressure is offset by an under spend in community support budget (-£367k).
- Budget pressure on Direct Payments (+£25k), additional income recovery is reducing the overall pressure on budget.
- Overspends on employees budgets due to lower than expected staff turnover, additional overtime and agency cover (+£57k).

**Physical & Sensory Disabilities (+£419k)**

- Continued Pressure on Independent Sector domiciliary care (+£218k) due to a continued increase in demand for service.
- Further increase in demand for Direct Payments (+ 10 clients), forecast overspend (+£681k).
- Under spend on community support (-£52k) as clients move to a direct payment.
- Forecast under spend on Residential and Nursing care due to planned slippage in developing alternatives to respite provision (-£294k).
- Reduction in contract with independent sector day care provider (-£73k).
- Under spend on equipment and minor adaptations budgets (-£35k).
- Forecast efficiency savings on contracts with Voluntary Sector providers and higher than forecast staff turnover (-£26k).

**Safeguarding (+£15k)**

- Over spend due to lower than expected staff turnover and use of agency support.

**Supporting People (-£86k)**

- Efficiency savings on subsidy contracts have already been identified against budget.

### 7.1.3 Agency and Consultancy

Actual spend on agency costs to end December 2013 was £263,206 (no off contract), this is an increase compared with actual expenditure of £251,010 (no off contract) for the same period last financial year. The main areas of spend are within Assessment & Care Management Teams, residential care and safeguarding to cover front line vacancies and sickness.

There has been no expenditure on consultancy to-date.

### 7.1.4 Non contractual Overtime

Actual expenditure in respect of non contractual overtime to the end of December 2013 was £300,655 compared with £290,284 for the same period last year.

The actual costs of both Agency and non contractual overtime are included within the financial forecasts.

### 7.2 Current Action

To mitigate any further financial pressures within the service, budget meetings and budget clinics are held with Service Directors and managers on a regular basis to monitor financial performance and further examine significant variations against the approved budget to ensure expenditure remains within the cash limited budget by the end of the financial year.

## 8. Finance

Finance details including main reasons for variance from budget are included in section 7 above.

## 9. Risks and Uncertainties

Careful scrutiny of expenditure and income and close budget monitoring remains essential to ensure equity of service provision for adults across the Borough within existing budgets particularly where the demand and spend is difficult to predict in such a volatile social care market.
One potential risk is the future number and cost of transitional placements from children's services into Learning Disability services.
In addition, any future reductions in continuing health care funding would have a significant impact on residential and domiciliary care budgets across Adult Social Care.

Regional Benchmarking within the Yorkshire and Humberside region for the final quarter of 2012/13 shows that Rotherham remains below average on spend per head in respect of continuing health care (10th out of 15 Authorities).

## 10. Policy and Performance Agenda Implications

The delivery of Adult Services within its approved cash limit is vital to achieving the objectives of the Council and the CSCI Outcomes Framework for Performance Assessment of Adult Social Care. Financial performance is also a key element within the assessment of the Council's overall performance.

## 11. Background Papers and Consultation

- Report to Cabinet on 20 February 2013 –Proposed Revenue Budget and Council Tax for 2013/14.
- The Council's Medium Term Financial Strategy (MTFS) 2011-2014.

This report has been discussed with the Strategic Director of Neighbourhoods and Adult Services, the Director of Health and Well Being and the Director of Financial Services.

**Contact Name:** Mark Scarrott – Finance Manager (Neighbourhoods and Adult Services)*, Financial Services x 22007, email Mark.Scarrott@rotherham.gov.uk.*

**ROTHERHAM BOROUGH COUNCIL – REPORT TO MEMBERS**

| | | |
|---|---|---|
| **1** | **Meeting:** | **Cabinet Member for Adult Social Care** |
| **2** | **Date:** | **17th February 2014** |
| **3** | **Title:** | **Debt Management and Recovery Policy for Adult Social Care Debt** |
| **4** | **Directorate:** | **Neighbourhoods and Adult Services** |

**5. Summary**

5.1. To seek approval of the Debt Management and Recovery Policy for Adult Social Care Debt.

5.2. The Policy provides a high level policy for how debt will be pursued and ensures staff and customers are clear how we take a fair and firm approach to recovery of money owed to the council for the provision of adult social care services.

**6 Recommendations**

6.1 **Members are requested to receive this report and approve the Debt Management and Recovery Policy for Adult Social Care Debt.**

## 7 Proposals and Details

7.1 The Council charges customers for a range of adult social care services in accordance with statutory requirements and local charging policy:

7.2 Whilst the majority of income due is paid on time, the council has a duty to ensure that all revenue owed to the council is collected promptly and effectively for the benefit of all Council Tax payers.

7.3 At present the Council does not have any overarching policy framework for the management of adult social care debt.

7.4 The policy sets out to formalise best practice and includes guidance to ensure that we have a transparent, consistent and proportionate approach to the recovery of money owed to the council having due regard to minimising arrears whilst not causing undue hardship or consequences to the customer as a result.

7.5 The Key Aims of the policy are to:

7.5.1 Collection of all money due; quickly and economically taking into account the financial circumstances and mental capacity of the customer.

7.5.2 Prevention of debt and arrears; by prompt notification of charges, billing and collection of money due and affordable repayment plans and early intervention when a customer is in arrears.

7.5.3 Ensuring that principles protecting the rights of vulnerable customers underpin all actions and that where there are issues of financial mismanagement or exploitation, appropriate investigations are carried out under the Council's Safeguarding Policy.

7.5.4 Provision of a legal framework to enable legal enforcement (where necessary and appropriate) to recover debts.

7.5.5 Compliance with the Council's Financial Regulations and Standing Orders

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## 8 Finance

8.1 A debt collection policy for adult social care charges will provide the framework for the council to collect debts owed to it and should contribute to increasing income for the council**.**

## 9 Risks and Uncertainties

9.1 Adoption of the policy will mitigate the risk of non-recovery of current and new adult social care debts by ensuring that there is a common understanding of our approach to debt collection.

9.2 This is a sensitive area dealing with a most vulnerable section of society in a highly legislated area of work. Inconsistent application of Council policy may lead to poor levels of service and place the Council open to challenge by judicial review

**10 Policy and Performance Agenda Implications**

10.1 No Implications

**11 Background Papers and Consultation**

11.1 Debt Management and Recovery Policy for Adult Social Care Debt

**Contact Name;** Gillian Buckley Operational Manager Revenue and Payments ext 34019 e.mail gillian.buckley@rotherham.gov.uk

Rotherham Metropolitan Borough Council
Where Everyone Matters

# Debt Management and Recovery Policy for Adult Social Care Debt

Rotherham Metropolitan Borough Council
Riverside House
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Author: Gillian Buckley
Approved by: Robert Cutts
Date & Issue: Issue 1, Draft 6, 15th January 2014

# Confidentiality Statement

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They are all hereby acknowledged.

## Approvers

| Name | Date |
|---|---|
| Robert Cutts | |
| Gillian Buckley | |

## Distribution

| Name | Location |
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| Stuart Booth | Riverside House |
| Shona McFarlane | Riverside House |
| Mark Scarrott | Riverside House |
| Legal Services | Riverside House |
| Financial Services Audit | Riverside House |
| Revenue and Payments Staff | Riverside House |

## Table of Contents

# 1 Introduction

## 1.1 Objectives and Scope

The purpose of this document is to set out consistent and effective processes for the collection, recovery and enforcement of Adult Social Care charges owed to RMBC.

Effective financial management is fundamental to being able to fund the quality of services the Council provides. The best method of debt collection is the prevention of debt arising and this policy covers both prevention and recovery.

Key principles of the Policy:

1. Collection of all money due; quickly, efficiently and economically taking into account the financial circumstances and mental capacity of the customer.
2. Prevention of debt and arrears; by prompt notification of charges, billing and collection of money due and affordable repayment plans and early intervention when a customer is in arrears.
3. Ensuring that principles protecting the rights of vulnerable customers underpin all actions and that where there are issues of financial mismanagement or exploitation, appropriate investigations are carried out under the Council's Safeguarding Policy.
4. Provision of a legal framework to enable legal enforcement (where necessary and appropriate) to recover debts.
5. Compliance with the Council's Financial Regulations and Standing Orders

## 1.2 Considerations

This document should read in conjunction with the Councils Financial Regulations and the Corporate Debt Policy. It is also supported by operational procedures for staff within the Revenue and Payments Service.

# 2 Legal and Policy Framework

This policy provides a framework to enable legal enforcement to be undertaken to recover debts where appropriate.

The method of recovery of money owed depends on whether the care services are provided in the community or in a residential care home. For care services which are provided in the community, the Fairer Charging Guidance is applied and for residential care, the Charging for Residential Accommodation Guide (CRAG) is used.

The main powers and duties for local authorities to charge for Social Care services are described in the following acts of legislation:

- Part 3 National Assistance Act 1948
- Section 17 of the Health and Social Services and Social Security Adjudications Act 1983 (HASSASSA)
- The National Assistance (Assessment of Resources) Regulations 1992

Powers to make reasonable charges for non residential services are included in the following accts of legislation:

- Welfare Services for Disabled Persons (section 29 of National Assistance Act 1948);
- Section 2 of the Chronically Sick and Disabled Persons Act; and
- Service for Older People (section 45 Health Services and Public Health Act 1968)

CRAG and the Fairer Charging Guidance provide statutory guidance to local authorities on how to interpret the regulations on charging for residential and non-residential care and support set out in the legislation.

Failure to pay cannot be the grounds for the termination of a service (Section 17 HASSASSA 1983); charges are recoverable as civil debt.

The draft Care Bill which was published on 11 July 2012 proposes to replace the above legal framework for adult care and support, which are deemed as outdated, with a single new law.

The Care Bill has completed all the parliamentary stages in the House of Lords but still has to complete all the stages in the House of Commons, and then receive royal assent before becoming an Act of Parliament (law).

# 3 Financial Assessment

As part of the Council's social care assessment to determine if there is a need for social care services to be provided, the Council will undertake a financial assessment. This financial assessment will determine how much the customer is required to contribute towards the cost of their social care services.

The Council will provide support through the assessment process and will need a full financial disclosure from the customer to undertake this assessment.

The financial assessment process for customers in residential care is conducted in accordance with CRAG.

The financial assessment process for customer using non residential care services is conducted using Fairer Charging Guidance.

## 3.1 Independent Sector Providers of Residential Care

Rotherham Metropolitan Borough Council is an in house provider of residential care. It also purchases residential and nursing care services from the independent sector. Under contractual arrangements, the council pays for the cost of the residential and nursing care services net of the customer's assessed charge and requires the Service Provider to collect the customer's assessed charge directly from the customer.

If there are arrears of a customer's charge, the service provider will commence the debt recovery process and are required to notify the Council within 6 weeks of the date of invoice.

Where the service provider meets their contractual requirement to undertake prescribed recovery steps and they prove unsuccessful, the Council will underwrite the debt to the service provider and commence the legal proceedings to recover the debt.

## 3.2 Residential Care Property Deferred Payment Scheme

For customers who are entering residential care (assessed in accordance with CRAG) their property will be considered as part of the financial assessment process. The treatment of property owned by the customer receiving care will depend on whether the customer is a legal or a beneficial owner. Where ownership is disputed, written evidence to prove ownership via the customer and Land Registry will be obtained and considered as part of this decision.

The Council will determine the value of the property at the time of the social care assessment. This will include asking the customer and making an assessment of the value of similar properties nearby. Where the value is disputed or there is doubt as to the value, the Council will arrange for a professional valuation to support the assessment.

In most circumstances, the Council will consider a Deferred Payment Scheme. Under this scheme the customer is not required to immediately sell the property they own or have a financial interest in. The Council will require a signed legal agreement that allows the Council to place a legal charge on the property and defer that part of their assessment relating to the value of their property until the property is sold. Once the agreement has been signed, a Charge will be placed on their property under Section 55 of Health and Social Care Act.

The Charge will show up in future land searches and providing that the outstanding care fees will are paid from the proceeds of the house sale; the Councils Solicitor will remove the Charge on the property.

## 3.3 Residential Care Third Party Top Ups

If a customer chooses a residential care provider that is more expensive than those rates set by the Council, then the customer's representative (third party) can pay the difference in the amounts. This is also known as Third Party Top Up Fee.

Customers are not permitted to pay their own Third Party Top Up. Instead their representative (third party) would enter into a legal agreement with the Council. This states that they are responsible to pay the top up fees and that any debts may be recovered from them through legal action. As part of this process, the Council will seek assurance that the third party has the means to make the payments and that they are fully aware of their responsibilities and the potential consequences of non-payment. The Council will not agree to any Third Party Top Up arrangement unless the legal agreement has been signed and agreed.

If there are arrears on a third party account, the Council will commence the legal debt recovery process. The Council may choose to terminate the agreement and reassess the accommodation with a view to moving the customer to a less expensive placement that where possible would be within the rates set by the Council.

Third Party agreements will be reviewed every year as part of the annual care review process.

# 4 Principles of Collection, Recovery and Enforcement

The intention of the Revenues and Payments Service is to maintain a “firm but fair” approach to the collection and recovery of Social Care Charges.

We will financially assess a customer in a timely manner to ensure customers are aware of how much they have to pay and when.

We will ensure that every individual undergoing a financial assessment under fairer charging is provided with written information on maximising entitlements to benefits.

We will issue prompt and accurate bills ensuring the correct calculated assessed charge is used.

We will make the payment of social care charges as easy and convenient as possible by prompting a wide range of payment methods including our preference of Direct Debit.

We will give our customers a variety of options to contact us to discuss payment of their accounts:

- By telephone to the dedicated Revenue and Payments lines
- By email, in writing or through web forms on our web site
- Face to face through at Riverside House

We will process changes to charges in a timely manner in order to ensure customer’s accounts are as up to date as possible.

We will inform customers who fall 28 days behind with their charges or payment arrangements, of the need to bring their payments up to date.

We will try to engage with the customer at every opportunity during the recovery process in order to discuss and make a suitable repayment arrangement and to avoid further recovery action. This includes clearly warning customers about further recovery actions that may happen and the additional costs and charges they may incur if they do not come to an earlier payment arrangement.

We will try to collect all debts owed where they are legally collectable, irrespective of age, in order that we can maximise revenue to the Authority to be fair to all those tax payers who have paid their liabilities.

We will review the appropriateness of each recovery option based on what we know about the customer’s circumstances, their ability to pay, their past payment history, their mental capacity or any other physical health or age related limitations and the requirement to recover outstanding monies in a timely and efficient manner.

We shall take special care in pursuing debts relating to particularly vulnerable customers. When pursuing debts relating to particularly vulnerable customers we shall seek to involve a responsible third party who can act for the customer in the customer’s best interests, and check the customer consents to the arrangements.

Where appropriate, we will direct the customer to sources of debt and benefits advice.

We will regularly review accounts which are in arrears to ensure that they are subject to ongoing recovery and enforcement action.

We have a complaints procedure to enable customers to challenge us where they believe we have not acted fairly or lawfully.

We regularly review our policies and procedures. This document is reviewed annually.

# 5 Invoicing and Payment Options

## 5.1 Non Residential Care

The Revenue and Payment Service is responsible for despatching invoices for non residential care throughout the year.

Invoices for weekly charges of £20.00 or more are issued on a 4 weekly basis; invoices for weekly charges of less than £20.00 per week are issued on a quarterly basis. All invoices should be issued within 4 weeks of the service period end date (this timescale is restricted by allowing for collection and administration of service provision data from independent sector providers).

All invoices are due for immediate payment upon issue.

Direct Debit is the most efficient and preferred method of payment for the Authority and is promoted at every opportunity. It also assists customers to avoid missing payments and being subject to recovery action. Direct Debits are collected every 4 weeks and are collected 12 days after the service period end date.

Other payment options include paying online, paying by telephone, paying by post, paying in person at one of the Customer Service Centres, or paying by swipecard at a Post Office.

## 5.2 In House Residential Care

The Revenue and Payments Service is responsible for despatching residential care invoices throughout the year.

Residential care invoices are issued on a 4 weekly basis and should be issued within 2 weeks of the service period end date.

All invoices are due for immediate payment upon issue.

Direct Debit is not currently offered for residential care due to the limitations of the existing IT solution but other payment options are available including paying over the telephone, paying by post, by standing order and paying in person/at a kiosk at one of the Customer Service Centres/district offices.

## 5.3 Independent Sector Residential Care

The authority requests independent sector providers of residential care to collect the charges on its behalf as part of the terms and conditions of the contract between the provider and the authority.

Providers are required to issue monthly invoices and to inform the authority should those charges remain unpaid 6 weeks following the date of the invoice.

The provider is also required to take reasonable steps to recover unpaid charges, including the issuing reminders

# 6 Recovery Action for Unpaid Invoices

The Revenue and Payment service has a timetable for recovery action which is set with the aim of ensuring that income is maximised to enable the Authority to provide services to the public of Rotherham.

If an invoice isn't paid within 28 days of issue, telephone contact with the customer may commence and continue for as long as considered appropriate, in addition a reminder letter will be sent. The reminder letter provides the customer with a further 28 days in which to bring the account up to date by paying the overdue balance.

If customer brings their payments up to date within 28 days following the issue of a reminder letter or no further action is taken.

If a payment arrangement is made providing that payment of the arrangement is maintained then no further recovery action is taken.

If the account remains unpaid 28 days after issue of the reminder letter, the second written communication is issued.

Arrangements may be made for a visiting officer to call to see the customer to agree a resolution to the arrears situation.

Should the account remain unpaid after a further 14 days the third written communication is issued.

Should the account remain unpaid after a further 14 days the Revenues and Payments service will liaise with the Council's Legal Department. The Legal Department will write to the customer explaining that legal proceedings are pending, the associated costs and the action that is required to avoid such proceedings.

## 6.1 Arrangement for Payment

When agreeing an arrangement for payment we will always ask that the customer pays an amount equal to their current weekly charge, plus an affordable amount in respect of any arrears. This ensures that the customer is able to maintain their payments and prevent the overall debt from increasing.

Where this is not possible due to a recent change, a temporary arrangement will be made with an appropriate date for its review.

When making the arrangement we will:

- Have proper consideration for a customer's circumstances.
- Where we feel an offer of payment is too low we will provide clear reasons why we are rejecting the offer and indicate an amount that we believe is reasonable.
- Where appropriate, allow time for benefits and debt advice through referral to advice agencies, or if the agency informs us that the customer is receiving advice from them.
- Accept that, in some exceptional circumstances, no payment scheme is affordable and a temporary deferral of payment can be agreed.
- Respect and protect customer's rights at every stage of the recovery process.
- Recognise where the customer has other priority debts (e.g. rent arrears or utility debts), or debts owed to other Council departments, and ensure that a fair balance is reached between claims.

- Make allowances for poorly organised customers.

We will always try to resolve debt problems at the earliest opportunity, without letting them get out of control by advising customers, or taking appropriate action, as soon as possible after an arrangement payment is missed.

## 6.2 Referral to Safeguarding Adults Team

In some arrears cases, concerns may arise that the individual acting as financial agent and responsible for paying the charges on behalf of the customer is not administering the finances appropriately, in cases such as this it will be appropriate to refer the case to Safeguarding Adults Team as potential financial abuse.

Each arrears case will be considered on an individual basis before a referral is made; only when it has been clearly established that the financial agent has the ability to pay, but is refusing to co-operate with all our attempts to enforce this will a referral be made.

An arrears visit will always be undertaken as part of this process to establish if there is a clear intention to avoid paying the charges and other factors such as whether any payments have been made, if the personal expenses allowance is being paid to the customer, and the level co-operation/communication from the Financial Agent will also influence the decision.

## 6.3 Welfare Benefit Appointeeship (Residential Care Only)

Where a customer is in residential care and an appointee is responsible for administering the welfare benefits on their behalf and using them to pay their accommodation charges, should they fail to undertake this duty, this will be reported back to the Pension Service/DWP with a request for benefits to be suspended whilst the appointeeship is reviewed to find a more suitable recipient.

The authority will take this action with the intention to limit the scale of the arrears and protect the customer's best interests.

## 6.4 Gift of an Asset under HASSASSA 1983

The Council will make full use of its enforcement powers under Section 21 of the Health and Social Services and Social Security Adjudication Act 1983. If a customer gifts an asset within six months before service commenced, with the intention of avoiding charges for accommodation, the recipient of the gift becomes liable for the social care charges

## 6.5 Charge on a Property under HASSASSA 1983 (Residential Care Only)

Where a customer is admitted to permanent residential care, and they fail to pay their assessed charge and the customer has a beneficial interest in a property, Section 22 of the Health and Social Services and Social Security Adjudication Act 1983 gives the Council the power to place a charge on the property to secure the debt.

The debt then has to be discharged upon sale of the property, subject to the sale value and any higher legal charges present.

The Council will make full use of these enforcement powers where available to secure the repayment of the debt.

Under exceptional circumstances, the authority may consider taking possession of the property and forcing its sale to discharge the debt. Any decision to force sale of a property has to be approved by the Director of Health and Wellbeing.

## 6.6 Absconders

Sometimes a customer may leave the area or residential care with debt still owing and without providing a forwarding address. These are sometimes referred to as ‘Gone Away’ or ‘absconders’.

We may be able to trace the customer through our internal systems. If we are unable to locate the customer using in-house information, we will use a data credit company or collection agent services.

# 7 Legal Proceedings through the County Court

## 7.1 Decision to Commence Legal Proceedings

A County Court Judgement gives the Authority the various powers of recovery,

The Authority will choose the appropriate recovery option based on what we know about the customer's circumstances, their ability to pay, their past payment history, their capacity to litigate, any physical health or age related limitations and the requirement to recover outstanding monies in a timely and efficient manner.

