CABINET MEMBER FOR ADULT SOCIAL CARE

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

Date: **Monday, 21st October, 2013**

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 - 6)

6. Health and Wellbeing Board (Pages 7 - 20)
   - Minutes of meeting held on 11th September, 2013

7. Rotherham Learning Disability Partnership Board (Pages 21 - 27)
   - Minutes of meeting held on 13th September, 2013

8. Police Assistance and Conveyance to Hospital for those detained under the Mental Health Act 1983 (Pages 28 - 52)

9. Armed Forces Independence Payments (Pages 53 - 55)

10. Safeguarding Adults Annual Report (Pages 56 - 86)

11. Adult Services Revenue Budget Monitoring 2013-14 (Pages 87 - 92)

12. Charges for Residential Accommodation (Pages 93 - 101)

13. Date of Next Meeting
    - Monday, 18th November, 2013, commencing at **9.30 a.m.**

CABINET MEMBER FOR ADULT SOCIAL CARE
23rd September, 2013

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

An apology for absence was received from Councillor Steele.

H22. DECLARATIONS OF INTEREST

There were no Declarations of Interest made at the meeting.

H23. MINUTES OF PREVIOUS MEETING HELD ON 22ND JULY, 2013

Consideration was given to the minutes of the meeting held on 22nd July, 2013.

Resolved:- That the minutes of the meeting held on 22nd July, 2013, be approved as a correct record.

H24. ROTHERHAM SAFEGUARDING ADULTS BOARD

The minutes of the Rotherham Safeguarding Adults Board held on 3rd July, 2013, were noted.

H25. HEALTH AND WELLBEING BOARD

The minutes of the meeting of the Health and Wellbeing Board held on 10th July, 2013, were noted.

The Chairman reported that there had been 2 events held recently:-

- LGYH organised an event in Brigg for Health and Wellbeing members. The main subject was integration with the message that for integration of Services to work effectively it had to be at customer level

- A meeting of the Joint South Yorkshire-wide Health and Wellbeing Boards held in Rotherham – an opportunity for the 4 authorities to get together for the first time to share experiences and good practice across the sub-region

The Chairman also reported on the temporary re-alignment of Cabinet responsibility and that Councillor Lakin and himself would be taking over responsibility for the Health and Wellbeing Board.

H26. ROTHERHAM LEARNING DISABILITY PARTNERSHIP BOARD

The minutes of the Rotherham Learning Disability Partnership Board meeting held on 19th July, 2013, were noted.

H27. ADULT SERVICES REVENUE BUDGET MONITORING REPORT 2013/14

Consideration was given to a report presented by the Finance Manager (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 July, 2013.

It was reported that the forecast for the financial year 2013/14 was an overspend of £1.886M against an approved net revenue budget of £72.558M. The main budget pressures relate 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 Management and Training

- A slight underspend based on estimated charges

Older People

- A forecast overspend on In-House Residential Care due to slippage on implementation of budget savings target and recurrent budget pressure on Part III income
- Recurrent budget pressures in Direct Payments
- Underspend on In House Transport.
- Forecast underspend on Enabling Care and Sitting Service, Community Mental Health, Carers' Services and slippage on the recruitment to vacant posts within Assessment and Care Management
- Overspend on independent sector Home Care due to an increase in demand since April, 2013
- Overspend on independent residential and nursing care due to an additional 10 admissions in July. 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

Learning Disabilities

- A forecast overspend on independent sector Residential Care budgets due to 3 new admissions in July and shortfall on Continuing Health Care income
- Forecast overspend on Day Care due to slippage on implementation of Day Care Review including increase in fees and charges plus recurrent budget pressure on transport

- Forecast overspend in independent sector Home Care due to increase in demand and slippage in meeting budget savings
- High cost placements including transitions from Children's Services in independent Day Care resulting in forecast overspend
- High cost Community Support placements resulting in forecast overspend
- Slippage on developing Supported Living Schemes including additional funding from Health and efficiency savings on Service Level Agreements for Advice and Information and Client Support Services was reducing the overall over spend.

Mental Health
- Projected overspend on Residential Care budget offset by an underspend in Community Support Services
- Budget pressure on Direct Payments and minor overspends on employees' budgets due to lower staff turnover and additional overtime

Physical and Sensory Disabilities
- Continued pressure on Independent Sector Domiciliary Care due to an increase in demand
- Further increase in demand for Direct Payments
- Underspend on Community Support as clients were redirected to Direct Payments and underspend on Residential and Nursing Care due to slippage in developing alternatives to residential provision
- Reduction in contract with independent sector Day Care provider
- Underspend on equipment and minor adaptations
- Forecast savings on contracts with Voluntary Sector providers

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 July, 2013, was £188,805 (no off contract) compared with actual expenditure of £67,738 (no off contract) 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 £127,024 spent up to the end of July, 2013, on non-contractual overtime for Adult Services compared with expenditure of £94,223 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.

Discussion ensued on the report with the following issues raised and clarified:-

- 2013/14 Health Support Grant had been increased so it was not anticipated that Winter Pressure funding would be forthcoming
- Continuing Health Care was one of the biggest budget pressures. A workshop was to be held with the CCG to discuss the National Framework, processes, procedures and implementation thereof
- Joint training had been organised for all staff (Council and NHS) on CHC assessments, the National Framework and Legislation, the quality and standards and consistency of decisions
- Demographic pressures were now putting great strain on the budget even though the normal financial disciplines were still applied e.g. budget clinics, review of high cost of care package, consistency of assessments, essential spend only

Resolved:- (1) That the latest financial projection against budget for 2013/14 be noted.

(2) That a briefing note be supplied to the Cabinet Member on the agency and consultancy spend.

H28. 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 those paragraphs, indicated below, of Part 1 of Schedule 12A to the Local Government Act 1972 (as amended March 2006).

H29. RECONFIGURATION OF ACTION HOUSING ACCOMMODATION PROVISION FOR HOMELESS

Claire Smith, Operational Commissioner, submitted a proposal for the reconfiguration/merge of the homeless provision in order to achieve significant savings and create an efficient/effective delivery process for the provision of housing for single homeless and young people currently

provided by Action Housing and Support funded through Supporting People.

The report also contained a summary of the current provision of housing for single homeless and young people.

The changes to the reconfiguration of Service would require significant data analysis in order to alleviate any concerns relating to the quality of provision or the mixing of 2 different client groups into 1 Service.

Resolved: That, subject to the agreement of the Cabinet Member for Safe and Attractive Neighbourhoods, the proposals to reconfigure/merge the homeless provision be approved.