The decision to commence legal proceedings for recovery of an unpaid debt will be approved by the Director of Health and Well Being. Where approval is declined, the debt will be submitted for write off.

## 7.2 Mental Capacity Act 2005

Where a decision is made to commence legal proceedings, consideration should be given to whether the customer has mental capacity for litigation purposes. The Mental Capacity Act provides a framework for assessing a persons' mental capacity and determining their best interests if they lack capacity to make a decision.

Where a customer lacks mental capacity to conduct or defend the litigation on their own behalf then an application should be made to the court to appoint a litigation friend.

It is the duty of a litigation friend fairly and competently to conduct proceedings on behalf of a protected party. The litigation friend must have no interest in the proceedings adverse to that of the protected party and all steps and decisions the litigation friend takes in the proceedings must be taken for the benefit of the protected party

## 7.3 Issue of County Court Claim

The court will issue a claim form with details of the claim to the customer who has a set period of time to respond; this is their opportunity to explain the situation to the court.

The customer can accept that they owe the debt and they will receive an admission form with the claim form, asking about their income and outgoings. On the form they can make an offer to repay the debt in instalments.

The customer can dispute that they owe the debt and can complete a defence.

If the customer does not respond or if the court agrees that the customer owes the debt then the court will issue an order to pay the debt.

Once a county court judgement has been obtained a notice will be sent to the customer, where no payment arrangement has been agreed, together with an income details form requesting they supply details of their income and expenditure. The notice also contains details of what action may be taken if payment, or an arrangement for payment, is not made.

If the customer doesn't make an offer on the form, or if they make an offer that both we and court do not agree with, or if they do not make the offer in the required timescale, then the court may order the customer to either:

- pay the full amount in one lump sum
- pay the debt back in set monthly payments

Records of judgments are kept for 6 years unless the customer pays the full amount within a month.

## 7.4 Enforcement Options

Once a county court judgement has been issued, there are various options open to us to enforce repayment:

Approval will be sought from the Director of Health and Wellbeing prior to any enforcement action commencing.

### 7.4.1 Warrant of Execution leading to Bailiff Action

We can ask the court to use bailiffs to collect the money.

The bailiff will ask for payment within 7 days.

If the debt isn't paid, the bailiff will visit the customer's home or business, to see if anything could be sold to pay the debt.

### 7.4.2 Attachments of Earnings

We can ask the court for an attachment of earnings order which is a method by which money will be stopped from a customer's wages to pay a debt.

An attachment of Earnings will only help if the defendant is in paid employment, due to this it will not always be an appropriate method for enforcing recovery action for debts for Adult Social Care.

### 7.4.3 Bankruptcy

We can petition to the court for a bankruptcy order, in order that the customer's assets can be used to pay their debts.

Bankruptcy may only be an appropriate method for enforcing recovery action for Adult Social Care in exceptional circumstances.

### 7.4.4 Third Party Debt Order to Freeze Assets/Bank Accounts

We can ask the court to freeze money in the customer's bank or building society account (or in a business account).

The court will decide if money from the account can be used to pay the debt.

### 7.4.5 Charging Order on a customer's Land or Property

We can ask the court to charge the customer's land or property.

If the land or property is sold, they must pay this charge before they get their money.

# 8 Write Off

We have an agreed procedure for writing off social care charges, provided the relevant criteria are met.

We will only consider writing off debts where they are deemed to be uncollectable, e.g. in circumstances where we are unable to trace the customer, where they have passed away (although we will normally look to collect any outstanding amounts from the deceased's estate), if it is considered uneconomical to pursue the debt further or where the Director of Health and Well Being has decided that legal action is not appropriate.

The age of the debt is not usually a reason itself to consider write off.

# 9 Assistance to Customers

We recognise that some people do not pay their social care charges because of genuine financial or other difficulties. Although we take a 'firm but fair' approach to recovery and enforcement, it is our policy also to offer help and support to all customers who are experiencing difficulties paying at every stage of the collection and recovery process.

Although we have a duty to collect all social care charges we also recognise that some customers will have financial and other difficulties that are not limited to paying social care charges. Wherever possible, therefore, we will try to achieve a long term solution, rather than just recovering money that is owed now, so that the customer is better able to manage their finances in the future, and meet their future liabilities.

We recognise that some customers experience genuine hardship because of financial problems. It is our intention, wherever possible, not to add to that hardship through collection and recovery (recognising that customers do have to pay what they are liable for), but to provide the customer with help and support to resolve their finances.

We will particularly try to help and support customers in the following key ways:

- We will offer a range of payment dates and payment methods to enable customers to be able to easier maintain payments.
- We will always try to resolve debt problems at the earliest opportunity, without letting them get out of control, by advising customers as soon as possible that charges are overdue.
- We will sign post customers towards relevant assistance, including advice agencies.
- When agreeing an arrangement for payment we will always ask that the customer pays an amount equal to their current weekly charge, plus an affordable amount in respect of any arrears. This ensures that the customer is able to maintain their payments and prevent the overall debt from increasing. Where this is not possible due to a recent change, a temporary arrangement will be made with an appropriate date for its review.
- We will provide time for benefits and debt advice through referral to advice agencies, or if the agency informs us that the customer is receiving advice from them.
- We will have proper consideration for a customer's circumstances and financial situation, including other priority debts, when taking recovery action and making arrangements for payment.
- Where we feel an offer of payment is too low we will provide clear reasons why we are rejecting the offer and indicate an amount that we believe is reasonable.
- We will respect and protect customer's rights at every stage of the recovery process.
- We accept that in some exceptional circumstances, no payment scheme is affordable.
- We will advise customers of their possible entitlement to any benefits, discounts or exemptions.
- We also work as co-operatively as possible with advice agencies. For example, wherever possible and appropriate, at the request of an advice agency we will agree to put a hold on any recovery action for an agreed period to enable the customer to receive specialist advice which will help them make a sustainable payment arrangement with us.

# 10 Glossary of Terms

| Abbreviation | Explanation |
|---|---|
| CRAG | Charging for Residential Accommodation Guide |
| HASSASSA | Health and Social Services and Social Security Adjudication Act 1983 |
| DWP | Department for Work and Pensions |
| RMBC | Rotherham Metropolitan Borough Council |

# 11 Reference Documents

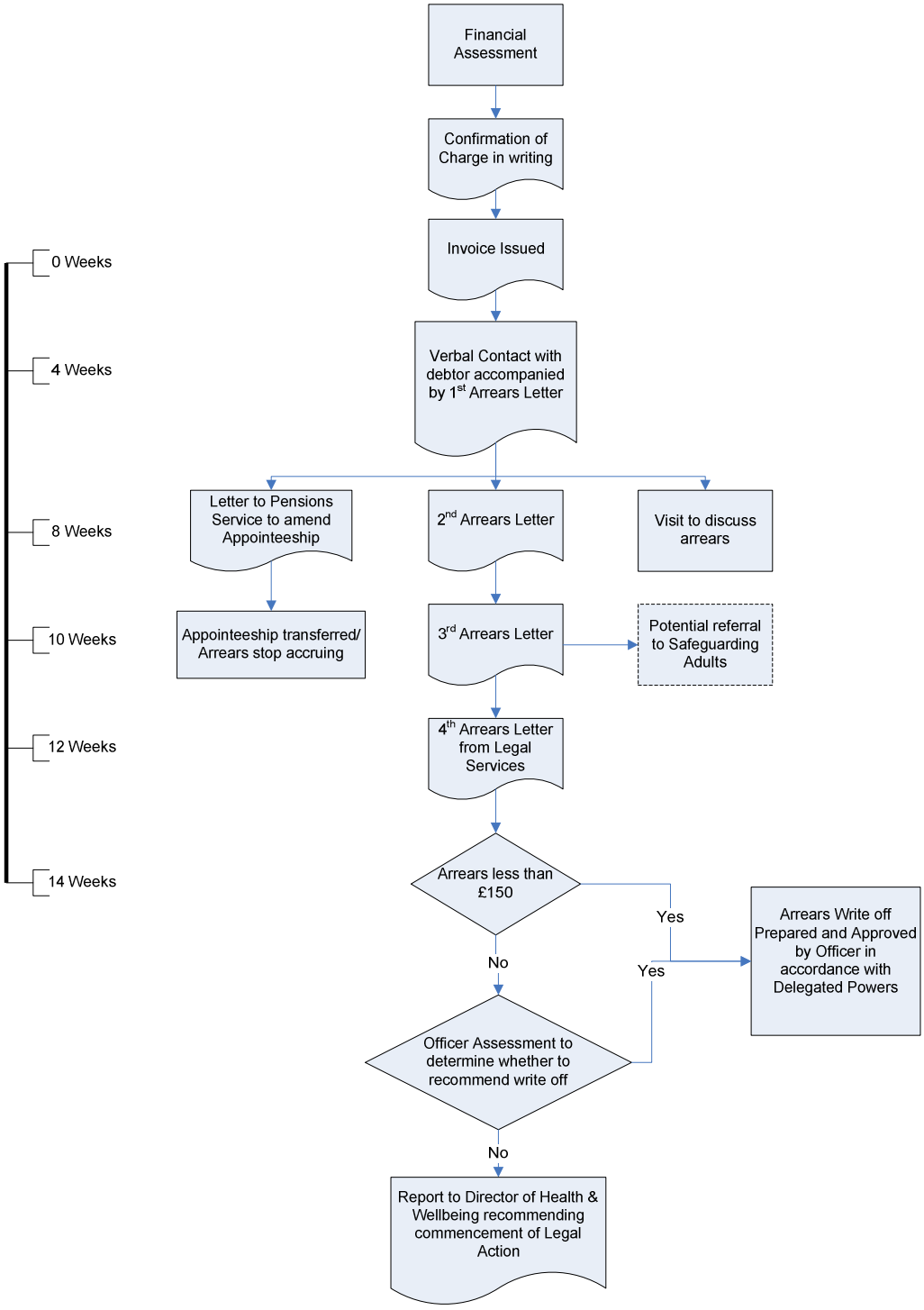
| Ref. No. | Document Title | Document Ref. |
|---|---|---|
| 1 | RMBC – Financial Regulations | http://intranet.rotherhamconnect.com/C9/C13/Key%20 |
| 2 | RMBC – Corporate Debt Policy | Financial information downloads - Rotherham Metropolitan Borough Council |
| 3 | OFT – Guidance for Businesses Engaged in the Recovery of Consumer Credit Debts. | http://www.oft.gov.uk/about-the-oft/legal-powers/legal/cca/debt-collection |

# 12 Change History

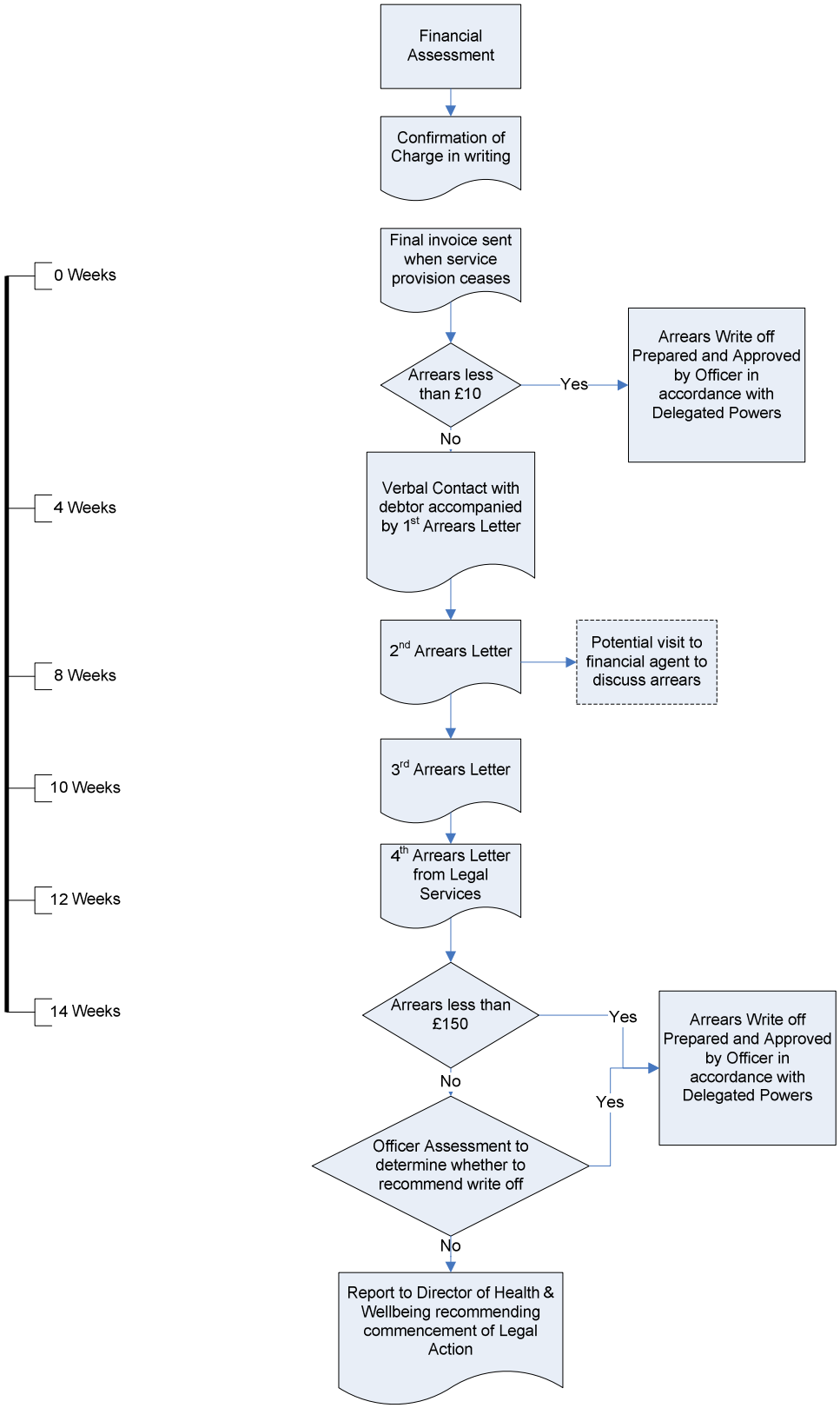
| Issue | Owner | Date | Change Details |
|---|---|---|---|
| 1, 1st Draft | Gillian Buckley | 05/08/13 | Initial Draft |
| 1, 2nd Draft | Gillian Buckley | 03/09/13 | Updated with amendments identified by;<br>• R Cutts Service and Development Manager |
| 1, 3rd Draft | Gillian Buckley | 20/11/13 | Updated with amendments identified by:<br>• S McFarlane Director of Health and Wellbeing, Neighbourhoods and Adult Services<br>• A Phillips Team Manager – Litigation, Legal Services |
| 1 4th Draft | Gillian Buckley | 29/11/13 | Updated with amendments identified by;<br>• A Bucknell Senior Financial Assessment Officer<br>• A Phillips Team Manager – Litigation, Legal Services |
| 1, 5th Draft | Gillian Buckley | 10/12/13 | Updated with amendments to Safeguarding referrals identified by;<br>• S Newton Safeguarding Service Manager |
| 1, 6th Draft | Gillian Buckley | 15/01/2014 | Updated with flowcharts as appendicies and addition of restriction on timescales in section 5.1. |

# 13 Appendices

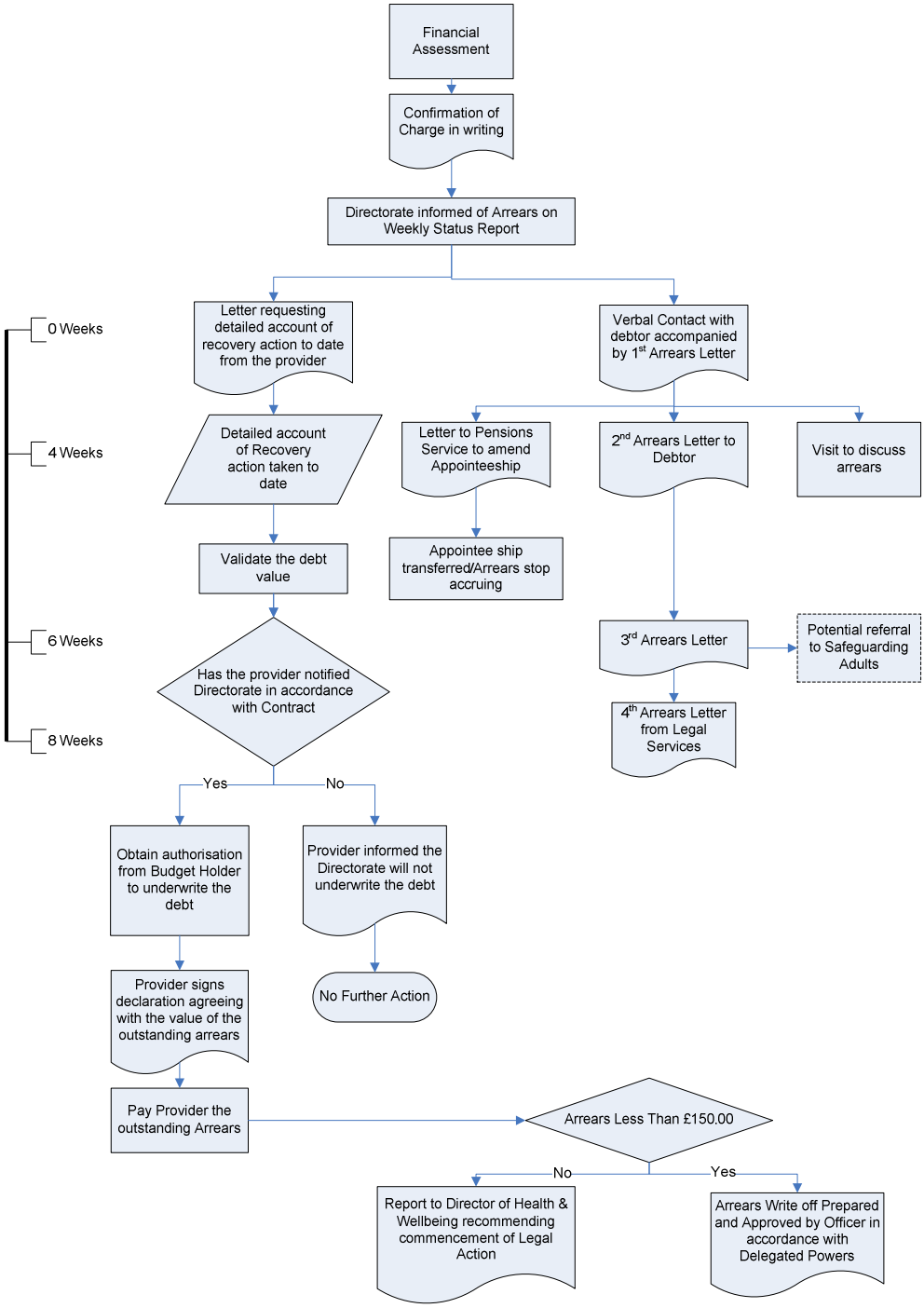
## 13.1 Appendix A: Residential Recovery Route – Council Managed Debt – Open Cases



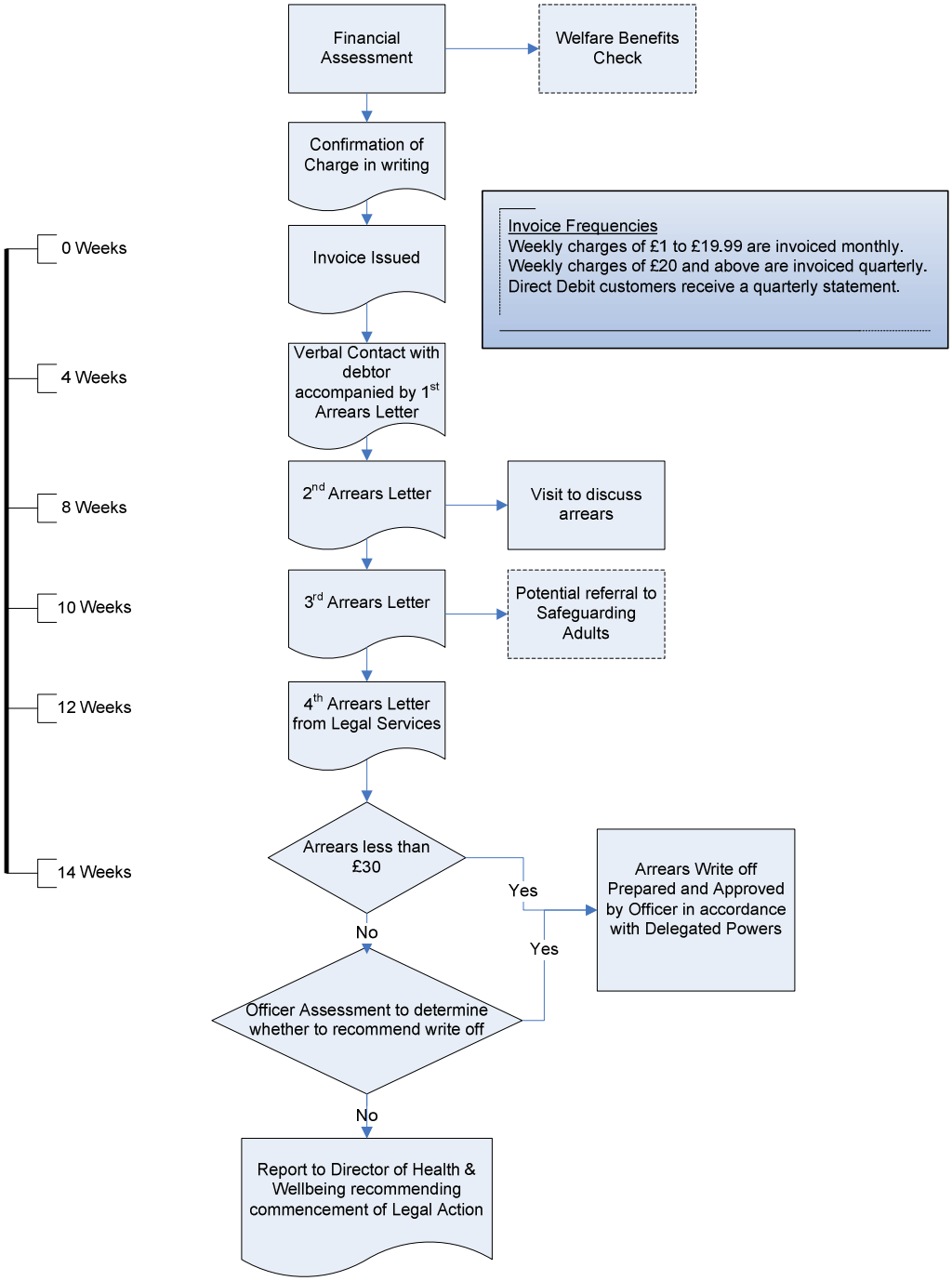
## 13.2 Appendix B: Residential Recovery Route – Council Managed Debt – Closed Cases