(Exempt under Paragraph 3 of the Act – information relating to the financial or business affairs of any particular individual (including the Council))

H30. BUDGET SAVING PROPOSALS: ASSESSMENT AND CARE MANAGEMENT

Michaela Cox, Service Manager, submitted a proposal to offer services to people with complex mental health issues over 65 years through the existing End to End process Teams within Neighbourhoods and Adult Services.

The financial details and risks and uncertainties associated with the proposal were set out in the report submitted.

Resolved:- (1) That the proposals contained within the report for the reconfiguration/integration of Service be approved.

(2) That a briefing note be supplied to the Cabinet Member for distribution to all Elected Members on the integration of Service.

(Exempt under Paragraph 3 of the Act – information relating to the financial or business affairs of any particular individual (including the Council))

H31. REVIEW OF SENSE DAY AND COMMUNITY PROVISION

Mel Daniels, Operational Commissioner, submitted a report on the findings of the contract review for Sense Day and Community Provision.

The Service was currently commissioned through both block and spot arrangements. The review had offered greater clarity and had allowed a series of actions, based on the findings, to ensure value for money was being achieved.

Resolved:- (1) That further clarification be sought from the provider on the actual services being provided to individuals including the number of hours supported per week in the day centre/community and the exact ratio of staff to Service user.

(2) That contract negotiations be commenced.

(3) That consideration be given to the alignment of budgets across Learning Disability and Physical Disability Sensory Impairment Services to match the actual usage across the client groups.

(Exempt under Paragraph 3 of the Act – information relating to the financial or business affairs of any particular individual (including the Council))

HEALTH AND WELLBEING BOARD
11th September, 2013

Present:-

Councillor Ken Wyatt	Cabinet Member, Health and Wellbeing (in the Chair)
Councillor John Doyle	Cabinet Member, Adult Social Care
Councillor Paul Lakin	Cabinet Member, Children, Young People and Families Services
Tom Cray	Strategic Director, Neighbourhoods and Adult Services
Joyce Thacker	Strategic Director, Children and Young People's Services
Chris Edwards	Chief Operating Officer, Rotherham Clinical Commissioning Group
Brian Hughes	NHS England
Michael Morgan	Acting Chief Executive, NHS Rotherham Foundation Trust
Dr. John Radford	Director of Public Health
Janet Wheatley	Chief Executive, Voluntary Action Rotherham

Also Present:-

Tracey Clarke	RDaSH
Catherine Homer	Health Improvement
Naveen Judah	Chair of Healthwatch Rotherham
Shona McFarlane	Director of Health and Wellbeing
Dave Richmond	Director of Housing and Neighbourhood Services
Kate Tufnell	NHS Rotherham Clinical Commissioning Group
Chrissy Wright	Strategic Commissioning Manager, RMBC
Kate Green	Commissioning, Policy and Performance, RMBC

Apologies for absence were received from Karl Battersby, Tracy Holmes, Dr. David Polkinghorn and Dr. David Tooth.

S26. MINUTES OF PREVIOUS MEETING AND MATTERS ARISING

Resolved:- (1) That the minutes of the previous meeting of the Health and Wellbeing Board held on 10th July 2013 be approved as a correct record, with a clerical correction of the inclusion of Brian Hughes in the list of persons who had sent their apologies for that meeting.

(2) That, with regard to Minute No. 19 (NHS South Yorkshire and Bassetlaw Primary Care Strategy), a report about the number of GP and dental practices in the Rotherham Borough area shall be submitted to the next meeting of the Health and Wellbeing Board, to be held on Wednesday, 16th October, 2013.

S27. COMMUNICATIONS

The Health and Wellbeing Board discussed the following issues:-

(1) Rotherham Borough Council Cabinet Member responsibilities – Councillor Wyatt referred to recent changes to the Council's Cabinet Member responsibilities, which would be in place temporarily; as a consequence, Councillor John Doyle would act as Chair of the Health and Wellbeing Board during that period of time.

(2) Making Every Contact Count : Applying the Prevention and Lifestyle Behaviour Change Competence Framework – a workshop is taking place at the Town Hall, Rotherham on Monday 16th September, 2013, with contributions from Leeds City Council and from the North Derbyshire Community Council (a report about this workshop will be submitted to the next meeting of the Health and Wellbeing Board).

(3) The first meeting of the South Yorkshire Joint Health and Wellbeing Board will take place on Thursday, 19th September 2013 at the Council's Riverside House building.

(4) 'Think Pharmacy' – this event will take place on Thursday 26th September 2013, at the New York football stadium, Main Street, Rotherham.

(5) The Regional Parliamentary Health and Well Being event – this event will take place on Friday, 25th October at the NHS Rotherham building, Oak House, Moorhead Way, Bramley.

(6) Self-Assessment of the Health and Wellbeing Board – the self-assessment is a part of the work plan for the Health and Wellbeing Board; all Members are encouraged to complete and return the evaluation document. A report containing an evaluation of the self-assessment will be submitted to a future meeting of the Health and Wellbeing Board.

(7) NHS Sustainable Development Unit – assessment of environmental performance – the document would be issued to Members of the Health and Wellbeing Board so that they may submit the appropriate returns giving evidence of their organisations' environmental performance. It was noted that the Borough Council has submitted its Environment and Climate Change Strategy document, as part of this assessment process.

S28. HEALTHWATCH ROTHERHAM

Further to Minute No. 76 of the meeting of the Health and Wellbeing Board held on 10th April, 2013, Mr. Naveen Judah attended the meeting and gave a presentation about the recently established Healthwatch organisation in the Rotherham Borough. The presentation included the following salient issues:-

: Mr. Naveen Judah had been appointed as the Chair of Healthwatch Rotherham with effect from September 2013;

: it was intended that there should be a partnership approach in respect of the role of Healthwatch and the Health and Wellbeing Board;

: Healthwatch, as a successor organisation to the LINk (Local Involvement Network), is to be a consumer champion for health and social care (a role whose importance was reinforced by the Francis Report, the independent inquiry into care provided by the mid-Staffordshire NHS Foundation Trust);

: ensuring the patient's voice is influential in the planning and improvement of health care provision (to be the 'eyes and ears' of the community);

: the implications of the Winterbourne View Joint Improvement Programme and the commitments made nationally that individuals should receive personalised care and support in appropriate community settings;

: the NHS England Call to Action – with neighbourhoods and communities stating the type of services they need from the NHS;

: endeavouring to establish good practice in the provision of health care services;

: the importance of what happens at a local level eg: working in accordance with the priorities of Rotherham's Joint Health and Wellbeing Strategy 2012 – 2015;

: establishing the appropriate structure for Healthwatch Rotherham, because different structures are being put in place for Healthwatch organisations around the country;

: details of the Healthwatch Rotherham business model and staffing structure were displayed (Healthwatch has only a finite resources); the organisation will also utilise a number of volunteers;

: engaging with the community in many forms; benchmarking with similar communities; identifying local issues and priorities; asking for issues to be investigated, for later consideration by the Health and Wellbeing Board;

: Healthwatch Rotherham is now based in premises at High Street, Rotherham, which helps with raising the profile of this new organisation.

The Health and Wellbeing Board discussed the level of assistance which could be provided for Healthwatch Rotherham, especially with regard to specific project work. Information (such as newsletters and posters) about Healthwatch Rotherham could be displayed in GP surgeries and other areas so as to attract the attention of the public. It was noted that effective day-to-day contact had already been established between Healthwatch Rotherham and public health service providers, in order that all

organisations may contribute to and benefit from the Joint Health and Wellbeing Strategy.

The Health and Wellbeing Board thanked Naveen Judah for his informative presentation.

S29. WORKSTREAM PROGRESS PRESENTATION - POVERTY

Consideration was given to a report presented by the Director of Housing and Neighbourhood Services describing progress with the Poverty theme of the Health and Wellbeing strategy. The report included the work plan outlining the activity being undertaken in respect of the strategy's priority to "make an overarching commitment to reducing health inequalities, particularly in areas suffering from a concentration of disadvantage".

The Director of Housing and Neighbourhood Services gave a presentation about the strategy's Poverty theme, which included the following salient issues:-

: the locally determined priorities and strategic outcomes;

: details of the lead Member and lead Officer contacts for each of Rotherham's deprived neighbourhoods;

: indices of multiple deprivation – showing a worsening of deprivation in these eleven areas of the Borough : Canklow; East Herringthorpe; Rotherham town centre; Dinnington; Eastwood; Ferham and Masbrough; Rawmarsh East; Aston North; East Dene; Maltby South East; Dalton and Thrybergh;

: examples of progress being made in each of the deprived areas – priority one (health inequalities) : the establishment of Community Alcohol Partnerships; the Community First Funded Wellgate Wellness Project; events focusing on health and employment;

: priority two : considering new ways of assisting those disengaged from the labour market to improve their skills and readiness for work; eg: job clubs funded by Community First; community development and the Community Organisers Programme; employment opportunities at the Rotherham's new Tesco store;

: priority three : ensure strategies to tackle poverty don't just focus on the most disadvantaged, but there is action across the Borough; the work of the Council's Officer group; mapping exercises being undertaken; research of other local authorities' anti-poverty strategies;

: priority four - consider how we can actively work with every household in deprived areas to maximise benefit take-up of every person; provision of benefits and debt management sessions; establishment of temporary posts of Money Advice Officer;

: other work in the eleven areas of deprivation – crime and anti-social behaviour; environmental issues (examples in Dinnington and in Maltby); community engagement (Canklow Community Connections; Adopt-a-Street campaign);

: challenges - getting all organisations to put a deprived neighbourhoods philosophy at the heart of their service planning and doing so without unduly impacting on appropriate service levels elsewhere;

: request to the Health and Wellbeing Board – to take back into all organisations and consider how this can shape service planning; especially, support for long-term unemployed people.

Discussion took place on the work already taking place to try and reduce the level of poverty in the Rotherham Borough area. A suggestion was made that a draft strategy should be formulated for further consideration by the Health and Wellbeing Board. Reference was made to the public service expenditure reductions, the Governments welfare reforms and the economic recession, all of which are factors having a continuing profound effect upon levels of deprivation and poverty.

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

(2) That the work plan for the Poverty theme of the Health and Wellbeing strategy, as now submitted, be endorsed.

(3) That partners take into account the deprived neighbourhoods work when service planning.

(4) That a report be submitted to a future meeting of the Health and Wellbeing Board providing a further update on progress with the Poverty theme work plan.

S30. LOCALLY DETERMINED PRIORITY - PRESENTATIONS

The Health and Wellbeing Board considered the following reports and presentations:-

(A) Fuel Poverty

Further to Minute No. 20 of the meeting of the Health and Wellbeing Board held on 10th July, 2013, the Board noted that Fuel Poverty and Excess Winter Deaths remain key national priorities and are both indicators contained in the Public Health Outcomes Framework. Fuel poverty levels in Rotherham are higher than the national average and occurs throughout the Borough area, not only in areas of high deprivation.

Catherine Homer, Health Improvement Specialist, gave a presentation about fuel poverty:-

Why is Fuel Poverty a priority?

- Current definition – when householders need to spend more than 10% of their income to heat their home adequately
- Causes of fuel poverty: energy efficiency of the property; fuel costs; behaviours and knowledge, characteristics and household income
- Fuel poverty is a serious problem from three main perspectives – poverty, health and wellbeing and carbon reduction
- Heat or Eat
- Cold weather kills – living in a cold home has significant implications on the health and wellbeing of residents across our Borough particularly the most vulnerable
- People with an existing chronic health condition or disability, the very young or older people are more at risk from the negative impacts of living in a cold home
- Children living in cold homes are likely to have poorer attendance and attainment in school

The private and social cost of Premature Death and Illness related to Cold Homes

- Source of evidence
  English Housing Conditions Survey
  Mental Health and Housing Conditions in England, National Centre for Housing Research 2010
  Housing Health and Safety Rating System
- Economic model mapping cold, damp and mould to probability of harm
- Probability of harm further mapped to economic and NHS cost
- Probable this is an underestimate of effect since the model assumes only one person per dwelling

Rotherham

- Fuel poverty levels above national average (16% of households in Rotherham, compared to 14% nationally)
- The rise in fuel prices – energy costs have risen 96% since 2004 or an average of £700 over the same period
- Average of 144 Excess Winter Deaths per year 1990-2010
- 17,800 Council properties have been supported through Carbon Energy Reduction Target (CERT)
- 400 Council properties have received solid wall insulation through CERT
- 1,049 private sector properties have received solid wall simulation through the Community Energy Saving Program (CESP)
- 1,649 non-traditional build properties in the Borough
- Green Deal including Energy Company Obligation

Strategic Objectives

- Reduce levels of fuel poverty across the Borough
- Significantly reduce levels of cold-related illness and excess winter deaths
- All of Rotherham's occupied private rented housing stock has an Energy Performance rating of E and above
- Target all Council stock not improved under Decent Homes because of resident choice
- Raise awareness of fuel poverty and associated interventions amongst Council staff, partner organisations and householders
- Meet vision and ambitions set in the Rotherham Warmer Homes Strategy
- Creation of electoral Ward profiles

What do we need to do?