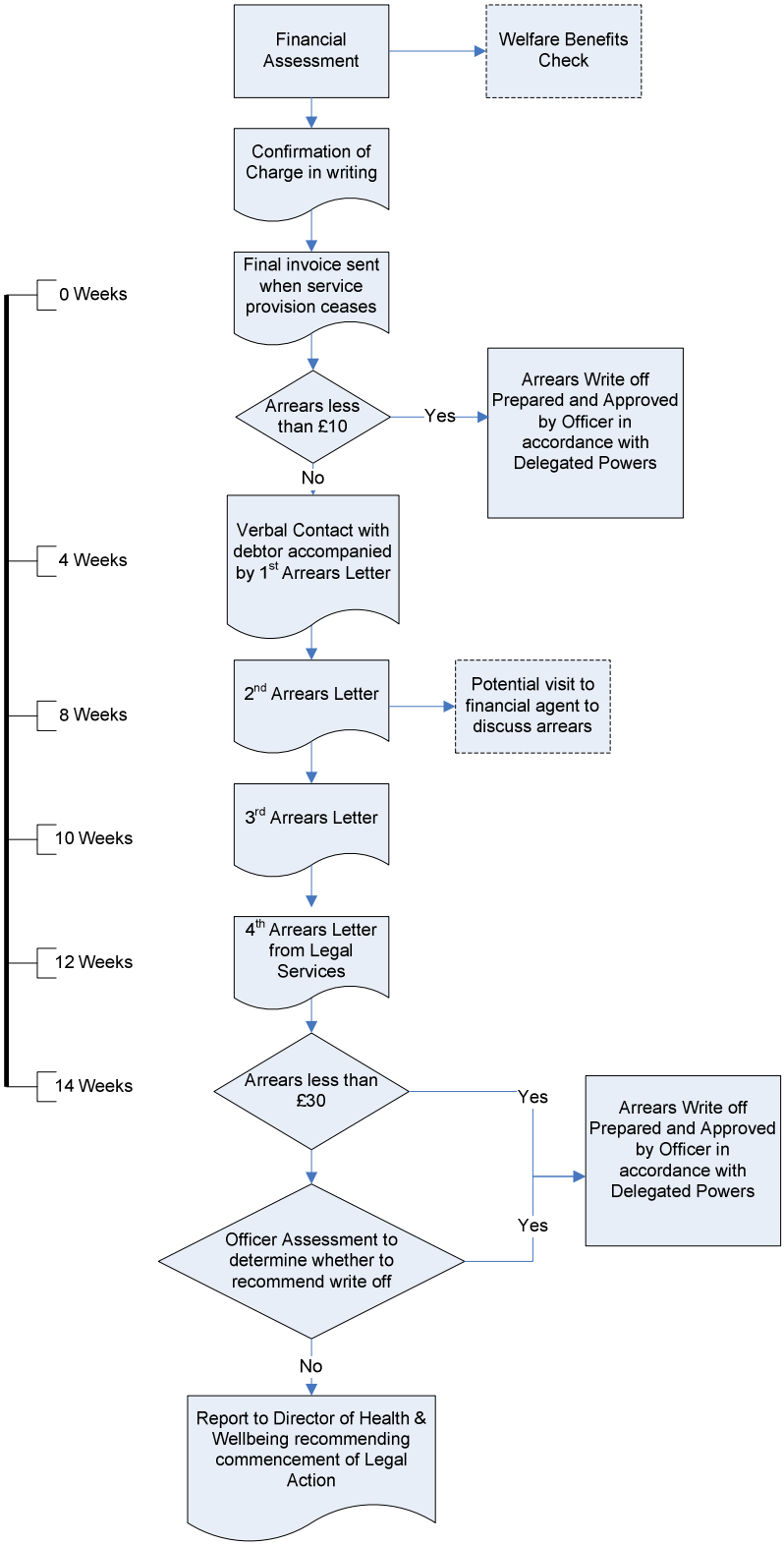
## 13.3 Appendix C: Residential and Nursing Recovery Route – Debt Managed by Independent Sector



## 13.4 Appendix D: Non Residential Recovery Route – Open Cases



## 13.5 Appendix E: Non Residential Recovery Route – Closed Cases



*Publications Gateway Reference 00498(s)*

**To**
**CCG Clinical Leads**
**HWB Chairs**
**L.A Chief Executives**

**Cc**
**CCG Accountable Officers**
**DASS**
**DCS**

Dear colleague,

## Winterbourne View Joint Improvement Programme - Stocktake of progress

Following the stocktake of progress document that you returned for analysis, I am pleased to enclose your report with specific analysis.

Firstly may I thank you for your stocktake return and the detail of your responses. With over 340 individual examples or practice of local activity sent in there is a wealth of material that will be disseminated over coming weeks. In addition, any requests for support and clarification that you made as part of your return will all be followed up.

The key next steps are:

- For you to review your analysis - ahead of the publication of the full national report.
- Receive an advance copy of the draft executive summary from the national report.
- Publication of the report on 17 October.
- Regional engagement to develop the Improvement offer with you and to support work you may already be doing.
- Individual contact with you responding to your request or to follow up on your analysis.

Your stocktake is clearly an important building block in developing your response at a local level to the Winterbourne View concordat and much good progress is reported. However as you will see in the attached report, progress is variable and in some places there is much to do.

The stocktake is your self analysis and I am sure you would want to use this with the analysis to support and inform discussions as necessary. In view of the role of the Health and Wellbeing Board you may think that is an appropriate setting to present this.

We have now appointed the Improvement team to work with you in the future and for ease of contact the regional links are:

- **East and West Midlands, East of England & Yorkshire & Humberside**
  Zandrea Stewart – zandrea.stewart@local.gov.uk – 07900 931056

- **North East, South East & South West**
  Steve Taylor – stephen.taylor@local.gov.uk – 07920 061189

- **London & North West**
  Ian Winter CBE – ianjwinter@gmail.com – 07963 144128

They will be in touch with you very shortly as set out in the improvement section of the report, but please feel free to contact them with any questions or suggestions.

The stocktake was designed to enable local areas to assess their progress against commitments in the Winterbourne View Concordat, share good practice and identify development needs. The report, published jointly by the Local Government Association and NHS England, is an analysis that covers all 152 Health and Wellbeing Board areas.

A letter was sent on 2 October from Norman Lamb, Minister of State for Care and Support, Cllr Sir Merrick Cockell, Chairman, Local Government Association and Jane Cummings, Chief Nursing Officer, NHS England which was sent out to Clinical Commissioning Groups Clinical Leads, NHS England Area Teams with responsibility for specialised commissioning, Council Leaders and Chief Executives. The letter, which can be found on the LGA website, stresses the urgency of moving forward in knowing that the commitments we have all made are kept and also sets out in more detail the additional steps we will be taking through the Enhanced Quality Assurance programme.

Once again please accept my personal thanks for the evidence of progress so far and for I am sure your ongoing support for continued progress.

Best wishes,

Chris Bull
Chair of the Winterbourne View Joint Improvement Board

**Winterbourne View Joint Improvement Programme**

**Stocktake of Progress**

**Local analysis:** Rotherham

Attached is your stocktake return with analysis
This analysis is set out in 2 parts.

Set out below are comments taken from your narrative and summarised to form an outline of key strengths and potential areas for development.

The strengths are taken from the responses you have made and are significantly summarised.

Many of the development points are taken directly either from your specific requests for further information or support or your comments about work in progress. Often the strength and the development go hand in hand.

The spreadsheet sets out the original stocktake questions, your responses and the coding that was used to collate the responses. There is no scoring or grading. What all this provides is a comprehensive picture about some excellent progress and pointers to what the priorities are to work on now. This will be the basis for our developing work with you.

Thank you for your detailed responses and for any submission of material, which will be made available in coming weeks.

The JIP Team

Ian Winter. ianjwinter@gmail.com
Steve Taylor. Stephen.taylor@local.gov.uk
Zandrea Stewart. Zandrea.stewart@local.gov.uk

10th October 2013

| Key Strengths | Areas for Development / Potential Development |
|---|---|
| **1 Models of partnership** | |
| There are clear local infrastructure, governance arrangements, and reporting mechanisms. The LD Partnership Board and the Health and Wellbeing Board are fully engaged with local arrangements for delivery and are receiving progress reports. Accountabilities are clear and understood. Partnership arrangements are an area of strength. | |
| **2 Understanding the money** | |

| | |
|---|---|
| It is evident from the response that costs and funding sources for current services are clearly understood. A pooled budget has been established with the joint Learning Disability service. There is a close working relationship between health and social care partners and forums in which the medium term strategy is considered. | |
| **3 Case management for individuals** | |
| The integrated community team is well established as part of the joint Learning Disability Service and it has the capacity to deliver the programme. Overall professional leadership of the programme is through service managers in the joint team, the Joint Commissioning Group to the Partnership Board. On the basis of the return, this appears to be an area of strength. | |
| **4 Current Review Programme** | |
| There is clear agreement about the numbers of people who will be affected by the programme and full information sharing is in place. Arrangements for review of people funded through specialist commissioning are clear. The Health Register is comprehensive and there is an identified co-ordinator in the joint service. All the required reviews have been completed. | |
| **5 Safeguarding** | |
| It appears from the return that all the necessary safeguarding arrangements are in place. | |
| **6 Commissioning arrangements** | |
| The return indicates that the appropriate commissioning arrangements are in place. | |
| **7 Developing local teams and services** | |
| - | |
| **8 Prevention and crisis response capacity** | |
| Recent and anticipated reconfiguration of local services have taken account of the need for enhanced crisis response and as a consequence IST has been strengthened. | |
| **9 Understanding the population who need/receive services** | |
| - | |
| **10 Children and adults – transition planning** | |
| Affective transition services are reported to be in place | |
| **11 Current and future market capacity** | |
| - | |
| **Other** | |
| | |
| **Dimensions of the stocktake about which you have requested support** | |
| | |

| | |
|---|---|

| | Winterbourne View Local Stocktake: | | | 149 Rotherham |
|---|---|---|---|---|
| **Q** | **1.Models of partnership** | **Codes Used Blank=NR** | **Coded as** | **Locality Response From Stocktake Return** |
| 1 | 1.1 Are you establishing local arrangements for joint delivery of this programme between the Local Authority and the CCG(s). | 0 - No arrangement<br>1 - Included in exisitng arrangement local<br>2 - Included in existing arrangement with other(s)<br>3 - New arrangement | 1 | 1.1 The Joint Health and Social Services Learning Disability Service has been established for over 10 years. This has been the foundation of this work which has ensured a joint delivery of this programme from the outset. The service is jointly commissioned by Rotherham Metropolitan Borough Council (RMBC) and Rotherham Clinical Commissioning Group (RCCG), with the local authority as lead commissioner, and is managed through a Learning Disability Commissioning Group and an effective Learning Disability Partnership Board. |
| 2 | 1.2 Are other key partners working with you to support this; if so, who. (Please comment on housing, specialist commissioning & providers). | A positive score below assumes answer is Yes - include all identified.<br>0 - No<br>1 - Asc<br>2 -Children Services<br>3 -Housing<br>4 -Other Council Depts<br>5 - CCG(s)<br>6 -Specialist Commissioners<br>7- Other providers | 3,4,5,6 | 1.2 Close working relationships exist with care providers, Supporting People programme, and housing providers which are able to support the programme in Rotherham e.g. 40 supported living schemes already in Rotherham. Supporting People spend 13% of total budget on services for people with learning disabilities. Partners include Mencap, Golden Lane Housing, Voyage Care, RCCG, RMBC Housing Department, and specialist commissioners. |

| | | | | |
|---|---|---|---|---|
| 3 | 1.3 Have you established a planning function that will support the development of the kind of services needed for those people that have been reviewed and for other people with complex needs. | 0 - No<br>1 - Yes<br>2 - Not clear<br>3 - In development | 1 | 1.3 We have a Learning Disability Commissioning Group and other planning groups which ensure that all service developments are planned and developed in partnership. The Commissioning Group reports directly to the Partnership Board and guides decision-making on future service investment and disinvestment, seeking to establish best quality services that can demonstrate value for money. It includes Commissioners from RMBC and RCCG and respective Finance Leads. Evidence from the CCG MH & LD QIPP Board (minutes & TOR) & Rotherham LD Board (Part A & B minutes & TOR). In the last year, an additional 6 supported living placements have been developed, in partnership, to support young people in transition and people living with older carers. |
| 4 | 1.4 Is the Learning Disability Partnership Board (or alternate arrangement) monitoring and reporting on progress. | 0 - No<br>1 - Yes<br>2 - Yes (via SAF)<br>3 - Not clear<br>4 - Other arrangement<br>5 - In Progress | 1 | 1.4 The LD Partnership Board consists of all major agencies, carers and service users who receive regular reports of the progress of the Joint Service and how it is delivering on this programme. The Board is chaired and co-chaired by a service user and carer. Evidence of monitoring can be found in the minutes from the LDPB |
| 5 | 1.5 Is the Health and Wellbeing Board engaged with local arrangements for delivery and receiving reports on progress. | 0 - No<br>1 - Yes<br>2 - Not clear<br>3 - In process | 1 | 1.5 The Health and Wellbeing Board are fully engaged with this agenda. They received an initial report for information regarding Winterbourne View. This Stocktake and the Annual report will be received by the HWB Board, giving the Board an up to date position. Regular update reports will be received on the resulting action plan. The HWB Board at its last meeting received and considered the recent letter from Norman Lamb the responsible government minister. |
| 6 | 1.6 Does the partnership have arrangements in place to resolve differences should they arise. | 0 - No<br>1 - Yes<br>2 - Not clear<br>3 - In process/ discussion | 1 | 1.6 Yes – the terms of reference of the LD Commissioning group are explicit regarding dispute resolution mechanisms. These include reporting through to the Adult Partnership Board (Joint Commissioning Board) and Chief Officers group |

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| 7 | 1.7 Are accountabilities to local, regional and national bodies clear and understood across the partnership – e.g. HWB Board, NHSE Local Area Teams / CCG fora, clinical partnerships & Safeguarding Boards. | 0 - No<br>1 - Yes<br>2 - Not clear<br>3 - In process<br>4 - In part | 1 | 1.7 The CCG is part of the NHS England LAT LD Group Chaired by Margaret Kitching, Director of Quality & Nursing (evidence – minutes). The membership of this group includes representation from Bassetlaw CCG, Doncaster CCG, Sheffield CCG, and Rotherham CCG & NHS England. Safeguarding Adults Board – Director of Health and Wellbeing (RMBC) reports to the Board with regard to the LA's response to Winterbourne and the Joint Improvement Programme (JIP). CQC chair a monthly business meeting with Rotherham health and social care agencies and comprehensive intelligence on local activity in relation to quality assurance/ compliance/ and safeguarding is shared consistently at this meeting. A quarterly CQC strategic meeting looks in-depth at themes and trends, and considers the implications of Winterbourne, the Francis Report and Serious Case Reviews. This stocktake will be presented to the July Strategic Meeting. The Cabinet Member for Adult Social Services also receives the partnership Board minutes and other relevant reports. |
| 8 | 1.8 Do you have any current issues regarding Ordinary Residence and the potential financial risks associated with this. | 0 - No<br>1 - Yes<br>2 - Not clear | 0 | 1.8 No issues at present |
| 9 | 1.9 Has consideration been given to key areas where you might be able to use further support to develop and deliver your plan. | 0 - No<br>1 - Yes<br>2 - Not clear<br>3 - Other local support | 1 | 1.9 It is not considered at present that additional support is required. |
| | **2. Understanding the money** | | | |
| 10 | 2.1 Are the costs of current services understood across the partnership. | 0 - No<br>1 - Yes<br>2 - Not clear<br>3 - In process<br>4 - In part | 4 | 2.1 Health element – we have a joint register of health funded out of area placements. (Evidence – Health Funding Register). Similarly all placements and services are closely scrutinised within the Local Authority Budget monitoring. Spend against the Pooled Budget, which funds the Rotherham Learning Disability Service through a S75 Agreement, is monitored by the LD commissioning Group |

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| 11 | 2.2 Is there clarity about source(s) of funds to meet current costs, including funding from specialist commissioning bodies, continuing Health Care and NHS and Social Care. | 0 - No<br>1 - Yes<br>2 - Not clear<br>3 - In process<br>4 - In part | 1 | 2.2. Yes, there is clarity about the funding sources. These include, in addition to joint funded costs (through the pool budget), CHC & S117 costs. These are detailed on the Health Funding Register (evidence Health Funding Register). Specialist Commissioning Bodies (NHS England) and CHC funded placements - this data is included on the Health funding Register and is monitored by the LD Commissioning Group and the RCCG QIPP Group Which has been established in order to ensure that NHS efficiencies are delivered in a clear and coherent way. |
| 12 | 2.3 Do you currently use S75 arrangements that are sufficient & robust. | 0 - No<br>1 - Yes<br>2 - Not clear<br>3- Informal arrangements<br>4 - Included in overall partnership agreement<br>5 - other medthods<br>6 - In progress | 1 | 2.3 Yes – A pooled budget has been established with the joint LD service and is monitored by the LD Commissioning Group and the LD partnership board |
| 13 | 2.4 Is there a pooled budget and / or clear arrangements to share financial risk. | 0 - No<br>1 - Yes<br>2 - Not clear<br>3 - Alternative risk share agreement<br>4 - being put in place | 1 | 2.4 The pooled is managed as above and is subject to a 3 yearly refreshed Partnership Agreement. |
| 14 | 2.5 Have you agreed individual contributions to any pool. | 0 - No<br>1 - Yes<br>2 - Not clear<br>3 - N/A<br>4 - being put in place | 1 | 2.5 Yes |

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| 15 | 2.6 Does it include potential costs of young people in transition and of children's services. | 0 - No<br>1 - Yes<br>2 - Not clear<br>3 - Included in ASC budget build<br>4 - Under review<br>5 - N/A | 3 | 2.6 The pool contains the potential costs of young people who are identified as being in the process on transition to adult services. Transition costs are calculated on the basis of information from children's services and through transition planning. Additional funding from the LA for transitions has been included in this year's budget. RMBC Commissioning is a corporate function (with Children and Young Peoples commissioners sitting alongside Adults commissioners). This maximises the opportunity to pool expertise and knowledge in seeking the best choice for individuals. |
| 16 | 2.7 Between the partners is there an emerging financial strategy in the medium term that is built on current cost, future investment and potential for savings. | 0 - No<br>1 - Yes<br>2 - Not clear<br>3 - in process/ development | 1 | 2.7 There is close working relationship between health and social care partners – forums in which the medium term strategy are considered exist– evidenced in CCG QIPP forum and LD Commissioning Group. QIPP group considers partner commissioning plans and considers the impact of partner efficiency programmes. The Council has a Medium Term Financial Strategy that collates intelligence from JSNA (and other information tools) and Service Plans to predict future demand for spend. |
| | **3. Case management for individuals** | | | |
| 17 | 3.1 Do you have a joint, integrated community team. | 0 - No<br>1 - Yes<br>2 - Not clear<br>3 Co-located<br>4 - other arrangements | 1 | 3.1 Yes- the Integrated community team is well established as part of the Joint LD Service– further evidence Service Specification included in the RDaSH Contract |
| 18 | 3.2 Is there clarity about the role and function of the local community team. | 0 - No<br>1 - Yes<br>2 - Not clear<br>3 - Under review | 1 | 3.2 As above |
| 19 | 3.3 Does it have capacity to deliver the review and re-provision programme. | 0 - No<br>1 - Yes<br>2 - Not clear<br>3 - Under review | 1 | 3.3 Yes – the review programme is person centred and individualised to the customer's assessed needs. There are relatively low numbers of patients involved – and they have consistently been monitored and reviewed – evidenced by ongoing review practise). There is also a CCG case manager in place who works closely with the LD Service. |

| | | | | |
|---|---|---|---|---|
| 20 | 3.4 Is there clarity about overall professional leadership of the review programme. | 0 - No<br>1 - Yes<br>2 - Not clear<br>3 - Under review | 1 | 3.4 Yes - operational management is led by the service managers in the joint service – who report progress of the JIP to the Joint Commissioning group and to the Partnership Board |
| 21 | 3.5 Are the interests of people who are being reviewed, and of family carers, supported by named workers and / or advocates | 0 - No<br>1 - Yes<br>2 - Not clear | 1 | 3.5 Yes – all our customers and families are supported by named workers. Evidence – Care Co-ordinator & Case Manager Notes, The Health Funding Register, Social Care Assessments, a range of Commissioned Advocacy Services, including IMCA and IMHA, specialist advocacy, and peer advocacy. In addition, Speak Up offers a service user perspective in reviewing the quality of provision in Rotherham care homes, and has a routine presence on the Council's Overview and Scrutiny Committee. |
| | **4. Current Review Programme** | | | |
| 22 | 4.1 Is there agreement about the numbers of people who will be affected by the programme and are arrangements being put in place to support them and their families through the process. | 0 - No<br>1 - Yes<br>2 - Not clear<br>3 - in part | 1 | 4.1 There is clear agreement and full information sharing in place. There are currently 4 people in out of area specialist commissioned places, there are 4 people placed in hospital out of area through section 117 funding. There are 4 people currently appropriately placed in Rotherham ATU. Arrangements to support them include – Care co-ordinators (LD Community nurses), CCG Case Manager. |
| 23 | 4.2 Are arrangements for review of people funded through specialist commissioning clear. | 0 - No<br>1 - Yes<br>2 - Not clear<br>3 - Futher discussion / in process<br>4 Not applicable (i.e.none funded by specialist commissioning ) | 1 | 4.2 The arrangements for review are in place and clear. People's circumstances are regularly reviewed with specialist commissioning colleagues and allocated community nurses in joint learning disability team. |

| | | | | |
|---|---|---|---|---|
| 24 | 4.3 Are the necessary joint arrangements (including people with learning disability, carers, advocacy organisations, Local Healthwatch) agreed and in place. | 0 - No<br>1 - Yes<br>2 - Not clear<br>3 - Futher discussion / in process | 1 | 4.3 Yes – the agreements around each individual are in place. All people placed out of area are engaged in the process. Any gaps are met by advocacy services commissioned by RMBC. |
| 25 | 4.4 Is there confidence that comprehensive local registers of people with behaviour that challenges have been developed and are being used. | 0 - No<br>1 - Yes<br>2 - Not clear<br>3 - Registers but not as specified | 1 | 4.4 There is full knowledge of everyone identified in 4.1 Evidence – the Health Register is in place, and is comprehensive. |
| 26 | 4.5 Is there clarity about ownership, maintenance and monitoring of local registers following transition to CCG, including identifying who should be the first point of contact for each individual | 0 - No<br>1 - Yes<br>2 - Not clear<br>3 - In process (e.g. registers in place but need to confirm point of contact) | 1 | 4.5 The Health Register has an identified co-ordinator in the Joint Service – who has close liaison with an identified case manager within the CCG. The first point of contact is the allocated worker within the Joint Service. These workers are all members of in the Community Learning Disability Team, which is managed within the Joint Service. |
| 27 | 4.6 Is advocacy routinely available to people (and family) to support assessment, care planning and review processes | 0 - No<br>1 - Yes<br>2 - Not clear<br>3 - in process development | 1 | 4.6 There are IMCA and IMHA arrangements in place which include advocacy support in relation to reviews and any safeguarding issues. Rotherham Advocacy Partnership provides professional issue based advocacy and Speak Up are funded to provide self/peer advocacy. In addition there are generic advocacy and advice services which work routinely with people with learning disabilities and mental health problems and will signpost people for more targeted support. |

| | | | | |
|---|---|---|---|---|
| 28 | 4.7 How do you know about the quality of the reviews and how good practice in this area is being developed. | 0 - No process<br>1 - Process in place<br>2 - Not clear<br>3 - Work in progress | 1 | 4.7 Reviews were undertaken in line with the guidance provided in February. In addition we are undertaking a case review/quality audit which will be completed by an independent Performance and Quality team by 31st July |
| 29 | 4.8 Do completed reviews give a good understanding of behaviour support being offered in individual situations. | 0 - No<br>1 - Yes<br>2 - Not clear<br>3 - in part / some instances | 1 | 4.8 Yes – as an extra measure of assurance reviews to be audited by Performance and Quality Team against model of good practise issued. |
| 30 | 4.9 Have all the required reviews been completed. Are you satisfied that there are clear plans for any outstanding reviews to be completed | 0 - No<br>1 - Yes<br>2 - Not clear<br>3 - Most completed, timescales for completion<br>4 - Some completed, timescales for completion | 1 | 4.9 Yes. There are no outstanding reviews. |
| | **5. Safeguarding** | | | |
| 31 | 5.1 Where people are placed out of your area, are you engaged with local safeguarding arrangements – e.g. in line with the ADASS protocol. | 0 - No<br>1 - Yes<br>2 - Not clear<br>3 - Under review | 1 | 5.1 We are aware of and work to the ADASS Guidance. Care co-ordinating staff are aware of local protocols for out of area placements and liaise with local safeguarding strategies as appropriate. Where safeguarding issues arise in respect of people placed out of district, there is attendance at any strategy meetings and action plans would be implemented. |

| | | | | |
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| 32 | 5.2 How are you working with care providers (including housing) to ensure sharing ofinformation & develop risk assessments. | 0 - No arrangement<br>1 - Provider forum (or similar)<br>2 - Not clear<br>3 - being developed<br>4 - Done on case by case basis | 1 | 5.2 Care Providers are invited to regular Shaping the Future (Provider Engagement) events to discuss future commissioning intentions, risk assessments will be reviewed as part of the holistic reviewing process and is part of the Contract Compliance Officer role alongside the Home from Home Quality assessment. A risk matrix has been developed that measures against contract compliance, QA, safeguarding activity, financial viability, business continuity etc. RMBC, RCCG and FTs share information routinely with CQC, including the gathering of more 'soft intelligence' arising from our Eyes and Ears processes. . |
| 33 | 5.3 Have you been fully briefed on whether inspection of units in your locality have takenplace, and if so are issues that may have been identified being worked on. | 0 - No<br>1 - Yes<br>2 - Not clear<br>3 - N/A | 1 | 5.3 Yes – Rotherham ATU inspected by CQC on the 1st and 2nd November 2011. This was part of the 150 urgent inspections which were part of the immediate response to Winterbourne. Outcomes 4&7 were met but required improvements. Outcome 21 was not compliant. The issues identified regarding, in particular care plans and recording were subsequently improved following an immediate and detailed Action Plan being implemented by all partners involved. CQC acknowledged the improvement on their subsequent inspection on the 2nd March 2012 when the ATU was found to be fully compliant. ( Action plans – evidence) Ongoing quality assurance of ATU as part of RMBC contract and performance monitoring. ( evidence – minutes) |
| 34 | 5.4 Are you satisfied that your Children and Adults Safeguarding Boards are in touch withyour Winterbourne View review and development programme. | 0 - No<br>1 - Yes<br>2 - Not clear<br>3 - In process / being developed | 1 | 5.4 Rotherham Adult Safeguarding Board has received Winterbourne reports and RMBC and NHS responses to it. The RSAB will review this Stocktake document and any future updates. There is a senior management representative form Children's services on the Adult Board, and adults service representation, on LSCB, both at Director level, which ensures an effective senior management link between the Boards. The LSCB will receive a copy of the stocktake and any subsequent reports. |
| 35 | 5.5 Have they agreed a clear role to ensure that all current placements take account ofexisting concerns/alerts, the requirements of DoLS and the monitoring of restraint. | 0 - No<br>1 - Yes<br>2 - Not clear<br>3 - In progress/ Being developed | 1 | 5.5 The Assessment and Treatment Unit (ATU) _uses the BILD accredited RESPECT model of restraint – closely managed by Service Manager who is tasked to investigate and report any identified incident to Senior Management within RDASH. Out of Area – restraint processes/DOLS requirements are fully considered in reviewing process. |

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| 36 | 5.6 Are there agreed multi-agency programmes that support staff in all settings to shareinformation and good practice regarding people with learning disability andbehaviour that challenges who are currently placed in hospital settings. | 0 - No<br>1 - Yes (Local)<br>2 - Not clear<br>3 - In progress/ Being developed<br>4 Yes, regional only | 1 | 5.6 ATU in Rotherham is part of the Joint LD service and is able to share good practise and share training and information across the whole joint service. Evidence RDaSH's report on Winterbourne. |
| 37 | 5.7 Is your Community Safety Partnership considering any of the issues that might impacton people with learning disability living in less restrictive environments. | 0 - No<br>1 - Yes<br>2 - Not clear<br>3 - Considered / not required<br>4 - IN progress | 1 | 5.7 There is a Vulnerable Persons Unit staffed by the Police and the Council with a remit to consider and act on oppression and Hate Crime, and to protect the interests of vulnerable people. Safer Neighbourhood Teams apply intelligence from VPU to their community safety activity and will actively support vulnerable tenants where indicated. Police representatives attend the Safeguarding Boards. Rotherham operates a 'Safe in Rotherham Scheme' with town centre traders, shops, and operators, which advertises where vulnerable people can go to receive welcome and support and a public place of safety. |
| 38 | 5.8 Has your Safeguarding Board got working links between CQC, contractsmanagement, safeguarding staff and care/case managers to maintain alertness to concerns | 0 - No<br>1 - Yes<br>2 - Not clear<br>3 - in development | 1 | 5.8 Yes – all parties linked to safeguarding board. Monthly risk matrix completed and discussed directly with CQC (evidence (minutes and risk matrix's) in regular meetings where concerns are shared. The highlights from the risk matrix are presented to adult Safeguarding Board at each meeting. Commissioners receive alerts from CQC around planned visits, and CQC contact RMBC Safeguarding team direct where safeguarding issues are encountered during visits. Named officers are in regular contact. Where issues relate to care homes or care providers CQC attend Strategy meetings and Case Conferences. |
| | **6. Commissioning arrangements** | | | |

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| 39 | 6.1 Are you completing an initial assessment of commissioning requirements to supportpeoples' move from assessment and treatment/in-patient settings. | 0 - No<br>1 - Yes<br>2 - Not clear<br>3 - In progress<br>4 - Already completed | 1 | 6.1 Yes – work is underway to progress the recommissioning of the Rotherham ATU. This will reduce bed capacity to the level of demand and other changes to the community based support that is provided will ensure increase in capacity, to prevent further admissions and support the gradual reduction of bed base . Evidence – ATU & Psychiatry Review currently under way (evidence – minutes from the MH & LD QIPP Group, Rotherham LD Board). ATU reducing beds from 10 to 5 by September 2013. Review will assess whether this level of provision will continue to be provided – in conjunction with a strengthening of support in the community. |
| 40 | 6.2 Are these being jointly reviewed, developed and delivered. | 0 - No<br>1 - Yes<br>2 - Not clear<br>3 - In progress | 1 | 6.2 The Joint Service Management Team and Commissioners ensure that commissioning intentions are clear and in line with Winterbourne JIP. Evidence as in 6.1 + TOR – membership of these groups included CG, RMBC, RDaSH (Mental Health Trust and lead provider NHS services). There is a Project Board in place which works jointly to ensure these plans are being delivered. |
| 41 | 6.3 Is there a shared understanding of how many people are placed out of area and of the proportion of this to total numbers of people fully funded by NHS CHC and those jointly supported by health and care services. | 0 - No<br>1 - Yes<br>2 - Not clear<br>3 - In progress | 1 | 6.3 Health Funding Register includes all out of area placements that are funded by health (includes joint funding). There is clear agreement on the numbers of placements that are funded. |
| 42 | 6.4 Do commissioning intentions reflect both the need deliver a re-provision programmefor existing people and the need to substantially reduce future hospital placements for new people | 0 - No<br>1 - Yes<br>2 - Not clear<br>3 - Yes, though significant challenges<br>4 - IN progress | 1 | 6.4 There is a planned reduction of Assessment and Treatment beds from 10 to 5 beds. All Out of Area Placements are subjected to rigorous examination. (Rotherham CCG Annual Commissioning Plan). Any Out of Area hospital placements have to be agreed with the CCG contract manager. There is an active position from RMBC to seek local community placements and least restrictive setting for everyone needing high level packages of care. |

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| 43 | 6.5 Have joint reviewing and (de)commissioning arrangements been agreed withspecialist commissioning teams. | 0 - No<br>1 - Yes<br>2 - Not clear<br>3 - In progress<br>4 Not applicable - e.g. none placed by specialist commissioners | 1 | 6.5 Joint reviewing agreements have been in place for some time and the Joint Learning Disability team have worked consistently closely with specialist commissioner s in returning people to Rotherham as, and when, appropriate. |
| 44 | 6.6 Have the potential costs and source(s) of funds of future commissioning arrangements been assessed. | 0 - No<br>1 - Yes<br>2 - Not clear<br>3 - In progress | 1 | 6.6 Future costs are kept under review by LD Joint Commissioning Group. |
| 45 | 6.7 Are local arrangements for the commissioning of advocacy support sufficient, if not, are changes being developed. | 0 - No<br>1 - Yes<br>2 - Not clear<br>3 - In progress/ under review | 1 | 6.7 Rotherham Advocacy Partnership and Speak Up SLA's have been reviewed in 2012/13 and provide sufficient advocacy. A consortium agreement exists for IMCA and there is sufficient capacity and IMHA services are adequately resourced. Services are regularly monitored and reviewed by the contracts team and provider Impact Assessments undertaken for any change in service delivery to make sure that service meets demand. |
| 46 | 6.8 Is your local delivery plan in the process of being developed, resourced and agreed. | 0 - No<br>1 - Yes<br>2 - Not clear<br>3 - In progress<br>4 - Already completed | 1 | 6.8 Initial plans are in place for the S117 Health Funded placements. The 4 Secure Placements are currently considered appropriate and people will not be moving. |

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| 47 | 6.9 Are you confident that the 1 June 2014 target will be achieved (the commitment is for all people currently in in-patient settings to be placed nearer home and in a less restrictive environment). | 0 - No<br>1 - Yes<br>2 - Not clear<br>3 - Timescales problematic / unrealistic<br>4 - Yes but challenging<br>5 - One or more people subject to court order | 4 | 6.9 We are confident that all in patients have been reviewed and those identified as being appropriate to move back have been supported to move already. Currently there are 8 people in either Specialist provision or Out of Area Section 117 accommodation ATU and for whom an immediate return to Rotherham is not appropriate. However 2 or 3 people may be returned to Rotherham within the next 12 months, depending on their personal circumstances, and person centred plan. Within Rotherham the number of beds is reducing from 10 to 5 by September 2014 – with an intention to review further as resources shift to more intensive support for people in crisis within the community |
| 48 | 6.10 If no, what are the obstacles, to delivery (e.g. organisational, financial, legal). | 0 - None<br>1 - Financial<br>2 - Legal (e.g. MHA)<br>3 - other | 0 | None at present |
| | **7. Developing local teams and services** | | | |
| 49 | 7.1 Are you completing an initial assessment of commissioning requirements to support peoples' move from assessment and treatment/in-patient settings. | 0 - No<br>1 - Yes<br>2 - Not clear<br>3 - In progress<br>4 - Already completed | 1 | 7.1 Same as 6.1 |
| 50 | 7.2 Do you have ways of knowing about the quality and effectiveness of advocacy arrangements. | 0 - No<br>1 - Yes<br>2 - Not clear<br>3 - In part<br>4 - In progress | 1 | 7.2 Advocacy is commissioned by RMBC – contracts are managed and reviewed by LD Commissioners and are regularly quality assured. (Evidence -Quarterly reporting mechanism). |

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| 51 | 7.3 Do you have plans to ensure that there is capacity to ensure that Best Interests assessors are involved in care planning. | 0 - No<br>1 - Yes<br>2 - Not clear<br>3 - In part | 1 | 7.3 The care planning for individuals in undertaken on a person centred individualised approach. The relatively low numbers of potential people involved in this programme means that Rotherham will have capacity to meet this demand. |
| | **8. Prevention and crisis response capacity - Local/shared capacity to manage emergencies** | | | |
| 52 | 8.1 Do commissioning intentions include an assessment of capacity that will be required to deliver crisis response services locally. | 0 - No<br>1 - Yes<br>2 - Not clear<br>3 - In progress / under review | 1 | 8.1 The commissioning plan on which the current service reconfiguration is taking place is based on an assessment of the capacity needed to respond to the needs of individuals once the service has been reconfigured. The Health part of the Joint Service has recently reconfigured its provision (including the reduction of ATU beds) – this has led to a strengthening of the Intensive Support Team (IST) which will strengthen the crisis response capacity in the service. |
| 53 | 8.2 Do you have / are you working on developing emergency responses that would avoid hospital admission (including under section of MHA.) | 0 - No<br>1 - Yes<br>2 - Not clear<br>3 - In progress / under review | 3 | 8.2 this is being considered as Phase 2 of the ATU and Psychiatry review which will move onto examine further systems and services which will be aimed towards supporting and treating people in the community in crisis wherever possible. |
| 54 | 8.3 Do commissioning intentions include a workforce and skills assessment development. | 0 - No<br>1 - Yes<br>2 - Not clear<br>3 - In progress / development | 3 | 8.3 Phase 2 will require a consideration of the skills and mixture of staff to achieve this |
| | **9 Understanding the population who need/receive services** | | | |

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| 55 | 9.1 Do your local planning functions and market assessments support the development of support for all people with complex needs, including people with behaviour that challenges. | 0 - No<br>1 - Yes<br>2 - Not clear<br>3 - In progress / under review | 3 | 9.1 The JSNA was been refreshed in 2012 in preparation for and to inform the Joint Health and Wellbeing Strategy and is in the process of review currently. The Market Position Statement from December 2013 will address the specific needs of people with complex needs and will link with the Adult Service Plan which is under development. |
| 56 | 9.2 From the current people who need to be reviewed, are you taking account ofethnicity, age profile and gender issues in planning and understanding future care services. | 0 - No<br>1 - Yes<br>2 - Not clear<br>3 - In part | 1 | 9.2 Yes – the reviews consider all these issues where appropriate |
| | **10. Children and adults – transition planning** | | | |
| 57 | 10.1Do commissioning arrangements take account of the needs of children and young people in transition as well as of adults. | 0 - No<br>1 - Yes<br>2 - Not clear<br>3 - In progress / under review | 1 | 10.1 The Learning Disability Commissioning Group and Partnership Board receive periodic reports from the Service regarding funding for the number of young people identified in transition into adult services and commissioners work together to consider needs in transition. |
| 58 | 10.2 Have you developed ways of understanding future demand in terms of numbers of people and likely services. | 0 - No<br>1 - Yes<br>2 - Not clear<br>3 - In progress / under review | 1 | 10.2 Yes. There is an effective transitions process in place, including person centred reviews in years 8 and 9. There is close liaison with Children's services – quarterly meetings with them has ensured an accurate up to date list of those expected into adult LD services and likely costs and demands for the next 2 -3 years ( evidence – transitions document) |
| | **11. Current and future market requirements and capacity** | | | |

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| 59 | 11.1 Is an assessment of local market capacity in progress. | 0 - No<br>1 - Yes<br>2 - Not clear<br>3 - In progress<br>4 - Already completed | 1 | 11.1 Yes –the Council has a Market Position Statement which is now being refreshed, supported by the IPC national development programme (Developing Care Markets for Quality and Choice). |
| 60 | 11.2 Does this include an updated gap analysis. | 0 - No<br>1 - Yes<br>2 - Not clear<br>3 - In progress<br>4 - Part completed | 1 | 11.2 The existing market position statement includes a gap analysis as informed by the JSNA – this work will be refreshed this year in line with 11.1. |
| 61 | 11.3 Are there local examples of innovative practice that can be shared more widely, e.g. the development of local fora to share/learn and develop best practice. | 0 - No<br>1 - Yes<br>2 - Not clear | 1 | 11.3 The numbers of people in Rotherham identified in this stocktake are indicative of the consistent measures and approach of the LD service in endeavouring to support people at home and in their own community. The approach taken has been a person centred approach to ensure that services are individualised. |

**ROTHERHAM BOROUGH COUNCIL – REPORT TO MEMBERS**

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| **1** | **Meeting:** | **Cabinet Member for Adult Social Care** |
| **2** | **Date:** | **20 January 2014** |
| **3** | **Title:** | **Training of Adult Social Care Workforce** |
| **4** | **Directorate:** | **Neighbourhoods and Adult Services** |

## 5. Summary

5.1 The purpose of this report is to request the agreement of Cabinet Member to seek Member approval for exemption from normal contract standing orders, so that three existing training providers may continue to be contracted to repeat their specialist 'branded' training courses in support of a capable and skilled adult social care workforce across Rotherham.

## 6. Recommendations

**It is recommended that:**

- **The contracting of training courses for Dementia Care Mapping, Cornerstones of Dementia Care, Carer Information and Support Programme, and The OTAGO Exercise Programme Leader be exempt from standing order number 48 - contracts valued at £50,000 or more.**

## 7. Proposals and Details

7.1 The Neighbourhoods and Adult Services Directorate plans and organises a broad range of training and development activities for the entire adult social care workforce across Rotherham including courses, qualifications, distance learning, e-learning and coaching. The majority of the training needs identified for the workforce will now be met going forward through the Council's new Dynamic Purchasing System for Learning and Development that has been let by the Corporate Procurement Team. There is, however, a very small number of existing specialist sole training provider courses planned to continue. As such, a request is made for the following four courses, from three existing providers, to be exempt from the provisions of standing order 48 - contracts valued at £50,000 or more.