- Continue to engage new and existing stakeholders through the Rotherham Warmer Homes Strategy
- Set up and deliver the Green Deal/Energy Company Obligation Framework
- Continue to utilise existing intelligence and support development of new research
- Raise awareness of links between health and fuel poverty
- Use 'Make Every Contact Count' (MECC) as a tool to ensure more departments/staff raise issues of fuel poverty
- Maximise personal assets, capability and behaviour
- Adopt a whole system approach to reduce levels of fuel poverty

Challenges

- Causes of fuel poverty
- Structural and organisational change (dealing with competing priorities)
- Reliance of new Policy as main vehicle
- Lack of engagement and understanding
- Most vulnerable and hard to reach populations most likely to be in fuel poverty
- Welfare Reform
- Climate impacts

What can the Health and Wellbeing Board do?

- Professionals consider the effect of cold on patients/clients and use the principles of MECC to signpost and advise eg: Willmott Dixon
- Support the use of the Winter Warmth England toolkit www.winterwarmthengland.co.uk
- Support Green Deal as a Council priority – eg: ensure that householders properly understand how to use the heating controls
- Support and attend the 'Warm Well Families Feedback' event and 'Abacus' workshop

Discussion ensued on the presentation with the following issues/comments raised:-

: the connection between 'heat or eat' – eg: demands for food;

: voluntary sector work – 'warm homes – healthy people";

: the Warm Well Families feedback event takes place on Wednesday 2nd October, 2013 at the Town Hall, Rotherham.

Catherine was thanked for her informative presentation.

(B) Dementia

Further to Minute No. 17 of the meeting of the Health and Wellbeing Board held on 10th July, 2013, the Health and Wellbeing Board considered a report about the cross-cutting theme of Dementia, which has been identified as a key priority for the future provision of services. The expectation is that there will be an increasing demand, within the next three years, for services both for people suffering dementia and also for their carers. Kate Tufnell, Head of Contracts and Service Improvement, NHS Rotherham Clinical Commissioning Group, gave a presentation about the Dementia priority:-

Overview
- Overseen by Older People's Mental Health Group
- 4 ways you can support the Programme

What is the Problem ?
- Dementia was now the greatest health concern for people over 55 and the economic cost of Dementia was more than Cancer, Heart Disease or Stroke
- Rotherham – 1,688 people on the GP Dementia Register (3,034)
- By 2025 the number of people in Rotherham with Dementia could rise to 4,397 (Joint Strategic Needs Assessment 2011)

The Cost of Dementia
- Dementia was an expensive condition with a considerable cost to both public and private finances
- a large proportion of the cost of caring for a person with Dementia was borne by the carer
- In the UK = £23 billions per year

Symptoms of Dementia (examples)
- Memory loss
- Difficulties of completing familiar tasks
- Confusion of time and/or place
- Trouble with visual images – eg: colours and contrasts
- Language difficulties – unable to follow conversations

- Misplacing items
- Changes of mood and personality – eg: depression; aggressiveness
- Withdrawal from hobbies and leisure activities
- Self-care problems
- Difficulties posed for carers of people with dementia

Dementia Programme
- The Programme incorporates four workstreams:-
  Dementia - Prevention Group
  Dementia – Early Diagnosis Group
  Living Well with Dementia Group
  Dementia and End of Life Care Group (eg: care planning)

Six Priority Outcomes
- Prevention and early intervention (RMBC bronze to platinum programme, for the care of people with dementia)
- Expectations and aspirations
- Dependence to independence
- Healthy lifestyles
- Long term conditions
- Poverty

Four ways in which the Board can support the Programme
- Continue the Dementia Workforce Development Programme
- Strong leadership to break down barriers on joint working
- Continue to support the further development of the Dementia Pathway
- Support the development of a Dementia Friendly Community and Dementia Alliance in Rotherham
- Partnership work with the Yorkshire Dementia Alliance and with the business community

Challenges
- This is everyone's business
- Increase demand on Service to be delivered within same resources
- Complexity of Pathway and independencies
- Variation across the system and potential inequalities

Discussion ensued on the presentation with the following issues/comments raised:-

: the priority given to the issue of dementia, by the Prime Minister;

: the likelihood of a significant increase in the number of people suffering dementia, with consequential pressure upon resources and services;

: Alzheimer and dementia champions in Rotherham and in Doncaster (National Alzheimer's Programme) – provision of training.

Kate was thanked for her informative presentation.

S31. CCG ANNUAL COMMISSIONING PLAN 'PLAN FOR A PLAN'

Consideration was given to the 'plan for a plan' document, presented by Chris Edwards, Chief Operating Officer, Rotherham Clinical Commissioning Group, outlining the necessary consultation and approvals process and timescale for the Rotherham Clinical Commissioning Group's Annual Commissioning Plan 2014/2015. The Board noted that there would be consultation about the contents of the Annual Commissioning Plan, prior to its approval during March, 2014.

The Health and Wellbeing Board acknowledged the various budget pressures affecting the Council and partner organisations and the Annual Commissioning Plan. Emphasis was placed upon the need for the priorities of the Plan to be aligned with other service plans utilised by the Council and partner organisations.

During discussion, Michael Morgan (Acting Chief Executive, Rotherham Foundation Trust) outlined the progress of the current re-structuring of the NHS Rotherham Foundation Trust.

Members of the Health and Wellbeing Board were requested to provide feedback on the Annual Commissioning Plan, during the consultation process.

It was noted that the Health and Wellbeing Board will be having discussions about finance and budgets at the meeting to be held on Wednesday 27th November 2013. In the interim, an issue concerning the funding for adults and children, young people and families' social care, in accordance with the provisions of Section 256 of the National Health Service Act 2006, would have to be considered at this Board's next meeting.

Resolved:- That the contents of the 'plan for a plan' document and the timescale for preparation and approval of the Annual Commissioning Plan 2014/2015 be noted.

S32. RIGHT CARE, FIRST TIME CONSULTATION UPDATE

Consideration was given to a report presented by Chris Edwards, Chief Operating Officer, Rotherham Clinical Commissioning Group, stating that the formal public consultation on the proposals for Urgent Care had concluded on 26th July, 2013, after 18 months of engagement which had taken the form of a series of discussions, focus groups, market research and briefings. Work with local stakeholders, including patient and community groups, had initially helped the Rotherham Clinical Commissioning Group to understand the use and perceptions of NHS services and how they could be improved and developed to meet patient needs. The formal consultation had sought views on the proposal to bring

together services for patients who required urgent care into one place, at a new Urgent Care Centre.