- *Carer Information and Support Programme* – this is a course delivered by the Alzheimer's Society. It is currently offered as part of the support available to family carers, two to three times per year, subject to demand and available resources. It offers a nationally recognized training and support for carers to discuss about the experience of caring and provide information about dementia, legal and money matters, and ways of coping and getting help from local services.

- *OTAGO Exercise Programme Leader course* – this is delivered by Later Life Training. It is currently offered, once per year, as part of supporting the Health and Wellbeing Strategy and in particular work associated with falls prevention, dependence to independence, and being active in later life. It offers a nationally recognized training to equip direct care staff with the knowledge and skills to run small group exercise options to prevent falls, injuries and improve cognition amongst older people.

- *Cornerstones of Person-Centred Dementia Care* course – this is delivered by Bradford University. It is currently offered as part of the Council's Bronze to Platinum dementia training pathway, two to three times per year, subject to demand and available resources. It offers a nationally recognized training to equip direct care staff with the knowledge with which to provide Person-Centred Dementia Care.

- *Dementia Care Mapping courses* – this is delivered also by Bradford University at basic and advanced user levels. Places on these courses are currently offered as part of the Council's Bronze to Platinum dementia training pathway, once or twice per year, subject to demand and available resources. Both courses offer nationally recommended methods for improving care practice for people with dementia.

7.2 Whilst there are other training providers in the marketplace that could deliver training similar course content in the areas covered above – carers, exercise and movement, dementia – these are specialised courses required as part of existing training pathways that are only available from the providers detailed with some courses being trademarked products.

## 8. Finance

8.1 The indicative cost per learner of the Carer Information and Support Programme to run in or outside of Rotherham is the same at £330, the difference being the additional associated travel and overnight accommodation required for courses delivered outside of the borough.

8.2 The indicative cost per learner of the OTAGO Exercise Programme Leader 4-day course to run in or outside of Rotherham is the same at £410, the difference being the additional associated travel and overnight accommodation required for courses delivered outside of the borough.

8.3 The indicative cost per learner of the Cornerstones of Person-Centred Dementia Care 3-day course to run in Rotherham is £300 compared to £500 for courses taking place in Bradford, with this excluding the additional associated travel and overnight accommodation required for outside of our borough.

8.4 The indicative cost per learner of the Dementia Care Mapping Basic User 4-day Course to run in Rotherham is £400 compared to £700 on courses taking place in Bradford or London, with this excluding the additional associated travel and overnight accommodation required for outside of our borough.

8.5 The indicative cost per learner for the Dementia Care Mapping Advanced User 3-day course to run in Rotherham, Bradford or London is the same at £500, the difference being the additional associated travel and overnight accommodation required for courses outside of the borough.

8.6 The cost of procuring the training courses required is met from the existing Neighbourhoods and Adult Services Learning and Development budgets and would only be contracted in 2014/15 subject to confirmation of budget and agreement of their inclusion in the 2014/15 learning and development programme.

8.7 Costs are significantly reduced by contracting for courses to take place in Rotherham opposed to booking places on courses taking place outside of the borough, where such courses would not only incur additional travel and accommodation costs but also involve travel time away from families and environmental impact. However, where numbers of workers needing the training course is low, in particular the specialist Care Mapping Training, and a local course is not viable workers would be supported on open courses taking place in Yorkshire to ensure value for money and that need is met.

## 9. Risks and Uncertainties

9.1 Continuing to offer the training programmes detailed above is crucial in the delivery of nationally recognised training programmes that are accessible locally for Rotherham's entire adult social care workforce to train together, and offering the training at the best price through contracting local courses where there is demand and a course is viable

## 10. Policy and Performance Agenda Implications

10.1 The Strategic Director of Neighbourhoods and Adult Services is required to ensure that the Directorate's adult social care workforce and the workforce within the adult wider social care services commissioned by the local authority are supported and developed so that they have the required competencies to deliver services to both national and local standards.

## 11. Background Papers and Consultation

11.1 Consultation has taken place with colleagues in Procurement Services and all have confirmed agreement with the proposals.

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Ext: 22397

**ROTHERHAM BOROUGH COUNCIL – CABINET MEMBER**

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| 1 | **Meeting:** | **Cabinet Member for Adult Social Care** |
| 2 | **Date:** | **17 February 2014** |
| 3 | **Title:** | **Response to the Improving Lives Select Commission from the Safer Rotherham Partnership (SRP) Domestic Abuse Priority Group (DAPG)** |
| 4 | **Directorate:** | **Neighbourhoods and Adult Services** |

5 **Summary**

The attached response to the Improving Lives Select Commission from the Safer Rotherham Partnership (SRP) Domestic Abuse Priority Group (DAPG) is submitted to Cabinet Member for Adult Social Care meeting for information only.

6 **Recommendations**

- **Cabinet Member to note the content of the attached response for their information only.**

7 **Background**

At its meeting on 23 January 2013 the Improving Lives Select Commission agreed to undertake a scrutiny review of domestic abuse services to establish how different agencies work together in Rotherham to support people who have experienced domestic abuse. The review wished to address any service gaps and areas of duplication, to identify opportunities for working more effectively and efficiently, and to ensure agencies could respond to future challenges. Domestic abuse has been the subject of previous scrutiny reviews in 2002 and 2005 and with many recent policy changes both locally and nationally it was considered an opportune time to revisit this area of work. (The full report is attached for the information of DLT).

The findings of the review were presented to DAPG on 28th November 2013. Following this, DAPG agreed the attached response to the recommendations. These have been shared with all key partner agencies including DAPG partners. The SRP Executive Board is also aware of the review's full report and are awaiting presentation of this response to DLT prior to their comment.

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***Cabinet's Response to Scrutiny Review - Domestic Abuse***

| **Recommendation** | **Cabinet Decision** *(Accepted/ Rejected/ Deferred)* | **Cabinet Response** *(detailing proposed action if accepted, rationale for rejection, and why and when issue will be reconsidered if deferred)* | **Officer Responsible** | **Action by *(Date)*** |
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| 1. In order to facilitate longer term planning and retain skilled and experienced staff IDVAS funding should be mainstreamed rather than being 12 monthly. | Defer | The council fully endorses the intention of this recommendation, but following discussions between Departments we are unable to accept this at this time. The proposal would require funding up front from mainstream budgets which, due to current budget pressures, it has not been possible to achieve. The responsible officer will have discussions with key partners to look at funding from a multi-agency perspective. | Joyce Thacker | February 2014 |
| 2. A full audit of need for domestic abuse support and services is recommended with a view to moving towards joint commissioning of services. | Accept | Domestic Abuse now features in the Joint Strategic Needs Assessment. Although the Joint Strategic Needs Assessment now includes Domestic Abuse and an analysis of Domestic Abuse provision for 16 – 18 years was undertaken by Children's and Young People's Services in 2013/14, a full needs audit is to be undertaken. This will be completed by March 2014 and this will be led by RMBC | Chrissy Wright | March 2014 |
| 3. Agencies need to ensure a balance of appropriate workshop based training and e-learning is available for all relevant staff, workers and professionals, considering joint commissioning and joint funding to make the best use of time and resources. | Accept | A proposal to review and refresh the domestic abuse training provision is being prepared for discussion and approval at DAPG | Helen Wood | March 2014 |

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| 4. Members recommend that the statutory agencies i.e. the Council, Police and Health explore and report back on the feasibility of a pooled budget for domestic abuse services. | Accept | The SRP Executive agreed this recommendation on 08.01.14, but noted this was an extensive piece of work which, if a pooled budget was approved, would transform Domestic Abuse service provision in Rotherham. | Steve Parry/Cherryl Henry-Leach | March 2014 |
| 5. Members recommend that agencies explore and report back on the feasibility of an integrated joint working approach across all risk levels, such as a "one stop shop" or a "golden number" for domestic abuse referrals. | Accept | We are currently exploring the co-location of Domestic Abuse service providers in order to improve the multi-agency working in cases of Domestic Abuse. If this is achieved it is anticipated there will be a central number for victims to telephone for support and advice.<br><br>We are also investigating the feasibility of linking in with help line provision in other areas of South Yorkshire and moving this forward will be subject to available funding. | CI Ian Womersley | Septemb er 2014 |
| 6. The SRP Board should ensure sufficient resource allocation to enable any domestic homicide reviews to comply with the revised statutory guidance published by the Home Office in June 2013. | Accept | A paper was presented to the Safer Rotherham Partnership Executive on the 29th November 2013. This proposed that the Independent Chairing and report authoring of future DHRs would be jointly financed by the statutory partners of the Safer Rotherham Partnership. This proposal was considered by the Safer Rotherham Partnership and agreed on (insert date).<br><br>The contributions will be as follows:<br><br>Health (CCG) – 30%<br>RMBC – 30%<br>SYP – 30%<br>NPS - 10% | Cherryl Henry-Leach | Complete d – 19/12/13 |

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| 7. Domestic abuse is an issue that cuts across multiple portfolios therefore Cabinet might wish to consider identifying a Cabinet lead for domestic abuse. | Defer | We wish to defer this recommendation to await the outcome of discussions between the Chair of the Safer Rotherham Partnership Domestic Priority Group, Council Leaders and the elected members for Safeguarding Adults and Children. | Joyce Thacker | May 2014 |
| 8. As Domestic Abuse is a priority it should be made more explicit within other key strategies and plans. The JSNA and HWBS are both being refreshed, as is the Council's Corporate Plan, so this provides an opportunity to strengthen the focus on domestic abuse. | Accept | This is completed, as the JSNA has recently been refreshed and now includes Domestic Abuse. The Health and Well Being strategy will incorporate Domestic Abuse when it is next refreshed. In the interim, the JSNA will be the key resource to inform plans and priorities across the council and partners.<br><br>Members may wish to note that the Safer Rotherham Partnership has identified its priorities for the Joint Strategic Intelligence Assessment (JSIA) and Domestic Abuse has been confirmed as one of the Safer Rotherham Partnership's priorities for 2014/15. The review that the SRP will undertake in relation to recommendation 12 will, it is anticipated, strengthen the links between the JSIA and the JSNA | Kate Green/Cherryl Henry-Leach | Completed - 19.12.13 |
| 9. Drugs and alcohol play a significant part in domestic abuse cases, especially for standard/medium risk; therefore work-streams should take account of domestic abuse. | Accept | The Drugs and Alcohol Team **(**DAAT) within Rotherham Public Health are to arrange a workshop and invite all relevant partners to attend. This will enable to build a data profile in relation to Domestic Abuse where substance misuse is a feature. This will inform service responses to victims and perpetrators who may be in need of NHS services to reduce the dependence on drugs and alcohol. | Anne Charlesworth | March 2014 |

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| 10. Links with schools/colleges and other local organisations who work with 16-17 year old young people need to be strengthened to ensure age appropriate services and support. | Accept | The PHSE Curriculum in schools does not feature Domestic Abuse as routine. However, PHSE leads are, at PHSE Leads meetings, updated as to how sensitive issues such as Domestic Abuse can be addressed with the PHSE curriculum. Discussions are underway to adapt current Domestic Abuse training materials to ensure they are relevant for delivery within schools.<br><br>Discussion is also underway with local colleges to ensure they are familiar with contemporary Domestic Abuse processes and referral pathways (e.g. referral to MARAC) in addition to their statutory safeguarding obligations. | Kay Denton-Tarn | March 2014 |
| 11. Sexual violence should be integral to strategies and plans for work on violence against women and girls, whether it occurs in domestic or non-domestic settings. | Accept | The South Yorkshire Rape Steering Group is looking at developing a South Yorkshire wide strategy. This group will feedback progress from the County level meetings and assist local authority leads to translate the county wide priorities into relevant local strategies. In the New Year, we will identify which Council lead will hold the lead for sexual violence - Public Health or the Community Safety Partnership. | Mel Simmonds | March 2014 |
| 12. A full review of domestic abuse structures, communications and governance arrangements within the SRP should be carried out to clarify and reaffirm roles and responsibilities between:<br><br>a) DAPG and RDAF | Accept | Discussions between the Safer Rotherham Partnership Domestic Abuse Priority Group and Forum are underway. It is anticipated that the outcome of those discussions will be the two | Joyce Thacker | April 2014 |

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| | | groups will be merged from April 2014. | | |
| b) SRP Executive, JAG and DAPG | Accept | The SRP accept there is a need to ensure other Boards and Partnerships are clear on the reporting structures for Domestic Abuse to the SRP. The Executive agreed, on 08.01.14, to lead this review | Steve Parry | April 2014 |
| 13. The ACPO DASH risk assessment form should be used by all agencies, supported by training, to ensure a universal and consistent approach to risk assessment | Accept | SYP advise that they are on target to switch to use of this risk assessment tool in February 2014 and will be training front line Police staff throughout January and February. The MARAC and Risk Assessment Workshop will also continue to be run and, as Multi Agency Training, will be open to all agencies who come into contact with cases where Domestic Abuse is a feature. | Pete Horner/Cherryl Henry-Leach | March 2014 |
| 14. A standard multi-agency protocol and process should be developed for standard and medium risk assessment to ensure consistency in approach and common pathways communicated and understood by all partners, to include risk assessment in children's health and social care such as pre-birth assessments | Accept | The RLSCB has a Domestic Abuse protocol (from 2008). This is to be reviewed to ensure consistency and common pathways that are clearly understood by partners in cases non-high risk cases of Domestic Abuse. Pre Birth Assessments where Domestic Abuse has been identified as an issue during pregnancy are now being undertaken. | Phil Morris/Cherryl Henry-Leach | April 2014 |
| 15. A standard multi-agency protocol and process should be developed for contacting victims at all risk levels to avoid duplicating referrals or initial contact. | Accept | Much of the duplication in contacting victims of Domestic Abuse links to national protocol between the Police and Victim Support. We are currently exploring how the duplication of contacting victims of Domestic Abuse and sexual violence can be reduced at a local level. | Cherryl Henry-Leach | April 2014 |

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| 16. Subject to agreement with CAADA Members recommend that NHS South Yorkshire and Bassetlaw be approached with a view to rolling out the GP flowchart setting out how to respond to domestic abuse to dentists and pharmacists. | Accept | Whilst we welcome this recommendation, CAADA informed us in November 2013 that their GP Flowchart cannot be rolled out to other services, but that they have no objection to our developing a similar flow chart for use by dentists, pharmacists, solicitors and other disparate service providers. This is now under development and launch is anticipated by 31st March 2014. It will need to be agreed by the CCG and NHS England prior to launch, which may delay the date. | Ruth Fletcher-Brown/Cherryl Henry-Leach | March 2014 |
| 17. A perpetrator programme should be established in Rotherham as part of the work on prevention and early intervention and to ensure compliance with the SDVC components. | Accept | A bid was submitted to the EEC Daphne funding stream to finance the development and roll out of a perpetrator programme. We were informed on 27th November 2013 that this bid was unsuccessful and we are now scoping for other funding opportunities to support this area of work. This includes approaching the Police and Crime Commissioner for funding of a non- criminal justice community based perpetrator programme. | CI Ian Womersley | |
| 18. A review should be carried out on resource allocation in order to focus more on standard/medium risk cases as part of the early intervention and prevention agenda and to prevent escalation to high risk and MARAC which is very resource intensive. | Agree | We are currently undertaking a review that covers this area of work and have established the need to train our Early Help workforce in the use of a Domestic Abuse Matrix that will ensure appropriate alignment of support of a child living with Domestic Abuse and the management of the risk posed to the abused adult parent or carer. This training will be completed by June 2014. In addition, we have also established the Early Help Panel which ensures, where Domestic Abuse is a feature in cases referred to this Panel, that Domestic Abuse is responded to appropriately where the risk is assessed as standard and medium to ensure risk escalation is prevented. | Clair Pyper/Warren Carratt | June 2014 |

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| Funding allocation for low cost but effective target hardening measures should be considered in the review. | Agree (subject to available funding) | This is available for victims of Domestic Abuse who reside in Local Authority Housing. Victim Support Rotherham has received temporary funding from the Ministry of Justice for this and this is reviewed annually at a national level. Funding opportunities at a local level are being sourced to ensure that increased security measures can be offered to victims of Domestic Abuse living in private tenure properties where the risk posed to the victims are standard or medium. | Cherryl Henry-Leach | |
| 19. Members emphasised the importance of raising awareness with children and young people of how to recognise coercive relationships and to recognise and report domestic abuse, but recommend a review of the training strategy, including who is best placed to deliver the training, in order to ensure the best use of staff resources. | Accept | This recommendation will be achieved through completion of the actions on recommendations 3 and 10. | Helen Wood and Kay Denton-Tarn | |
| 20. Members recommend that Forced Marriage and so called “Honour” based violence be the subject of a separate review by Improving Lives Select Commission in 2014. | Accept | The JSIA has identified Forced Marriage and “Honour” based violence as an area of work to be developed by the Safer Rotherham Partnership. We will be undertaking a review of Forced Marriage and “Honour” based violence during February to April 2014 which will enable us to map the prevalence of this form abuse and identify gaps in local service provision. Findings will be presented to the Safer Rotherham Partnership Domestic Abuse Priority group in May/June 2014.<br><br>Members may wish to undertake their review once the findings from the above planned review are available. | Cherryl Henry-Leach | June 2014 |

Rotherham Metropolitan Borough Council

# Scrutiny review: Domestic Abuse

## Review of the Improving Lives Select Commission

*April – July 2013*

**Scrutiny Review Group:**

Cllr Jo Burton (Chair)
Cllr Shabana Ahmed
Cllr Maggi Clark
Cllr Denise Lelliott
Cllr Ann Russell

*6/11/2013*

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**Executive summary**

Domestic abuse is one of the four priority areas for the Safer Rotherham Partnership (SRP) as determined through the Joint Strategic Intelligence Assessment - "Reducing the threat and harm to victims of Domestic Abuse, Stalking and Harassment, Honour Based Abuse and Forced Marriage". It is also a priority in the Children and Young People's Plan and features in the South Yorkshire Police and Crime Commissioner's plan for 2013-17.

A wide number of organisations currently deliver domestic abuse-related support within Rotherham; across local authority, criminal justice, health and voluntary sector services. It is important that a coordinated approach is taken across partner agencies to ensure appropriate and timely support is provided through effective use of resources.

The review recognised that some excellent work is taking place locally driven by the Domestic Abuse Priority Group, on behalf of the SRP, with the Domestic Abuse Coordinator leading on many positive changes to local practice in the last few years.

Voluntary and community sector partners play a major role across all risk levels, but particularly in standard/medium risk cases, in delivering specialist services and in providing ongoing practical and emotional support for victims and their families, with very much an "open door" policy.

The two Independent Domestic Violence Advocates represent the voice of the victim at the Multi-Agency Risk Assessment Conference (MARAC) and other panels, and coordinate a range of measures, often working very creatively, to reduce risk to victims. However the IDVA service is only funded on a year by year basis which appears inconsistent with the level of priority afforded to domestic abuse within the SRP. This short-term approach inhibits service planning for what is an essential and effective service.

The MARAC works effectively on high risk cases, many of which are exceedingly complex, despite staffing resources being below the levels recommended by Coordinated Action Against Domestic Abuse. Good information sharing between partners and a willingness to work together is evident.

However the view is that long term success for Rotherham in addressing domestic abuse would ultimately mean fewer incidents of domestic abuse, including fewer MARAC cases and fewer repeat cases to MARAC. This leads to questions of resource allocation between high risk cases, where people are assessed as being in danger of serious harm or death, balanced against resource allocation for standard/medium risk cases through preventive and early intervention measures to try and avoid escalation.

While the prime focus of the review was concerned with support for victims of domestic abuse it was noted that currently there is no non-criminal justice system perpetrator programme, an important element in prevention, despite this being a component of the Specialist Domestic Violence Court.

The impact on children and young people of domestic abuse is significant and in addition to dealing with immediate issues it is important to ensure that children are coping with the impact of domestic abuse in the longer term, building resilience and developing positive relationships. Sustainable support and services for children and young people of all ages under 18 need to be available.

Although work on high risk cases is governed by clear protocols there is much less consistency and integrated working by partners for standard and medium risk cases, which has led to some areas of duplication, particularly in relation to referrals and with regard to

different agencies contacting the victim initially. There are also inconsistencies in risk assessments as all partners do not yet use a common assessment tool.

Domestic abuse structures within the SRP and attendance at meetings should be reviewed as the current structure seems resource intensive in terms of officer/worker attendance at meetings. Roles and responsibilities within the structure for commissioners and service providers also require clarification as a number of people attend both the Domestic Abuse Priority Group and the Rotherham Domestic Abuse Forum.

Statutory health partners play an active role in the MARAC and within the SRP structures, but uncertainty exists over their wider role and responsibilities. Positive work is ongoing to raise awareness with health staff on how to recognise and report domestic abuse, as referrals are still low from many health partners, such as GPs and dentists. In a time of austerity and needing to maximise the efficient use of resources an integrated approach should be explored between the Council, police and health partners for joint funding and joint commissioning. This should also be extended to consider possible models for joint working, across all risk levels, such as a “one stop shop” approach.

A number of recommendations have been made by the review group and these focus on ensuring that agencies in Rotherham work together effectively and efficiently to tackle domestic abuse at all risk levels and to ensure appropriate support for victims. There also needs to be greater integration of domestic abuse as an explicit golden thread within major plans and strategies, including the Joint Strategic Needs Assessment, Health and Wellbeing Strategy and RMBC Corporate Plan when they are refreshed.

The review recommendations are summarised below, covering the following areas:

**Commissioning and funding** – mainstreaming funding for the IDVAS; carrying out an audit of need for domestic abuse support and services; exploring joint commissioning and joint funding of services and training; and considering the feasibility of more integrated working through a “one stop shop” or a “golden number”.

**Strategy** – as a priority for SRP domestic abuse should be explicit within other key strategies when they are refreshed; workstreams for drugs and alcohol need to take account of domestic abuse; sexual violence in non-domestic settings should be more integrated in work on violence against women and girls; and links with local organisations who work with 16-17 year olds need to be strengthened.

**Roles and responsibilities** – reviewing the structures, communications and governance arrangements with the SRP to clarify and reaffirm roles and responsibilities.

**Protocol and process** – ensuring the ACPO DASH risk assessment form is used by all agencies; developing a standard multi-agency protocol and process for contacting victims at all risk levels to avoid duplication; and developing a similar protocol and process for standard/medium risk assessments to ensure consistency and common pathways.

**Prevention and early intervention** – developing a perpetrator programme to comply with the Specialist Domestic Violence Court components; reviewing resource allocation in order to focus on standard/medium risk cases to prevent escalation to high risk; and continuing to raise awareness with young people about coercive relationships and domestic abuse, reviewing who is best placed to deliver the training.

**Forced marriage and so called “honour” based violence** – to be the subject of a separate review by Improving Lives Select Commission in 2014.

## 1. Why Members wanted to undertake this review

At its meeting on 23 January 2013 the Improving Lives Select Commission agreed to undertake a scrutiny review of domestic abuse services to establish how different agencies work together in Rotherham to support people who have experienced domestic abuse. The review wished to address any service gaps and areas of duplication, to identify opportunities for working more effectively and efficiently, and to ensure agencies could respond to future challenges. Domestic abuse has been the subject of previous scrutiny reviews in 2002 and 2005 and with many recent policy changes both locally and nationally it was considered an opportune time to revisit this area of work.

There were four main aims of the review, which were to consider:

- What a 'good' service looks like (drawing on national guidance and best practice elsewhere)
- How well partners work together at a strategic level
- How well partners work together operationally
- How well partners listen to the voice of the victim and their families

## 2. Method

The review was carried out by a sub-group of the Improving Lives Select Commission, consisting of Cllrs Ahmed, Burton (Chair), Clark, Lelliott and Russell.

An initial presentation to the full commission provided an introduction and set the context, both national and local – including the definition of domestic abuse and how this manifests; profiles of domestic abuse victims and offenders; and domestic abuse services. Several evidence gathering sessions then followed during which a range of partners from both statutory and voluntary and community sectors participated to provide information (details in Appendix 1). Current structures and processes, resources, information sharing between partners, assessing and reducing risk, and work at both strategic and operational level were themes explored in depth during the review.

Anonymised case studies were used to scrutinise service user experiences and to understand how our existing approaches are used to protect victims of abuse, taking account of differing individual circumstances and protected characteristics such as age or disability.

Members would like to thank everyone who gave evidence for the review and in particular they gratefully acknowledge the help and support received from Cherryl Henry-Leach and Helen Wood in identifying witnesses and sources of evidence to inform the review.

## 3. Background

Domestic abuse is defined as: "Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members, regardless of gender or sexuality. It can encompass, but is not limited to the following types of abuse - psychological, physical, sexual, financial or emotional abuse."

As the definition removes the focus on single incidents of domestic violence it encourages practitioners to look at patterns of abusive behaviour beyond any physical violence –

ensuring victims receive appropriate support regardless of risk.

High risk cases are ones where people are at risk of serious harm, where the risk is either life threatening and/or traumatic, and from which recovery, whether physical or psychological, can be expected to be difficult or impossible.

Domestic abuse is a global issue experienced across every section of society regardless of social group, ethnic background, age, gender, disability, sexuality or religion. Its effects are profoundly damaging for individuals, families and society as a whole and it will need a radical transformation in attitudes and cultures worldwide to eliminate it.

Domestic abuse has a considerable affect on services in terms of monetary cost and the long term harmful effects, both physical and emotional to primary victims and their children. Over recent years, the current Government and previous administration, has recognised that, in addition to the tragic incidents of domestic homicides and serious injury, domestic abuse is fundamentally linked to other social problems be it poor mental health, substance misuse, or homelessness. Its impact on children is also profound with it being a major factor in child abuse and neglect, issues of sexual exploitation, and adolescent violence.

In November 2010, the Government set out its vision and ambition to tackle domestic and sexual violence in 'A Call to End Violence against Women and Girls'. In March 2011, it published 88 supporting actions for taking that strategy forward; with the Action Plan reviewed and updated in March 2012 and again in March 2013 when the broader definition of domestic abuse to include 16-17 year olds and coercive control was introduced. One of the guiding principles in the strategy is:

> "To prevent violence against women and girls from happening in the first place, by challenging the attitudes and behaviours that foster it and intervening early to prevent it."

A wide number of organisations currently deliver domestic abuse-related support within Rotherham; across local authority, criminal justice, health and voluntary sector services. It is important that a coordinated approach is taken across partner agencies to ensure appropriate and timely support is provided through effective use of resources.

To give a brief indication of the scale of domestic abuse in Rotherham in 2012-13 5555 incidents were responded to by the police and of these 961 were crimes (see page 23 for an explanation of crimed and non-crimed incidents). Of the 5555 incidents, 348 (336 women and 12 men) were high risk and referred to the Multi-Agency Risk Assessment Conference (MARAC). In the same year domestic violence accounted for 31% of all violence against the person offences in Rotherham, slightly up on the year before. 2,957 children and young people were the subject of new contacts to the Contact and Referral Team in 2012 due to domestic abuse. 26% of these contacts (769 young people) then progressed to referrals for services including assessment. Further national and local statistics are included in Appendix 2.

## 4. Rotherham's Response to the Call to End Violence against Women and Girls

The Government strategy and action plan underpins the work of all partner agencies working within the domestic and sexual abuse sector. It requires a coordinated response and seeks to protect and support victims and to hold perpetrators to account.

### 4.1 Strategy

Rotherham's response is led by the Domestic Abuse Priority Group (DAPG) on behalf of the SRP through a three pronged strategic approach:

**Prevent** - We will make it more difficult for domestic abuse to happen.

**Protect** - We will identify and safeguard those at risk.

**Pursue** - We will identify perpetrators, disrupt and prosecute where possible.

In the short to medium term, work is focused on encouraging victims to come forward and report violence and abuse, whilst at the same time reducing repeat victimisation. In the longer term the focus will be seeking to eliminate violence against women and girls. More specifically agencies in Rotherham have responded by:

- recognising domestic abuse as a safeguarding issue
- aligning work on domestic abuse and sexual violence
- complying with the Specialist Domestic Violence Court (SDVC) components
- developing a process to review domestic homicides and serious incidents of domestic abuse
- ensuring support for direct victims of domestic abuse aged 16 and 17
- delivering multi-agency training, which is regularly updated
- agreeing an operating protocol to establish accountability and reporting structures for the MARAC and to outline the MARAC process
- ensuring early intervention agendas are reflected in responses, such as taking account of the needs of children living with domestic abuse
- developing a strategy and action plan
- creating a robust new performance framework to measure and monitor progress
- providing support for men and boys although recognising that domestic abuse is primarily a gender based form of abuse
- initiating a project to work with serial perpetrators
- having clear procedures in the housing allocation policy

Rotherham is seeing an increase in referrals each year and expects this upward trend to continue. Although this may be attributable in large part to growing awareness of what and how to report following all the work that has been carried out, it could also mean more incidents are happening. Either way it creates increased work for agencies and adequate resources used effectively and efficiently to meet demand is imperative.

Rather than provide details of the precise roles of every individual partner involved in tackling domestic abuse a broad overview follows. Specific points for individual agencies who are not mentioned below, such as health partners, are covered in section 6.

### 4.2 SRP Domestic Abuse Coordinator

The review recognised that some excellent work is taking place locally (as indicated above) driven by the DAPG, on behalf of the SRP, with the Domestic Abuse Coordinator leading on many positive changes to local practice, training and strategy development in the last few years. The coordinator is involved with the DAPG, RDAF and the MARAC and as such retains a key overview of both strategic and operational issues.

### 4.3 Independent Domestic Violence Advocacy Service

Rotherham currently has two Independent Domestic Violence Advocates (IDVAs) whose main role is to secure the safety of victims at high risk of harm from intimate partners, ex-partners or family members and the safety of their children. Following a referral the IDVAs attempt to contact a victim within 48 hours and they are the victim's primary point of contact, working with the victim to assess the level of risk, discuss suitable options and develop safety plans. As well as addressing immediate safety issues the IDVAs also work on developing longer term solutions through MARAC, the courts and other services such as housing.

The IDVAs are independent, which is essential for them to be effective advocates and their caseload is up to 30 clients at a time. Their role in all multi-agency settings including MARAC is to represent the victim and make sure the victim's perspective and safety is at the centre of proceedings. However the posts are not mainstream funded and are renewed on an annual basis, at short notice. From the case studies discussed during the review it was evident how vital the knowledge, skills and experience of the IDVAs is in Rotherham and the service should not be jeopardised through the short term approach to funding.

### 4.4 Multi-Agency Risk Assessment Conference (MARAC)

This is a multi-agency meeting chaired by the Public Protection Unit in South Yorkshire Police (SYP) which takes place fortnightly to discuss the highest risk cases of domestic abuse in order to reduce the risk of serious harm or murder. Partners are committed to the MARAC but it is resource intensive in terms of time commitment and there are concerns regarding attendance at meetings by some agencies when referrals are made.

### 4.5 Voluntary and Community Sector partners

In Rotherham the VCS partners provide an extensive range of emotional and practical support and services for victims of domestic abuse and their families, across all risk levels, but particularly in standard/medium risk cases. Specialist services include counselling; access to safe accommodation; support for Black and Minority Ethnic women; advocacy; support through the criminal justice system for victims and witnesses; support with immigration status; applications for criminal injury compensation; and maternity services liaison – ensuring the voice of women affected by domestic abuse is heard in the development of services. Training delivery is another key element of their work.

Other services involve: 1:1 and group work with victims; floating support; safety planning and risk assessment; help with benefits, debt and related money issues; parenting support; target hardening; children's activities including therapeutic work; skills and personal development; and outreach. Outreach services are important in helping and supporting victims of domestic abuse to identify choices and make informed decisions. Outreach support also includes looking at healthy relationships and trying to prevent engagement in future abusive or violent relationships.

As is the nature of the voluntary and community sector here in Rotherham organisations very much have an "open door" policy, which is positive and much relied upon, but does have resource implications and services may become more stretched as a result.

The evidence presented during the review illustrated the depth of experience and specialist knowledge within the VCS partners. However like the IDVAS the sector also experiences short term funding for many contracts, which again impacts on service planning and may also affect continuity and stability for service users. One partner agency also noted that the competitive nature of tendering has a destabilising effect.

## 5. Findings

### 5.1 What a 'good' service looks like

Overall a good service could be summarised very briefly as one which achieves a good outcome for the victim and their family. This may mean increased safety and support if the victim does decide to stay with the perpetrator, as for many reasons victims do not always leave an abusive relationship, or may not leave for a long period of time.

Developing and maintaining a good service will draw upon the following for guidance:

- 'A Call to End Violence against Women and Girls' strategy and action plan - the national policy framework
- Specialist Domestic Violence Court (SDVC) programme - which aims to provide continuity of support to victims and a victim centred approach to the criminal justice process
- Co-ordinated Action Against Domestic Abuse (CAADA) - practical help to support professionals and organisations working with high risk domestic abuse victims
- Domestic Homicide Review findings and recommendations – nationally and locally

CAADA's view is that the Rotherham MARAC is well established and therefore should receive more cases and more repeats than the present volume. Whilst the review group fully endorsed the need for the MARAC to protect people at high risk our measure of success in the long term would be fewer cases of domestic abuse overall. This would include fewer cases going to MARAC, and fewer repeat cases, because cases have been responded to in a manner which has avoided escalation or prevented recurrence. This leads to questions of resource allocation between high risk cases, where people are assessed as being in danger of serious harm or death, balanced against resource allocation for standard/medium risk cases through preventive and early intervention measures to try and avoid escalation.

Existing good practice in Rotherham has already been acknowledged, but it is worthwhile highlighting examples of good practice in other parts of the country that Rotherham may be able to learn from in order to realize further improvements to our services.

The national VAWG strategy promotes a number of good practice examples such as Cardiff, which has a Women's Safety Unit, comprising a comprehensive range of services at one referral point for women who have survived domestic violence and/or known perpetrator rape. Oxford has set up a one stop shop for victims located in a neutral location, where a multi-agency team provides the frontline element of integrated support and advice. More detail about Oxford's Champions Scheme and services in Sheffield, also cited as good practice in the strategy, is given below, together with other examples from across the country.

- **Sheffield – Helpline and Co-location**

In 2010 Sheffield reorganised its domestic abuse services so they were co-ordinated in a more strategic way. A helpline was instigated as a single point of contact for both victims

and agencies to telephone with referrals, with signposting then resulting as appropriate. The outreach service, helpline and IDVAS were co-located with the police and children's social care. Benefits of co-location in the same building include rapid information sharing which helps to reduce duplication. Police attending incidents will ask the victim if they wish to be referred to the helpline and if consent is given this results in a proactive call (for standard/medium risk cases) to explain possible support available, thus enabling an early intervention to be offered to people who may not otherwise have accessed support.

- **Oxfordshire County Council – Champions Scheme**

The aim of the scheme was to encourage early disclosure and an effective multi-agency response to domestic abuse. Champions act as the lead for domestic abuse within their own agency and as a link to other local support services. Oxfordshire currently has a total of over 800 active champions in local organisations. The scheme has been successful in leading to increased incident reporting and in being an effective approach for early intervention.

- **Hackney – Vulnerable Families Centre**

Hackney's in-house Domestic Violence and Hate Crime Team supports standard risk victims of domestic violence through advice, information, advocacy, support and counselling services. In 2011 they moved to joint premises with the Drug and Alcohol Services to create a Vulnerable Families Centre in recognition of the links between the two services. (Home Office research has shown that alcohol use was a feature of 62% of DV offences.) The team also runs a freephone DV Helpline number.

- **Gateshead – Youth Offending Team and Children's Services**

The Youth Offending Team provides advice to victims of domestic abuse and signposting to other specialist services that can offer more appropriate help. If there is a risk of domestic abuse identified within the household or in a relationship of any YOT clients the individual will be offered a place on the voluntary Respect Adolescent Program.

Gateshead's Children's Service supports families in which domestic abuse is a feature (for both Child In Need and Child Protection cases) and includes direct work with victims, perpetrators and children around the impact of abuse within families. The service also offers Specialist Children's Domestic Violence Workers within the Referral and Assessment Team and Safeguarding Teams, which allows direct work with children experiencing domestic abuse.

- **Cambridge – Mainstream Resources and Multi–agency referral unit**

The Multi-agency Referral Unit provides a seamless service to 999 callers and agencies reporting domestic abuse and can be used as a point of contact for all risk levels. This helps to reduce the likelihood of escalation and duplication, with obvious benefits to victims, whilst reducing the impact on the agencies involved. Resources for the Domestic Abuse Partnership and the IDVAS have been mainstreamed so they are not reliant on grant funding.

### 5.2 How well partners work together at a strategic level

Section 6 details specific issues that emerged during the course of the review in relation to partnership working at strategic level. The main finding from the review is that although there is much good work taking place locally on domestic abuse it is not yet a fully integrated function at a strategic level across all partner agencies or within the structures of the SRP. No overall audit of need for the borough has been carried out to inform commissioning and budget allocation and there is no reference to domestic abuse and its impact on adults in the JSNA.

### 5.3 How well partners work together operationally

Members found a clear distinction between operational partnership working at high risk level, which is more unified, and operational partnership working on standard/medium risk cases, which is less evolved. Section 6 draws attention to potential areas for improvement.

Two major areas of duplication identified in the review were victims being contacted initially by more than one agency, and referrals being made to more than one agency simultaneously. This may in part be due to the lack of clear pathways and protocols for standard/medium risk cases, although it does also occur in high risk cases, but it is not a good use of resources.

- **High risk**

The MARAC is an effective group for work on high risk cases with good commitment, agreed protocols and timescales for actions to be completed and effective information sharing between members, despite staffing resources for both the IDVAS and administrative support being below the levels recommended by CAADA.

Many very positive working relationships have developed between staff in partner agencies and following receipt of a high risk referral by the IDVAS within an hour there may be 16 agencies working together to support that person/family.

Out of hours cover is provided through Rothercare Direct and SYP. Rothercare Direct will provide sign posting advice and ensure the IDVAs are informed of any cases picked up out of hours.

A joint working arrangement is in place between the IDVAS and the SARC (Sexual Assault Referral Centre) whereby the two services liaise to determine whether the IDVA or the Independent Sexual Violence Advocate (ISVA) would be best supporting a victim.

- **Standard/medium risk**

Although work on high risk cases is governed by clear protocols there is much less consistency and integrated working by partners for standard and medium risk cases, which has led to the areas of duplication, as mentioned above. As not all partners use the ACPO DASH form as a common assessment tool inconsistencies are also found in risk assessments.

### 5.4 How well partners listen to the voice of the victim and their families

Agencies do try and capture the voice of the victim but it is a sensitive area and often difficult to know when might be an appropriate time to ask for feedback. Understandably many victims just want the abuse to stop and may not wish to revisit their experiences, for example through journey mapping, once their safety is secured. However the new performance framework will endeavour to capture more qualitative information in addition to the quantitative measures.

For high risk cases the IDVAs work very closely with victims and advocate on their behalf at meetings in order to put forward the victim's perspective. They do get feedback from clients as the positive quotes below show but there is no formal process to record this, although it is under consideration:

"I could not have left without your support"

"You supported me to make my own choices"
"You never judged me"
"You believed me and I felt safe"

Service user involvement in delivering services features strongly in the work of VCS partners, helping to inform service development and delivery:

- **Apna Haq**:

– there are 12 places on the management board and seven are service users who have been trained up to fill those roles
– service user stories are published on their website which include feedback about the organisation and support provided
"extremely grateful to Apna Haq for how supportive they were and how quickly they acted once I realised that he was not going to change"

- **Choices and Options**:

– people come back and help/volunteer once they are ok themselves
– feedback is requested and fed in (expected as part of Supporting People contract) but there are barriers around sensitive issues e.g. mentioning social services and children
– experiences vary but for most it is "thank goodness someone is listening"

- **GROW**:

– service user comment: "My GROW worker was fantastic and made me realise I wasn't alone and I was able to speak freely without judgement"
– Friends of GROW is a service user group that helps shape services
– maternity services liaison ensures the voice of women affected by domestic abuse is heard in the development of services

- **Rotherham Women's Counselling Service**:

- weekly drop-ins run by service users for service users
- at the AGM three survivors spoke about their personal experiences

- **Rotherham Women's Refuge**:

- women will come back as they have built a relationship and trust with a worker, even if it is a few years on
- service user comments are posted on their website, for example:
"I have come a long way, without you people I would not have got where I am"

- **Victim Support**:

- seek qualitative feedback from victims through quality of service calls to check needs are met
- national satisfaction surveys are published monthly, 92% positive (May 2013)

## 6. Conclusions

### 6.1 Independent Domestic Violence Advocacy Service

The IDVAs are skilled, experienced staff who have undergone an intensive, specialist six month training programme with CAADA and who represent the voice of victims of domestic abuse at MARAC and other panels. Longer term funding would assist in planning future services, help to retain experienced workers and would prevent the service from having to prepare an exit strategy each February. As such and given the priority afforded to domestic abuse in the JSIA and by SRP, Members were unanimous that their most important recommendation is to secure mainstream funding for the IDVAS.

### 6.2 Joint Strategic Needs Assessment (JSNA)

The JSNA establishes the current and future health and social care needs of the community. Using this information to agree commissioning priorities and targeting resources to those most in need leads to improved outcomes and reductions in health inequalities.

In the current JSNA there is no reference to the incidence and impact of domestic abuse on the health of adults although the prevalence in referrals into children's social care services is mentioned. The review group noted that misuse of drugs and alcohol plays a significant part in cases of standard and medium risk domestic abuse and through identifying need workstreams in these areas should link in with prevention work. Drug and alcohol harm and offender management are also overarching themes in the JSIA.

### 6.3 Audit of need

No full audit of need for domestic abuse support services for both adults and children and young people has been carried out across the borough to inform commissioning and resource allocation. An audit could potentially be included within the refresh of the JSNA and would enable an integrated joint commissioning plan to be developed, taking a more strategic approach to targeting resources effectively across statutory partners.

In addition to support for victims and their families this approach could also extend to training for staff across partner agencies.

Insufficient counselling to meet local needs was one area identified in the review as there are lengthy waiting lists for specialist counselling for adults and no specialist or play therapy for children. Further support and services for children and young people affected by domestic abuse, or who experience domestic abuse in their relationships, including for children under the age of 16, was identified as a need.

Carrying out a full audit of need would not preclude the necessity of securing the funding for the IDVAS as an immediate priority.

### 6.4 MARAC

The DAPG acts as the steering group for the MARAC and is currently overseeing the completion of a MARAC self assessment under the auspices of CAADA, which will assist in identifying any areas for improvement. The MARAC is working effectively but is resource intensive with regard to officer/worker time with up to 20 people involved for potentially a full day every fortnight. In addition to the core membership other partners are required to attend if they have made a referral to the MARAC and this coupled with attendance at DAPG and/or RDAF does amount to a significant time resource implication, particularly for smaller VCS organisations. This is one reason why Members recommend a review of the SRP structure and roles/membership of DAPG and RDAF (see below) to ensure appropriate attendance at all meetings whilst trying to reduce resource pressures.