The consultations results were now being analysed. There had been 98 responses from individuals/groups with an equal division between those who either agreed/strongly agreed with the proposals and those who disagreed/strongly disagreed. 11% of responders were neutral. The main issues raised included:-

- Car parking at the hospital (availability, convenience, cost, proximity to Urgent Care Centre)
- Quality of care (i.e. the desire to see quality at least maintained or improved overall as well as the opportunities closer working with Accident and Emergency would bring)
- Convenience of the Walk-in Centre location (this included both its physical location and the convenience of the services it offered)

Comments had also been received about the physical accessibility of the proposed building and how the design and planning of the new service could improve the patient and carer experience.

The Board noted that the Governing Body of the Rotherham Clinical Commissioning Group would also be considering this issue during November 2013.

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

S33. WINTERBOURNE VIEW JOINT IMPROVEMENT PROGRAMME: LOCAL STOCKTAKE

The Director of Health and Wellbeing submitted a reported about the Winterbourne Stocktake of the progress made in Rotherham against the key commitments required by the Winterbourne Joint Improvement Programme established in 2012 following the emergence of the scandal of sustained ill treatment of people with a learning disability at the Winterbourne View Hospital.

Contained within the Stocktake document were specific questions asked in each of the eleven specific areas under consideration and reported upon accordingly. Issues included partnership working, co-ordinated financial management, case management of individuals, reviews, safeguarding, commissioning, local team working, crisis management, understanding future needs, transition planning from Children's Services into Adult Services and understanding future requirements.

The Stocktake document for Rotherham was able to demonstrate excellent partnership working arrangements across Health and Social Care which were meeting the overall requirements in all the areas of the Joint Improvement Programme.

Reference was also made to (i) the Joint Self-Assessment on Learning Disabilities and (ii) the Autism Self Assessment, both of which will be reported to future meetings of this Health and Wellbeing Board.

It was noted that the report would also be submitted to the Rotherham Local Safeguarding Children Board.

Resolved:- That the Winterbourne Stocktake report, as now submitted, be noted and its contents endorsed.

S34. ROTHERHAM SMOKEFREE CHARTER

Further to Minute No. 90 of the meeting of the Health and Wellbeing Board held on 8th May, 2013, the Director of Public Health presented a report stating that consultation on the Rotherham Smokefree Charter had been carried out during a period of six weeks and included a range of individuals and groups including Elected Members, the Rotherham Health and Wellbeing Board, the Council's Health Select Commission and the Rotherham Partnership Board. Feedback from the consultation had been wholly positive, with all responders indicating a willingness to adopt the Charter's principles.

The Charter (a copy of which was included with the submitted report) would be formally launched in October, 2013, as part of the Stoptober campaign which this year included a focus on employers.

Resolved:- (1) That the Rotherham Smokefree Charter be adopted.

(2) That commissioned services be required to adopt the Rotherham Smokefree Charter.

(3) That the Rotherham Smokefree Charter be promoted through professional networks.

S35. CARING FOR OUR FUTURE: IMPLEMENTING SOCIAL CARE FUNDING REFORM

The Chairman referred to the submitted correspondence from the Department of Health (letter dated 18 July 2013) concerning the consultation on the implementation of care and support funding reform. The period of consultation would end on 25th October, 2013. Plans to help people better prepare for the cost of their future care needs had been published alongside details of how the new fairer funding system would protect homes and savings.

From 2016, the Government's reforms would deliver a new cap of £72,000 on eligible care costs, additional financial help for people of modest wealth with less than £118,000 in assets including their home and, from 2015, a scheme to prevent anyone having to sell their home in their lifetime.

Views were being sought on how the changes to the funding system should happen and be organised locally.

Resolved:- That the contents of the letter dated 18 July 2013, from the Department of Health, be noted.

S36. BETTER HEALTH OUTCOMES FOR CHILDREN AND YOUNG PEOPLE PLEDGE

The Chairman reported receipt of a letter dated 20th July, 2013, issued jointly by the Department of Health, the Local Government Association, the Royal College of Paediatrics and Child Health and by Public Health England. Contained within the letter was an invitation for Health and Wellbeing Boards to sign up to the "Better Health Outcomes for Children and Young People Pledge" which was part of the February 2013 system-wide response to the Children and Young People's Health Outcomes Forum Report (2012). A copy of the Pledge was appended to the letter.

It was hoped that signing up to the Pledge would demonstrate a commitment to giving children the best start in life. Local authorities and other organisations were being encouraged to share good practice so that learning could be promoted nationally.

During discussion, the Board requested the submission of a further report about the Disabled Children's Charter (previous Minutes of the Health and Wellbeing Board refer: Minute No. 86(1) of the meeting held on 8th May 2013 and Minute No. 2 of the meeting held on 12th June, 2013).

Resolved:- (1) That the contents of the letter dated 20th July, 2013, be noted.

(2) That the Rotherham Health and Wellbeing Board agrees to sign up to the "Better Health Outcomes for Children and Young People Pledge".

S37. PHARMACEUTICAL NEEDS ASSESSMENT

The Director of Public Health presented a report stating that the Health and Social Care Act 2012 conferred responsibility for developing and updating the Pharmaceutical Needs Assessment to Health and Wellbeing Boards. The report stated that the Pharmaceutical Needs Assessment was designed to inform commissioners about the services which were or could be provided by community pharmacies to meet local need. This assessment would contribute to the overall Joint Strategic Needs Assessment.

NHS England would rely upon the Pharmaceutical Needs Assessment when making decisions on market entry for applications to open new pharmacy and dispensing appliance contractor premises. Such decisions

were appealable and decisions made on appeal could be challenged through the Courts.

The Health and Wellbeing Board was required to issue a Pharmaceutical Needs Assessment for its area by 1st April, 2015 and to publish a revised assessment as soon as was reasonably practicable after identifying significant changes to the availability of pharmaceutical services since the publication, unless it was satisfied that making a revised assessment would be a disproportionate response to the changes. Health and Wellbeing Boards were required to publish a revised assessment within three years of publication of their first assessment. Rotherham would be working with neighbouring Boards to consider cross-border commissioning of Services and impact within the Pharmaceutical Needs Assessment.

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

(2) That the requirement for the publication of the Pharmaceutical Needs Assessment by 1st April, 2015 and the proposed timetable for delivery be noted.

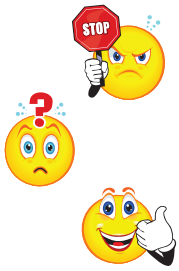
S38. DATE OF NEXT MEETING

Resolved:- That the next meeting of the Health and Wellbeing Board be held on Wednesday, 16th October, 2013, commencing at 1.00 p.m., at the Town Hall, Rotherham.

Agenda Item 7

Rotherham Learning Disability Partnership Board

Notes of the Meeting
Friday 13th September 2012
10.05 am to 12.00 noon



Voting Members

At the meeting:

Patricia Russell	Councillor – RMBC (**Co-chair)**
Robert Parkin	People's Representative **(Co-chair)**
Jan Frost	Housing Services - RMBC
Ann McMahon	Carer Representative
Alison Owen	Regional Forum Representative (arrived 10.40 am)
Kate Tufnell	Head of Contracts & Service Improvement - NHS-CCG (left at 11.00 am)
John Williams	Learning Disability Service

Who said they could not come to the meeting:

Bryan Adams	People's Representative
Shona McFarlane	Director of Health and Well Being – RMBC

Who did not come to the meeting:

Linda Jarrold	Voluntary Action Rotherham
Brian Wood	Children & Young People's Service - RMBC

Non-Voting Members

At the meeting:

Louise Metali	RDaSH (for Sandra Grinnell – for item 4)

Also:

Paula Hill	Rotherham Hospice (for item 2)

Taking the notes of the meeting:

Jo Frear	Learning Disability Service

Key:

NHS-CCG	NHS Clinical Commissioning Group
RMBC	Rotherham Metropolitan Borough Council
RAP	Rotherham Advocacy Partnerships
RDaSH	Rotherham Doncaster and South Humber NHS Foundation Trust

Robert opened the meeting and introductions were made.

1 **Introductions + Apologies**

The meeting started with introductions being made (people said who they were).

Jo then read out the people who said they could not come to the meeting (voting members) – see page 1.

2 **Hospice Care for People with Learning Disabilities**

Paula Hill came to the meeting to talk about the Rotherham Hospice, which is the only adult hospice for Rotherham people.

Paula gave a presentation which set out information such as:

- The hospice has an old style building as well as a new style building on the side.
- Work also takes place out in the community.
- The hospice has a team of people working together – doctors, nurses, social workers, occupational therapists, hairdressers, etc.
- Staff provide specialist (palliative) care and end of life care.
- There is a day hospice from Monday to Friday which cares for up to 15 people each day.
- There is an inpatient unit, with 14 beds and all rooms have their own bathroom and toilet facilities.
- The Family Support Services provide support to families, carers and friends.

Paula handed out copies of information to people at the meeting.

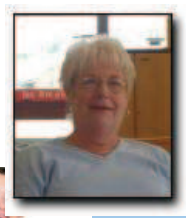
Action:

2a Paula to email the information to Jo, who will circulate with the minutes of the meeting.

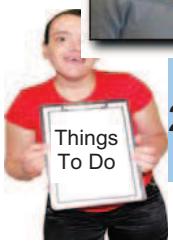
People with learning disabilities at end of life are usually supported from the hospice in the person's own home in the community. Feedback from people is that they prefer to stay where they are and for the hospice to support them there.

Paula told the meeting that the hospice is not just about end of life care. It also gives specialist care (called palliative care). This about managing people's pain and getting them back to as well as they can be.

There is also an advice line available 24 hours a day. This gives carers confidence knowing that if they need someone quickly to help with anything, they can contact someone.



Ann asked if Paula went out to give talks to groups? Paula said she is more than happy to do this.



Action:
2b Councillor Russell and Ann agreed to let day services know about this – with the possibility of attending coffee mornings.

Kate reminded people about an offer for members of the Partnership Board to visit the hospice – to see the changes that have been made to the building and see how the hospice works.

Ann told the meeting that she had been asked by a carer to let people know about care that her son had received in intensive care. The carer said that people should not be frightened about going into intensive care because the care her son received had been "marvellous".

3 Carer Representation – Voting Outcome

John reminded the meeting that at the last Partnership Board, it had been agreed how we were going to elect a carer representative onto the Board. Expressions of interest from carers had been asked for and voting members of the Board voted their 1st, 2nd and 3rd choices.

The outcome of the election was that Jayne Price has been elected as Carer Representative on the Board.

Action:

3a The Partnership Board formally recognised the outcome of the vote. Jo to write to all 3 carers to let them know about this.

3b Jayne to be invited to the next Partnership Board meeting.

4 RDaSH Internal Review following Winterbourne

Louise Metali came to the meeting to talk about what we are doing in Rotherham following Winterbourne for Sandra Grinnell, who could not come to the meeting. Louise said that there is a big report about this and that today's presentation gives the main headlines from this in easy read.

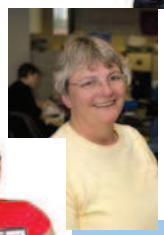
Louise went on to give a presentation, which set out findings from Winterbourne and what we are doing in Rotherham, for example:

- **Winterbourne Finding**: Too many people are in Assessment and Treatment Services.

Rotherham: People are not staying in hospital for longer than they need to.

- **Winterbourne Finding**: Poor "Greenlight" working with Mental Health Services.

Rotherham: A "Greenlight" meeting has started with Learning Disability and Adult Mental Health staff. Learning Disability awareness package e-learning for all RDaSH staff.



Jan asked whether there is an external link to the learning disability e-learning that we can use. Louise agreed to let Jo have the link to include in the minutes.

Action:

4a Louise to send Jo a link to the RDaSH learning disability e-learning.*

*__Louise__: After the meeting, I found out that unfortunately, currently only RDaSH employees can access this via the ESR. However, they may be able to complete it externally. If they do this, they will need to send in evidence of completion as it will not automatically update their records. I will explore the options and get back to you if its possible. The Regional Network is working on this as it is an issue for many.

There was a break for tea / coffee – 11.00 to 11.10 am.

5 People's Issues

Alison gave a presentation to the meeting, which included:

- The National Forum of People with Learning Difficulties is looking at changing the way it works.
- The next Regional Forum is on 1st October 2013 about employment.
- The next People's Forum will be on 7th October 2013 to look at what is working and what is not.
- The Council is launching its Active Ability Programme on 24th September 2013 and is about getting more disabled people into sport at all levels.

- GPs, nurses and administrators have received autism training. This awareness training is given by people with autism.
- Learning Disability training is taking place later today to GPs, nurses and Receptionists.

6 Carers' Issues

Ann said there are lots of issues at the moment. Meetings have been arranged with Heather Mallen and a small group of carers to talk about these issues. Informal meetings with Councillor Doyle and a small group of carers have also been arranged for the next year. Ann said that carers will take it in turns to meet Councillor Doyle. Feedback from these meetings will be given to the Partnership Board

7 Health and Social Care Self-Assessment Framework

John explained that in the past there were 2 reports – the Learning Disability Partnership Board Report and the Health Self-Assessment Framework. This year, these have been put together into a Health and Social Care Self-Assessment Framework.