### 6.5 Safer Rotherham Partnership structure (Appendix 3)

- **Roles and responsibilities**

Domestic abuse structures and attendance at meetings for the Domestic Abuse Priority Group (DAPG) and the Rotherham Domestic Abuse Forum (RDAF) within the SRP should be reviewed and possibly streamlined, as the current structure seems resource intensive in terms of officer/worker attendance at meetings.

Roles and responsibilities within the structure for both commissioners and service providers also require clarification as a number of people attend both the DAPG and the

RDAF. Although the DAPG is the strategic group and the RDAF more operational in focus in practice the respective roles and responsibilities of the two groups are blurred.

Both groups have fairly recently appointed new Chairs so it is timely to revisit this to avoid any duplication and perhaps reduce the number of meetings people attend as many people currently attend both groups, which is a considerable commitment for smaller partners, especially from the VCS, who may also have to attend MARAC on a fortnightly basis.

- **Governance and communications**

There is a lack of clarity with regard to governance arrangements and although domestic abuse is a SRP priority it is uncertain if this is reflected in the actual work and emphasis within the SRP structure above DAPG level. Although recognising that improvements are being made with regard to two way communication and reporting between the different tiers within the SRP, Members felt this was an area necessitating further work, particularly linkages between the SRP Board/Executive, Joint Action Group (JAG) and DAPG.

Members recommend a review is carried out of the membership, roles and responsibilities of the DAPG and the RDAF. They also recommend a review of governance arrangements and communications between the SRP Board/Executive, Joint Action Group (JAG) and DAPG.

### 6.6 Services for 16-17 year olds

All four areas in South Yorkshire had already run a successful MARAC pilot for this age group, with Rotherham receiving two referrals and obtaining positive outcomes for the young people, before the new national definition was introduced by the Government. Providers of floating support through Supporting People contracts have extended their provision to include people who are 16+. There were some clear recommendations from the pilot to take forward and further work is needed to link in with other local agencies who work with this age group, including strengthening the involvement of the Integrated Youth Support Service (IYSS) within the multi-agency structures.

### 6.7 Portfolio responsibilities

Domestic abuse is a complex issue with implications for many areas of strategy and policy, with service provision requiring a multi disciplinary approach. By its very complexity it cuts across the portfolios of several Cabinet Members – adults; children and young people; equality and Integrated Youth Support Service; health and wellbeing; and safe communities – all of whom recognise the importance of the issue, but there is no single clear lead. In order to facilitate a strategic approach at Cabinet level the review group recommends that one Cabinet Member is nominated as the overall strategic lead for domestic abuse.

### 6.8 Risk assessments

Ensuring consistency in completing risk assessments for domestic abuse incidents, at all risk levels, is important in order to provide appropriate interventions and support for victims and their families. This is the case both within and between different partner agencies. The review group noted disparities in the level of risk sometimes assigned to cases between assessments carried out by domestic abuse professionals and those carried out by the police, which may be attributable to the use of different risk assessment forms. Members recommend that all partners use the ACPO DASH risk assessment form, with training to support this roll out.

Domestic abuse risk assessments are not carried out as routine for standard/medium risk in pre-birth assessments, which is a potential missed opportunity. A consistent approach

to assessment is required by both social care and wider partner agencies, including health professionals, with regard to the Common Assessment Framework (CAF). Further work is needed to align the MARAC risk assessment process with other risk assessment processes in CYPS.

### 6.9 Standard and medium risk referrals

If a worker completes an ACPO DASH risk assessment form and using their professional experience decides it is a standard or medium risk case rather than high risk there does not seem to be a clear standard agreed process and pathway for referring this appropriately. Members recommend that this is a key area to develop.

### 6.10 Pathways and protocols

The JSIA stressed the importance of agencies within the SRP avoiding duplication of work, and as stated in Section 5 the two main areas of duplication identified in the review were victims being contacted initially by more than one agency, and referrals being made to more than one agency simultaneously.

Pathways and protocols in Rotherham need to be sensitive to local need. Evidence shows that duplication is not good for victims, possibly also increasing risk through different agencies making contact, in addition to not being an effective use of resources.

A further step beyond developing clear pathways and protocols to reduce duplication would be to develop a service on similar lines to Sheffield, which features a co-located team in a “one stop shop” and a dedicated telephone helpline. Recognising that Rotherham borough is very different and much smaller than Sheffield the review group are keen to explore the feasibility of having either an integrated “one stop shop” approach or a single “golden number” for all initial referrals and queries with specialist trained staff.

### 6.11 Prevention and Early Intervention

Increasingly in recent years there has been a focus on prevention and early intervention (or early help) across a number of workstreams in Rotherham, and as stated earlier it is a guiding principle in the national VAWG strategy. Domestic abuse is an area where potentially there is scope to revisit the present allocation of resources to allow greater investment in prevention and early intervention. This would entail a greater focus on standard and medium risk cases, in order to try and reduce escalation to high risk for the victim and the need for referral to the MARAC. Training and awareness raising, for example with staff in schools so they can identify and report concerns, as well as awareness raising work with young people also lends support.

- **Work with perpetrators**

Although the review scope was primarily scrutinising support for victims central to the prevention and early intervention agenda will be the establishment of a non-criminal justice system perpetrator programme, which is also one of the core SDVC components and is not currently complied with locally.

- **Target hardening**

Funding for target hardening has been reduced in recent years. Currently council tenants are able to access target hardening through Housing and Neighbourhood Services for any risk level and the IDVAs will contact the relevant team for any high risk cases they are involved in where work is needed urgently. High risk non-council tenants can be given some target hardening as this is funded by the IDVAS but if the tenure is private and the risk is standard or medium then there is no funding available at present. Funding allocation for target hardening should be reviewed as Members noted the effectiveness of easy and low cost interventions such as changing door locks, installing chains and bolts or

sealing letterboxes that may prevent escalation, which costs significantly more to deal with and means victims may endure more sustained abuse.

- **Children and Young People's Services**

Although it is at an early stage Members welcomed the new multi-agency Early Help Support Panel that has been established, with involvement from the Domestic Abuse Coordinator. The IDVAs are also involved in Families for Change work and the Multi Agency Support/Legal Gateway Panel in CYPS. The Early Help Support Panel is a forum for practitioners to discuss cases where they feel there are significant risks for families but below the threshold for social care and other statutory complex or acute services. This is an important development given the high percentage of domestic abuse cases impacting on children (407 children from 221 families in the 348 cases to MARAC in 2012-13, plus the referrals to CART mentioned above) and will improve collaborative working to resolve these cases and prevent escalation.

All domestic abuse notifications originating from SYP (GEN118 forms) go to the Contact and Referral Team (CART) with high risk ones usually leading to a child protection assessment known as an S47. However the vast majority of notifications are standard risk and are now screened by the Early Help Assessment Team, who then determine any action that is required.

### 6.12 Training and awareness raising

Some of the issues have been covered in other sections of the report, so they are briefly summarised again here:

- Risk assessment - consistency is the key at all risk levels
- Joint commissioning of training – for more efficient use of resources
- Referral pathways and protocols – need to be understood by all workers, officers and professionals across partner agencies

- **Children and Young People**

The British Crime Survey in 2009-10 identified young people aged 16-19 as the group most likely to experience partner abuse. Educative work with young people on positive relationships and how to identify and report abuse is therefore vital and it is imperative to involve schools in this work. The Healthy Schools website has a number of teaching resources on domestic abuse and positive/abusive relationships. In addition to raising young people's awareness teachers and school staff also need to be aware of referral pathways to report incidents and access support for their students.

Currently the IDVAs deliver some awareness raising sessions in schools but the review group questioned whether their specialist skills and experience would be more valuable in supporting victims and families in medium risk cases as well as high risk. Members emphasised the importance of working with colleges and children's centres as well as schools in raising awareness of domestic abuse with children and young people, but recommend a review of the training strategy, in particular who is best placed to deliver such training.

Besides having effective support for children and young people affected by domestic abuse support is also needed for parents to understand the effects of domestic abuse on children and parenting. Training for agencies who are involved with families experiencing domestic abuse is also critical to enable professionals to understand the significant impact on children and the importance of supporting the non-abusive parent. Often there is a lack of understanding of risks that may be present within an abusive relationship, and the lasting effect this can have on a parent even when the intimate relationship has ended.

- **Multi-agency training**

Training for staff across all partner agencies in relation to domestic abuse is essential. However accessing training sessions is frequently problematic for workers in direct service delivery roles as it may be difficult for services to cover staff absence without a negative impact on services. Recognising these pressures means an appropriate balance needs to be found in terms of workshop based training and building in time for workers to access the new e-learning modules that are being developed. Joint commissioning and joint funding for training should be explored.

### 6.13 Statutory health partners

Statutory health partners play an active role in the MARAC and within the SRP structures, but uncertainty exists over their wider role and responsibilities. Positive work is ongoing to raise awareness with health staff on how to recognise and report domestic abuse, as referrals are low from many health partners, such as GPs and dentists. The review was unable to explore referrals from Accident and Emergency services (A&E) at Rotherham Hospital.

Members welcomed the development of the referral flowchart for GPs that is being developed and recommend it is rolled out to include dentists, who must come across facial injuries, and possibly pharmacists.

Work is ongoing with midwives to develop a practical and safe mechanism for them to ask questions of women using their services, given that risk escalates during pregnancy.

Although domestic abuse affects people's physical and mental health and wellbeing few referrals are made to RDASH other than for drug and alcohol misuse support services.

It is important to monitor referrals from GP's, A&E and health partners to measure the impact of any new measures, and this will be captured through the new performance management framework and feedback from the VCS partners who are providing support to GPs on risk assessments.

In a time of austerity and needing to maximise the efficient use of resources an integrated approach should be explored between the Council, police and health partners for joint funding and joint commissioning of services and training.

Public health moving into the Council presents new opportunities for integrating domestic abuse within the health agenda to improve services for all. The Director of Public Health has responsibility for the local authority's role in co-operating with the police, probation service and prison service to assess the risks posed by violent or sexual offenders. There are "placeholders" for domestic abuse and violent crime (including sexual violence) in the national Public Health framework but it is not certain whether these will become performance indicators with targets.

### 6.14 Public Protection Unit

The forthcoming centralisation of the unit raised concerns with Members regarding the impact this will have for Rotherham given the current differences in approach across the four districts in South Yorkshire. Members were also concerned about a potential loss of local knowledge about Rotherham which could impact negatively on victims and their families.

### 6.15 Sexual violence

Sexual abuse and sexual violence are behaviours that may manifest as part of domestic abuse and are included within the national VAWG strategy and within Rotherham's

structures and protocols for domestic abuse. However, sexual violence perpetrated by strangers also occurs outside domestic settings and although that falls outside the specific scope of this review Members wish to ensure that adequate support and provision is in place to support victims of sexual abuse in all circumstances.

### 6.16 Domestic homicide reviews

Tragically domestic homicides do occur and a domestic homicide that meets the definition in the legislation will result in a domestic homicide review. Agencies are required to establish and act upon lessons learned regarding how professionals and partners work individually and collectively to ensure appropriate support for victims and to avoid future incidents. SRP has delegated the Domestic Homicide Review Process to the DAPG but reviews are time consuming and costly and sufficient resources should be allocated by the SRP Board to allow for any additional work. SRP also need to ensure compliance with new statutory guidance published under section 9(3) of the Domestic Violence, Crime and Victims Act (2004) which came into force on 1 August 2013. The guidance is clear that review panels should appoint an independent Chair, who is not directly associated with any of the agencies involved in the review. The Chair will oversee the review and the production of the overview report, and may also be the report author, but if they are separate roles then the report writer should also be independent.

### 6.17 Forced marriage and so called "Honour" based violence

One of the Anonymised case studies scrutinised by the review group involved a potential forced marriage and Members noted that the case was handled very well by the agencies involved. During the review there was less time to consider Forced marriage and so called "Honour" based violence as specific issues within domestic abuse than envisaged and Members would like to have the opportunity to scrutinise this area in greater depth as a separate piece of work.

## 7. Recommendations

### Commissioning and funding

1 In order to facilitate longer term planning and retain skilled and experienced staff IDVAS funding should be mainstreamed rather than being 12 monthly.

2 A full audit of need for domestic abuse support and services is recommended with a view to moving towards joint commissioning of services.

3 Agencies need to ensure a balance of appropriate workshop based training and e-learning is available for all relevant staff, workers and professionals, considering joint commissioning and joint funding to make the best use of time and resources.

4 Members recommend that the statutory agencies i.e. the Council, Police and Health explore and report back on the feasibility of a pooled budget for domestic abuse services.

5 Members recommend that agencies explore and report back on the feasibility of an integrated joint working approach across all risk levels, such as a "one stop shop" or a "golden number" for domestic abuse referrals.

6 The SRP Board should ensure sufficient resource allocation to enable any domestic homicide reviews to comply with the revised statutory guidance published by the

Home Office in June 2013.

**Strategy**

7 Domestic abuse is an issue that cuts across multiple portfolios therefore Cabinet might wish to consider identifying a Cabinet lead for domestic abuse.

8 As domestic abuse is a priority it should be made more explicit within other key strategies and plans. The JSNA and HWBS are both being refreshed, as is the Council's Corporate Plan, so this provides an opportunity to strengthen the focus on domestic abuse.

9 Drugs and alcohol play a significant part in domestic abuse cases, especially for standard/medium risk; therefore workstreams should take account of domestic abuse.

10 Links with schools/colleges and other local organisations who work with 16-17 year old young people need to be strengthened to ensure age appropriate services and support.

11 Sexual violence should be integral to strategies and plans for work on violence against women and girls, whether it occurs in domestic or non-domestic settings.

**Roles and responsibilities**

12 A full review of domestic abuse structures, communications and governance arrangements within the SRP should be carried out to clarify and reaffirm roles and responsibilities between:
   a) DAPG and RDAF
   b) SRP Executive, JAG and DAPG

**Protocol and process**

13 The ACPO DASH risk assessment form should be used by all agencies, supported by training, to ensure a universal and consistent approach to risk assessment.

14 A standard multi-agency protocol and process should be developed for standard and medium risk assessment to ensure consistency in approach and common pathways communicated and understood by all partners, to include risk assessment in children's health and social care such as pre-birth assessments.

15 A standard multi-agency protocol and process should be developed for contacting victims at all risk levels to avoid duplicating referrals or initial contact.

16 Subject to agreement with CAADA Members recommend that NHS South Yorkshire and Bassetlaw be approached with a view to rolling out the GP flowchart setting out how to respond to domestic abuse to dentists and pharmacists.

**Prevention and early intervention**

17 A perpetrator programme should be established in Rotherham as part of the work on prevention and early intervention and to ensure compliance with the SDVC components.

18 A review should be carried out on resource allocation in order to focus more on standard/medium risk cases as part of the early intervention and prevention agenda and to prevent escalation to high risk and MARAC which is very resource intensive. Funding allocation for low cost but effective target hardening measures should be considered in the review.

19 Members emphasised the importance of raising awareness with children and young people of how to recognise coercive relationships and to recognise and report domestic abuse, but recommend a review of the training strategy, including who is best placed to deliver the training, in order to ensure the best use of staff resources.

**Forced Marriage and so called "Honour" based violence**

20 Members recommend that Forced Marriage and so called "Honour" based violence be the subject of a separate review by Improving Lives Select Commission in 2014.

## 8. Thanks

**Our thanks go to the following for their contributions to our review:**

Councillor John Doyle, Cabinet Member for Adult Social Care
Councillor Mahroof Hussain, Cabinet Member for Communities and Cohesion
Councillor Paul Lakin, Cabinet Member for Children, Young People and Families' Services
Councillor Rose McNeely, Cabinet Member for Safe and Attractive Neighbourhoods
Councillor Ken Wyatt, Cabinet Member for Health and Wellbeing

Shaun Wright, South Yorkshire Police and Crime Commissioner

**Partners**
Zlakha Ahmed – Apna Haq
Sue Barratt – GROW
Yvonne Cherry – Victim Support
Deborah Drury – Rotherham Foundation Trust
Beverley Garbett – Choices and Options
Alison Higgins – Sheffield Domestic Abuse Coordination Team
Zena Jones – Sexual Assault Referral Centre
Mark Monteiro – South Yorkshire Police
Sandra Moule – Rotherham Women's Counselling Service
Michaela Power – RDASH
Chris Prewett – RDASH
Mel Simmonds – Sexual Assault Referral Centre
Tim Staniforth – South Yorkshire Police
Jean Summerfield – RDASH
Kate Tufnell – Rotherham Clinical Commissioning Group
Emma Wells – Probation Service
Emma Wheatcroft – South Yorkshire Police
Alun Windle – Rotherham Foundation Trust
Ian Womersley – South Yorkshire Police
Susan Wynne – Rotherham Women's Refuge

**RMBC Officers**
Janette Burgin
Sally Dodson
Ruth Fletcher-Brown
Cherryl Henry-Leach
Nicola Humphries
Sam Newton
Kay Nicholes
Steve Parry
Clair Pyper
Dr. John Radford
Amanda Raven
Joyce Thacker
Sue Wilson
Helen Wood

## 9. Background papers

Presentation to Improving Lives Select Commission 24 April 2013

Notes of evidence sessions:
9 May 2013
15 May 2013
16 May 2013
5 June 2013
12 June 2013
3 July 2013

*Call to End Violence against Women and Girls* HM Government November 2010

*A Call to End Violence Against Women and Girls: Action Plan* HM Government April 2013

Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews Revised – applicable to all notifications made from and including 1 August 2013, Home Office, June 2013

Joint Strategic Intelligence Assessment 2013-14

Joint Strategic Needs Assessment 2011

Early Help Support Panel Terms of Reference

Domestic abuse scrutiny review reports:
- Cambridge County Council
- Gateshead
- Hackney

Local information:
Draft SRP Strategy to Eliminate Domestic Abuse and Sexual Violence 2012- 2015
Draft Performance Management Framework
Domestic Abuse Priority Group Action Plan 2011-14
Domestic Abuse Priority Group Terms of Reference
Rotherham Domestic Abuse Forum Terms of Reference
DASH Risk and MARAC Referral Form
SRP MARAC Operating Protocol
Domestic Violence Statistics for South Yorkshire 2012-2013
Domestic Violence Statistics Overview 2012-2013
Specialist Domestic Violence Court Data 2012-2013
Specialist Domestic Violence Court Performance Report
Comparative Data 2012 and CAADA Recommendations

**Appendix 1 Details of evidence sessions**

| 9 May | 15 May | 16 May | 5 June | 12 June | 3 July |
|---|---|---|---|---|---|
| **Themes discussed** | | | | | |
| Multi-agency domestic abuse framework | Anonymised MARAC case studies | Domestic abuse service in Sheffield | Cabinet portfolios | Health overview | Role of Police |
| Performance management | | Role of VCS partners | | | Role of Health |
| IDVAS | | | | | |
| **Witnesses** | | | | | |
| Chair of Domestic Abuse Priority Group | Children and Young People's Services:<br>- education welfare<br>- children's safeguarding | Manager of Sheffield Domestic Abuse Co-located Team | Cabinet Member for Adult Social Care | Public Health Specialist (Mental Health and Domestic Abuse) | Public Protection Unit, South Yorkshire Police |
| Domestic Abuse Coordinator | Independent Domestic Violence Advocate IDVA | Apna Haq | Cabinet Member for Children, Young People and Families' Services | | Chief Inspector Operations, Rotherham District, South Yorkshire Police |
| Adult Safeguarding Coordinator | NAS:<br>- housing<br>- adult safeguarding | Choices and Options | Cabinet Member for Communities and Cohesion | | Rotherham Clinical Commissioning Group |
| Neighbourhood Crime & Justice Manager | Probation Service | GROW | | | Rotherham Foundation Trust |
| Performance & Quality Manager | Rotherham, Doncaster and South Humber Foundation Trust | Rotherham Women's Counselling Service | | | Rotherham, Doncaster and South Humber Foundation Trust |
| Independent Domestic Violence Advocate IDVA | Rotherham Foundation Trust | Rotherham Women's Refuge | | | |
| | Sexual Assault Referral Centre | Victim Support | | | |
| | Public Protection Unit, South Yorkshire Police | | | | |

**Appendix 2 National and local statistics about domestic abuse**

**National 2011-12**

- 112 women and 21 men were killed by a current or former partner
- 750,000 children were affected
- Accounted for 25% of violent crime
- 12 million incidents – NHS
- Key factor for 63% of homeless women aged between 30 and 49
- Costs to the State, victims and employers - £23billion per year
- The cost to the NHS of repairing physical damage to victims of domestic abuse is estimated to be £1.22 billion (NHS Employers), excluding dental or mental health treatment
- Employers lost £2.7billion due to time off due to injuries