The big things that are being measured are staying healthy, being safe and living well. We have to produce a report by the end of November and have started contacting people for information.

John went on to give an easy read presentation about the Self Assessment. There are lots of questions and the report also asks for sharing stories, which we will be contacting people about.

The report will need to go to the Health and Wellbeing Board and we will also bring it back to the Partnership Board for people to look at.

8 Autism Self-Evaluation

John explained that this is another self-assessment about autism. It is not just about learning disability but covers mental health services as well.

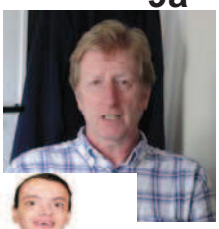
The Adult Autism Strategy was published in 2010 and in 2012 we had to report on how we were doing about having our own strategy (big plan). We now have to report on what we have been doing since 2012. There are some areas of the strategy that we are doing OK on – such as training for autism.

We are working on pulling together information and will bring this back to a Partnership Board meeting – although this will be after we have sent in the report as we have to complete the report by the end of September. The report will also go to other Boards.

9 Notes of the Last Meeting – 19th July 2013 + Matters Arising

John went through the notes of the last meeting to remind people what had happened. Everyone said that the notes from the meeting were okay.

9a Confidential Inquiry into premature deaths of people with learning disabilities



Bring forward – John is to check with Judi Kyte whether there are any people with a learning disability in Rotherham who are significantly underweight.

Action:
9a John to contact Judi, as agreed before.

10 Any Other Business

10a Carers' Rights Day

Ann told the meeting that this year's Carers' Rights Day is on 29th November 2013. We are not sure what form this will take yet.

10b Let's Talk Event

Councillor Russell asked about a Let's Talk event for carers and service users. Jo explained that this event was going to be about the learning disability strategy (big plan). John advised that we have had a Let's Talk Employment event this year.

Action:

10b John and Jo to talk about having another Let's Talk event and will bring back to the next Partnership Board meeting.

11 Date and Time of Next Meeting

October

Friday 25th October 2013
@ 10.00 am

Councillor Russell closed the meeting and thanked people for their time.

LDS/JFr/PB130913
(02.10.13)

ROTHERHAM BOROUGH COUNCIL – REPORT TO MEMBERS

1	**Meeting:**	**Cabinet Member for Adult Social Care Meeting**
2	**Date:**	**21st October, 2013**
3	**Title:**	**Police Assistance and Conveyance to Hospital for those detained under the Mental Health Act 1983**
4	**Directorate:**	**Neighbourhoods and Adult Services**

5 **Summary**

The 2008 Mental Health Act (MHA) Code of Practice requires Local Social Services Authorities, defined in section 145 (1) Mental Health Act 1983, the National Health Service and the Local Police Authority to establish a clear policy for the use of the power to convey a person to hospital under S.6 (1) MHA. This policy and procedure outlines the roles and responsibilities of the Approved Mental Health Professionals (AMHP), the ambulance service, medical and/or other healthcare practitioners, and police who may be called upon to facilitate the conveyance of an individual to hospital, or in the case of Guardianship an appropriate placement. The policy is to support good joint working and minimise the distress that service users, their family and friends can experience when admission is necessary. It has been developed in conjunction with a wide range of stakeholders and this final version is now presented for acceptance as council policy.

6 **Recommendations**

- **For Rotherham Metropolitan Borough Council to confirm its approval of this policy and demonstrate its commitment to this multi-agency policy as a signatory body.**

7 Proposals and Details

It is recognised that arranging admission to a mental health unit is unpredictable and that circumstances and levels of risk to the service user and others will vary from one situation to another. However, the overall aim is to:

- To ensure that the person detained under the Mental Health Act 1983 is conveyed to hospital or alternative placement in an appropriate vehicle and in the most human way possible following an assessment of their mental health needs by 2 doctors and an Approved Mental Health Professional

Therefore, in accordance with Section 118 of the Mental Health Act 1983 as amended by the Mental Health Act 2007 (referred to in the policy as the MHA '83), the Department of Health issued a Code of Practice to provide guidance for managers and staff of Health and Social Services to assist them in undertaking duties under the Mental Health Act. The code places a requirement on statutory agencies to draw up a number of policies. Among these is the requirement for the provision of a jointly agreed policy for the conveyance of individuals who have been made subject to the Act.

The Code of Practice also specifies that policy should clearly identify what arrangements have been agreed with the police should they be asked to provide assistance to the AMHP's and the doctors, and how that assistance will applied to minimise risk of the patient causing harm to themselves and maximise the safety of everyone involved in the assessment.

8 Finance

There are no financial implications of this report.

9 Risks and Uncertainties

This policy will be monitored through the Mental Health Legislation Monitoring Group on a monthly basis and reviewed at 3 monthly intervals during the first year following implementation. This will not only ensure its fitness for purpose in its practical application but also provide assurances that where decisions are made and actions compromise the liberty and Human Rights of an individual, that this is done lawfully and informed by good practice.

10 Policy and Performance Agenda Implications

None Known.

11 **Background Papers and Consultation**

- The Mental Health Act Code of Practice
- The Mental Health Act Manual
- Mental Health Act 2007, New Roles, Guidance for Approving Authorities and employers on Approved Mental Health Professionals and Approved Clinicians. National institute of Mental Health in England
- The Mental Capacity Act 2005
- Police and Criminal Evidence Act 1984
- Criminal Law Act 1995
- Human Rights Act – specifically Articles 2,3,5, 8,10,11

Consultation

- Consultation has taken place and legal advice sought with and within
- South Yorkshire Police
- Yorkshire Ambulance Service
- Rotherham Doncaster and South Humber NHS Foundation Trust
- Rotherham Metropolitan Borough Council

Contact Name: **Marie Staves**
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E-mail: marie.staves@rdash.nhs.uk

Rotherham Doncaster and South Humber NHS
NHS Foundation Trust

POLICE ASSISTANCE AND CONVEYANCE, FOR THE ADMISSION OF PATIENTS DETAINED UNDER THE MENTAL HEALTH ACT 1983 TO HOSPITAL

DOCUMENT CONTROL:	
Version:	2
Ratified by:	Mental Health Legislation Committee
Date ratified:	
Name of originator/author:	Social Work Consultant/MHA Manager/South Yorkshire Police/Humberside Police/Yorkshire Ambulance Service/East Midlands Ambulance Service
Name of responsible committee/individual:	Mental Health Legislation Committee
Date issued:	
Review date:	
Target Audience	

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Privacy, Dignity and Respect
Mental Capacity Act

10. LINKS TO OTHER TRUST PROCEDURAL DOCUMENTS

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FORWARD

In accordance with Section 118 of the Mental Health Act 1983 as amended by the Mental Health Act 2007 (referred to subsequently as the MHA '83), the Department of Health issues a Code of Practice to provide guidance for managers and staff of Health and Social Services in undertaking duties under the Mental Health Act. The code requires statutory agencies to draw up policies for a number of Mental Health Act duties. Among these is the jointly agreed policy for the conveyance of patients. This conveyance of patients detained under the Mental Health Act Policy represents good practice.