**Local 2012-13**

- 5555 incidents responded to by SYP
- 961 incidents were recorded as a crime
- Of these 961 – 702 (73.05%) resulted in arrests
- Of the 5555 incidents, 348 were high risk and referred to the Multi-Agency Risk Assessment Conference (MARAC) supported by the IDVAS
- 348 cases at MARAC
  - 336 women and 12 men
  - 40 Black and Minority Ethnic women
  - 1 Lesbian, Gay, Bisexual and/or Trans person
  - 0 disabled people
  - 407 children affected from 221 families
- 74 of the MARAC cases were repeats (21%)
- 0 domestic homicides
- 42 victims of so called “Honour” based violence were supported by Apna Haq and 7 were being forced into marriage
- 2,957 children and young people were the subject of new contacts to the Contact and Referral Team in 2012 due to domestic abuse. 26% of these contacts, or 769 young people, progressed to referrals for services including assessment.
- 58% of recorded harassment crimes/incidents were domestic related (1/4/12 - 17/12/12); many occur when a couple have separated and the majority of incidents in Rotherham relate to unwanted gifts and communications
- The SARC supported 160 victims of sexual violence, an 9% increase from 2011/12 – 56 were supported by the ISVA

**Appendix 2 National and local statistics about domestic abuse**

**Data for South Yorkshire by District 2012 - 13**

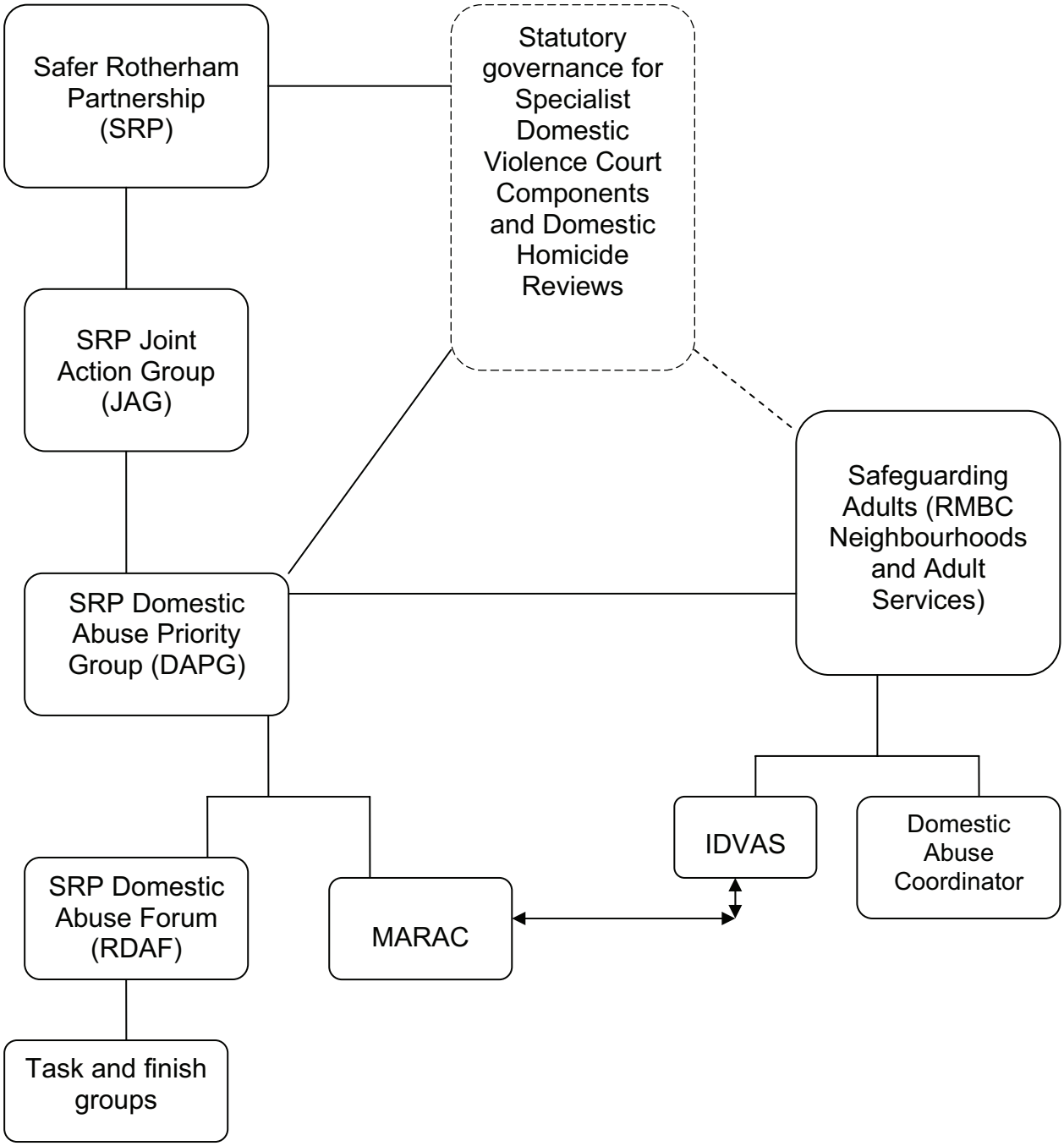
| | Crimes | | Non-crime | | Total incidents |
|---|---|---|---|---|---|
| | Total | % of total incidents for district | Total | % of total incidents for district | |
| **Doncaster** | 1279 | 20% | 5073 | 80% | 6352 |
| **Barnsley** | 665 | 15% | 3659 | 85% | 4324 |
| **Rotherham** | 832 | 18% | 3825 | 82% | 4657 |
| **Sheffield** | 1461 | 17% | 7303 | 83% | 8764 |
| **Total for South Yorkshire** | **4237** | **18%** | **19860** | **82%** | **24097** |

**Notes**

1) A crimed incident is an incident recorded as a crime on the Police National Computer, and from these a sanction will follow such as a criminal prosecution, harassment warning or police caution. Non crimed incidents cover breaches of the peace, verbal arguments, instances where the victim wants the perpetrator to be informally warned by the police to stop abusive behaviour or civil breaches that do not constitute an offence, such as a breach of undertaking.

2) Data is for 10 months - March 2012 to January 2013

**Appendix 3 Safer Rotherham Partnership structure for domestic abuse**



**Glossary for Domestic Abuse Scrutiny Review**

| | |
|---|---|
| ACPO | Association of Chief Police Officers |
| CAADA | Co-ordinated Action Against Domestic Abuse |
| CAF | Common Assessment Framework |
| CART | Contact and Referral Team |
| CPS | Crown Prosecution Service |
| DAPG | Domestic Abuse Priority Group |
| DASH | Domestic Abuse, Stalking and Harassment and "Honour" Based Violence |
| IDAP | Integrated Domestic Abuse Programme |
| IDVA | Independent Domestic Violence Advocate |
| IDVAS | Independent Domestic Violence Advocacy Service |
| ISVA | Independent Sexual Violence Advocate |
| JSIA | Joint Strategic Intelligence Assessment |
| JSNA | Joint Strategic Needs Assessment |
| LCJB | Local Criminal Justice Board |
| MAPPA | Multi-Agency Public Protection Arrangements |
| MARAC | Multi-Agency Risk Assessment Conference |
| NPS | National Probation Service |
| PPU | Public Protection Unit |
| RDAF | Rotherham Domestic Abuse Forum |
| RDASH | Rotherham, Doncaster and South Humber NHS Trust |
| RFT | Rotherham Foundation Trust |
| RWCS | Rotherham Women's Counselling Service |
| RWR | Rotherham Women's Refuge |
| SARC | Sexual Assault Referral Centre |
| SDVC | Specialist Domestic Violence Court |
| SRP | Safer Rotherham Partnership |
| SYP | South Yorkshire Police |
| VAWG | Violence Against Women and Girls |

**ROTHERHAM BOROUGH COUNCIL – REPORT TO CABINET MEMBER**

| | | |
|---|---|---|
| **1** | **Meeting:** | **Cabinet Member for Adult Social Care** |
| **2** | **Date:** | **17 February 2014** |
| **3** | **Title:** | **Response to Scrutiny Review of Continuing Healthcare** |
| **4** | **Directorate:** | **Neighbourhoods and Adult Services** |

## 5 Summary

Continuing Health Care (CHC) relates to NHS funding which is allocated to people whose health care needs meets a nationally agreed threshold. Following concerns that citizens in Rotherham were not being served well due to CHC spend being lower than nearby and statistical neighbours; a Review of Continuing Health Care was led by the Joint Health and Improving Lives Select Commissions in 2012. A number of recommendations were made which it is intended will improve the experience of citizens and ensure that a fairer share of CHC funding is received within Rotherham.

Following receipt of the report, a senior management working group consisting of both RMBC and NHSR staff agreed a set of actions to ensure effective multi disciplinary working and deliver better outcomes for customers. This report provides a further update to Cabinet regarding progress made against the action plan.

CHC and social care assessments are completed by health and social care staff presently or recently involved in assessing, reviewing, treating and supporting the customer. In terms of highlights from the process, a better working relationship exists and understanding of each professional's role in participating in a multi disciplinary assessment and completing the Decision Support Tool (DST), however, it is yet to be seen whether this will impact on the financial position as positively as is required.

## 6 Recommendations

- **Cabinet Member update on progress and issues arising from scrutiny review of Continuing Healthcare.**

- **Cabinet Member recommends that a further update is received.**

## 7 Proposals and Details

7.1 The recommendations of the Joint Select Commissions have been addressed through joint work between NHS Rotherham and RMBC. Good progress has been made in addressing the recommendations, as can be seen from the attached plan, which has been reviewed. Unfortunately significant changes in the NHS, including the transfer of responsibilities to the Clinical Commissioning Group and the local National Commissioning Board did result in some delays in agreeing the devised joint protocol, which reflects the National Guidance for NHS Continuing Healthcare and NHS Funded Nursing Care and which addresses local issues identified by the Select Commission. This piece of work has been delayed following the restructure and the move of CHC team over to CCG/Commissioning Support Unit, along with the actions required to drive Personalisation of services in Rotherham forward across Health and Social Services.

7.2 Attempts to ensure that this process continued were made and a joint leadership meeting took place between the CCG and RMBC to discuss progress. At this meeting, the progress that had been made by Adult Services was noted; however it became clear that there were a number of issues relating to assessment, decision making and access to CHC (Continuing Health Care) for children with complex needs. It became apparent that for children and young people with significant needs, there are two main areas which need to be improved: first, reviews of current cases and consideration of a number of new cases which have yet to be assessed and considered by the Panel; and second, an improved system of decision making through a revised Continuing Care Panel which complies with national guidance on Children's Continuing Healthcare and 'Who Pays'. At this meeting there was a commitment to address the backlog by the end of March 2014. However, it has become apparent that the CCG and CSU are unable to meet these deadlines. As a result, the Chief Executive raised this as a concern with the CCG in writing. The commitment which has now been made is that the CCG will backdate their financial commitment for cases in 2013-4 to the date from which the package of care started for children and young people agreed as eligible for CHC funding; and that they are seeking clinical assessment support to carry out the work. A group of CCG and LA staff are meeting fortnightly to progress the agreed programme of work.

7.3 With regards to the joint protocol, it has been drafted and work has commenced with continuing healthcare manager/staff and RMBC CHC champions now CHC lead is in post. Specific training for those working in children's services will be based on regional advice, following the National Guidance on CHC, and take account of the new Panel arrangements. The protocol will include how to resolve disputes, and written guidance for staff will be produced to ensure consistency and compliance once it has been issued.

7.4 It has been agreed that training will be delivered jointly by CHC/LA leads and rolled out across hospital, community health and social care

teams. As recommended, examples of local case studies, with examples of completed and anonymised Decision Support Tools will be used, ensuring that staff can learn from the experience of Rotherham customers. Progress on the delivery of the training has been delayed and we now require the CCG to provide information regarding the start date for that training.

7.5 The RMBC/CHC Senior Management group, Personalisation Workstream will continue to meet and consider budget issues and to develop cost effective delivery of personal health budgets by 1st April 2014 based on a pilot project implemented from 1st April 2013.

7.6 Improved engagement has been achieved through the attendance at CHC panels. It is now routine that RMBC CHC champions attend ratification panel meetings as part of the Multi Disciplinary Team and implement joint actions. CHC Champions ensure that issues are addressed in a timely manner.

## 8 Finance

The latest Yorkshire and Humberside CHC benchmarking information for the final quarter ending 31 March 2013, Rotherham is ranked 7 out of 15 in terms of the number of people receiving CHC funding. In terms of actual expenditure Rotherham is ranked 10th and therefore still below the average spend per person within the region.

## 9 Risks and Uncertainties

9.1 The following actions have been taken forward by RMBC/CHC strategic leads to implement Scrutiny's recommendations and minimise risk to the council

9.1.1 Monthly meetings are held between strategic leads to consider budget issues, address joint protocols, transitions between funding streams and services etc.

9.1.2 Operational leads continue to meet weekly to address day to day issues and improve communication.

9.1.3 Written protocols – work has commenced and a joint training plan is in place, and plans are in plan to disseminate to health and social care professionals.

## 10 Background Papers and Consultation

Review of Continuing Health Care in Rotherham – Joint Report of the Health and Improving lives Select Commissions

National Framework for Continuing Health Care – Department of Health

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## *Cabinet's Response to Joint Select Commission Review of Continuing Healthcare*

| **Recommendation** | **Response**<br>*(detailing proposed action if accepted, rationale for rejection, and why and when issue will be reconsidered if deferred)* | **Officer Responsible** | **Action by** ***(Date)*** |
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| ***1. Assessments:***<br><br>1a) To consider options for ensuring the CHC and social care assessments are undertaken together and develop an agreed protocol for how this should be delivered | Requirement within the National Framework to conduct reviews in a timely manner and work with RMBC through Joint Working Group.<br><br>Work has commenced to devise a joint local CHC/LA protocol which reflects the National guidance for NHS Continuing Healthcare & NHS Funded Nursing Care which addresses local issues. This piece of work will continue following the restructure and the move of CHC team over to CCG/CSU and changes within CHC team have been fully implemented.<br><br>**UPDATE**<br>This piece of work is delayed and needs to be progressed<br><br>2/7/2013<br>Following the restructure of the NHS, CHC has now successfully moved over to be part of the CSU. The implementation of the National Framework for NHS Continuing Health Care and NHS Funded Nursing care December 2012 was implemented from 1st April 2013. CHC continues to follow the National Framework for NHS Continuing Health Care and NHS Funded Nursing Care December 2012 to ensure that reviews are conducted with in a timely manner and work with RMBC. Any issues to be flagged through the joint working Group | **MC**<br><br>**SMc/SL** | Ongoing |
| 1b) To consider options for utilising the use of step up/step down units much more widely, and enable assessments to be undertaken in this setting | Community hospital now in operation providing a degree of step up/down care. Additional Step Up Step Down beds in Intermediate Care Service have 89% occupancy rate. Impact of community hospital to be monitored | **DB** | Complete |

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| ***2. Training:***<br><br>2a) To refresh the CHC training package, ensuring it is up to date, appropriate for the different staff involved and rolled out to all relevant staff periodically | Refreshed National Framework released for implementation April 2013<br>CSU nominated lead to develop an appropriate CHC training package to be rolled out locally across SY&B area<br><br>2/7/2013<br>The CSU has appointed an individual who is in post to develop an appropriate CHC training package to be rolled out locally across SY&B area. The training will be accessible to all health professionals and Social workers and Social services officers<br><br>24/10/2013<br>CHC have developed a CHC training package for Health and Social Care professionals. The Package as been discussed with LA Paula Brown and Lyndsay Bishop.<br>A meeting has been arranged with Paula Brown on the 31st October to discuss an plan for dissemination the training package<br><br>**UPDATE**<br><br>Implementation is delayed, CHC to be required to provide a deadline for completion. | **DM/SM** | Complete<br><br>Ongoing |
| 2b) To ensure the training package incorporates local case studies and opportunities for feedback to relevant workers on completing the assessment process to enable shared learning | CHC training package incorporate case studies to assist in application and learning CSU operational lead with responsibilities for training to undertake training delivery<br>Examples of local case studies, completed and anonymised DST will be used and feedback given.<br><br>2/7/2013<br>The CSU has appointed an individual to develop an appropriate training package to be rolled out across SY&B. All training will incorporate case studies<br><br>24/10/2013<br>CHC have developed a CHC training package for Health and Social Care professionals. The Package has been discussed with LA Paula Brown and Lyndsay Bishop.<br>A meeting has been arranged with Paula Brown on the 31st October to discuss an plan for dissemination the training package<br>Scenario has been included in the training package | **DM/SM** | Complete<br><br>Complete |

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| ***3. Written Protocols:***<br><br>3a) To clarify issues in relation to who should be the lead worker for individual cases and how to resolve disputes by producing written, agreed guidance for all to adhere to | As per National framework<br>Work to be undertaken through Joint Working Group Joint protocol, work will re commence with continuing healthcare manager/staff and RMBC CHC champions. Protocol is drafted – includes how to resolve disputes, written guidance will be produced.<br><br>2/7/2013<br>Work to be undertaken through the joint working group to revisit the local resolution/ dispute process which is currently in place and to develop a protocol to include a written guidance to include and resolve disputes with agreement with all parties<br>involved – CSU,CCG and LA<br><br>**UPDATE**<br><br>**This work to be completed by 28.2.14** | **SMc/SL** | 28.2.14 |
| 3b) To put in place written agreement regarding the backdating of funding when a person is admitted to a nursing unit based on a fast track or checklist, pending a full DST being completed (protocols for weekends/holidays etc) | As per Framework. Any issues to be discussed through Joint Working Group. Guidance will be provided within the joint protocol.<br><br>2/7/2013<br>The National Framework For NHS Continuing Healthcare and NHS Funded nursing Care December 2012 and Refund Guidance will be followed with regards backdating of funding when a person is admitted to a nursing unit based on a fast track or checklist - pending a DST being completed | **SMc/SL** | Ongoing |
| 3c) To agree and put in place an appropriate joint 'exit strategy' for people moving from high level of care to lower level (within and across service providers) | Agreed 14 day turnaround in principle with LA - agreed | **SMc/SL** | Complete |
| 3d) To agree joint protocols for engaging with service users to gather their experience and views for the purpose of service improvement | Currently patient feedback sought for Domiciliary care packages and captured in service user/customers survey. Outcomes are fed through to Joint Working Group. Customer Outcomes also to be monitored through new Personal Health Budgets pilot .<br>22/8/2013 - the current process continues. CHC nurses continue to use Quality of Domiciliary care proforma each time a review is completed – these allows any issues/ compliments to be discussed with care providers therefore improving the service provided to our patients. | **SMc/SL** | 30/8/2013<br>Ongoing |

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| ***4. Joint Working***<br><br>4a) To ensure the continuation of MDT meetings on a regular basis to improve joint working and communication across agencies | Currently meeting are organised by RMBC . To continue with inclusion of the identified CHC leads within the CSU.<br>RMBC CHC champions to continue to attend eligibility panel as part of the MDT. | **DM & Op lead** | Complete |
| 4b) To put in place joint strategic liaison meetings on a twice yearly basis, to allow for issues to be raised across agencies in an open and honest forum (including budget issues, transition planning and implementing the proposals within the Care and Support Bill) | Joint approach between RMBC & CCG agreed to take place alternate months with input from CHC nominated lead.<br>RMBC/CHC working group to continue to meet and address budget issues and implementing the proposals within the Care and Support Bill. | **SMc/SL & CHC lead** | Complete |
| 4c) For the NHS and Local Authority to agree appropriate arrangements to consider discharge planning to avoid delays | Work has been undertaken through discharge strategy group which includes LA and CHC members NHS and Local Authority consider a customer's needs and start planning for discharge on admission. Guidance will be given in the joint protocol. | **SMc/SL & CHC lead** | Complete |
| 4d) To consider options in relation to closer working across agencies, based on examples of good practice e.g Maltby Service Centre | RCCG commissioned integrated Health & Social care teams across Rotherham as part of the wider strategy to improve the care of patients with long term conditions | **SMc/SL & CHC lead** | Complete |
| **5. Panels and Appeals**<br><br>5a) To address concerns in relation to the lack of representation from the Local Authority at CHC panel meetings | CHC ratification panel undertaken daily LA reps now attending Tuesday and Thursday. | **LB/PB & SM** | Complete |
| 5b) To ensure there is expert knowledge via an appropriate worker (such as a learning disabilities representative) on future CHC and Dispute Panels | Currently distinct LD panel runs monthly. CHC rep present on appeal panels also attended by LD service leads.<br><br>John Williams Service Manager Learning disability Service attends. | **DM & Op lead** | Complete |

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| 5c) To review the current Dispute Panel, and take action to ensure this is an independent, multi-disciplinary panel which includes representation from the Local Authority | Appeals & disputes currently handled by central CSU retrospective team who organise MDT panel inclusive of a LA rep. Any revision to be taken forward through Joint Working Group | **DM & op lead** | Complete |
| 5d) To review the decision making process and look to streamline panels where possible to reduce delays and inconsistencies | Ratification of applications as per the principles of the National Framework. Any issues to be discussed through Joint Working Group | **DM & op lead** | Complete |
| 5e) To ensure that all workers are routinely giving service users information leaflets and that the appeals process and their right to appeal is clearly explained at the beginning of the process | Principles of National Framework followed - information and/or leaflets supplied routinely.<br>Staffs have access to information, leaflets and explain the appeals process at the offset when assessments are completed and the CHC process explained. | **DM & op lead** | Complete |
| **Reviewing Recommendations:**<br><br>6) For the Health Select Commission to receive a report from the CHC manager 6 months from the recommendations being approved, to ensure they are being implemented and making progress to improve this service in Rotherham. | Progress has/is being made to improve services in Rotherham. These are contained within this report and any further requests for updates to be discussed through Joint Working Group | **SMc/SL** | Complete |

**Key to named individuals:**

MC – Michaela Cox DM – Debbie Morton DB – Dominic Blaydon SM – Sheena Moreton
SMc – Shona McFarlane SL – Sarah Lever LB – Lindsay Bishop PB- Paula Brown

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