It is the intention of the author and the Mental Health Act Manager to negotiate across Rotherham Doncaster and South Humber NHS Foundation Trust and between its partner agencies demonstrating their commitment to improving the efficiency and dignity with which people who are subject to the Mental Health Act 1983 are conveyed to hospital. This policy will be regularly monitored.

Partner Organisations	**Signatories**
Rotherham Metropolitan Borough Council	
Doncaster Metropolitan Borough Council	
North Lincolnshire Council	
South Yorkshire Police	
Humberside Police	
Yorkshire Ambulance Service	
East Midlands Ambulance Service	
Rotherham Doncaster and South Humber NHS Foundation Trust	

COMMITMENT OF SIGNATORY BODIES

Yorkshire and East Midlands Ambulance Service will exercise its authority to convey under S.6 (1) Mental Health Act, using the most appropriate vehicle for the presenting circumstances. All Mental Health Act requests for conveyance under this policy will be graded as requiring an urgent response that is, within two hours, unless exceptional circumstances merit a more immediate level of response.

Rotherham Doncaster and South Humber NHS Foundation Trust recognises the importance of multi-agency work under the Mental Health Act. The Trust is committed to providing an efficient and effective response to requests for support and/or assessment. RDASH NHS Foundation Trust will also ensure that mental health staff have appropriate training to support actions that may be required, such as bed management, in the execution of this policy and procedure.

Rotherham Metropolitan Borough Council, Doncaster Metropolitan Borough Council and North Lincolnshire Council will ensure that there are sufficient numbers of Approved Mental Health Professionals (AMHP's) available under S.114 Mental Health Act 1983 for the purposes of statutory intervention under this policy and procedure and are committed to providing an efficient and responsive 24-hour AMHP Service.

South Yorkshire and Humberside Police recognise the importance of multi-agency work under the Mental Health Act and in particular, to support the AMHP and the Ambulance Service in the delivery of its conveyance responsibilities. The Police recognise that where there is an identified threat or risk of violence or harm to staff carrying out an assessment, or to Ambulance Service personnel, that the assistance of officers may be required. The Police further acknowledge that there are appropriate powers available to them in order to prevent or reduce the risk of harm to others under various pieces of legislation and statutory powers.

INTRODUCTION

The 2008 Mental Health Act (MHA) Code of Practice requires Local Social Services Authorities, defined in section 145 (1) MHA 1983, the National Health Service and the Local Police Authority to establish a clear policy for the use of the power to convey a person to hospital under S.6 (1) MHA. This policy and procedure outlines the roles and responsibilities of each of the organisations that are the signatory bodies. This policy and procedure therefore provides guidance for ambulance service personnel, medical and/or other healthcare practitioners, Approved Mental Health Professionals (AMHP) and police officers.

In the case of a formal application for admission to hospital other than an emergency application, the period of 14 days beginning with the date on which the person was last examined by a registered medical practitioner is the period within which the applicant or any person authorised by the applicant can take the patient and admit them to hospital.

In the case of an emergency application, the period is 24 hours from when the application was made within which the patient can be conveyed to hospital.

The overall aim of this policy and procedures is:

- To ensure that persons detained under the Mental Health Act 1983 are conveyed to hospital in an appropriate vehicle and in the most humane way possible following an assessment of their mental health needs by doctors and an Approved Mental Health Professional.

2. PURPOSE

The purpose of the policy is to describe best practice in the process of admitting mentally ill patients to hospital by ambulance, and to explain the agreed roles and responsibilities of each of the services involved in an admission under the Mental Health Act 1983. It will contribute to good joint working, and minimise the distress that patients, their friends and family can experience when admission is being undertaken.

It is recognised that arranging admission to a mental health unit is unpredictable, circumstances will vary from one situation to another and each of the services operates under resource constraints. However, this policy, in describing best practice, sets out the standards for each service.

3. SCOPE

This policy is relevant to the personnel of RDASH, Local Authority partners, South Yorkshire and Humberside Police and Yorkshire / East Midlands Ambulance Service and covers:

- Roles and responsibilities
- The Assessment process
- Admission arrangements
- Arrangements for the resolution of disputes

The Policy does not cover the full range of all individuals and professionals who may play key roles in the mental health admission process, but does identify the roles of the AMHP, the Police and Ambulance Service.

The Policy covers Police assistance and the conveyance of an individual detained under the Mental Health Act 1983 to a hospital or appropriate placement where the patient is subject to guardianship.

4. RESPONSIBILITIES, ACCOUNTABILITIES AND DUTIES

4.1 RDASH - Mental Health Legislation Committee

The RDASH Trust's Mental Health Legislation Committee is responsible for:

- Overseeing the implementation of the Act within the organisation.
- The review and issuing of all policies and procedures which relate to the Act.
- Monitoring the Trust's compliance with the legal requirements of the Act.
- Undertaking audit work and agreeing action plans in relation to the Act.
- Providing an annual report on Mental Health Act activity within the Trust to the Board of Directors.

4.2 Approved Mental Health Professional (AMHP)

The Approved Mental Health Professional (AMHP) will take the lead in all matters relating to the conveyance of patients who are liable to be detained under the MHA 1983, they will:

- consult appropriately with staff from other agencies
- establish the most appropriate conveyance arrangements
- complete and document a risk assessment
- share the risk assessment with Ambulance, Police and other colleagues
- be available to offer assistance if the Nearest Relative is the applicant
- ensure that all the necessary arrangements are made for the patient to be conveyed to hospital
- ensure the needs of the patient are taken into account and give particular consideration to:
    - The patient's wishes.
    - The views of relatives or friend(s) involved with the patient.
    - The views of other professionals involved in the application who know the patient.
    - His or her judgment of the patient's state of mind, and the likelihood of the patient behaving in a violent or dangerous manner.
    - Previous experience of conveying the patient.
    - The impact that the use of a police vehicle may have on the patient's relationship with the community, to which he or she will return.

5. POLICY FRAMEWORK

5.1 Who has the authority to convey the patient?

This applies in all cases where patients are compulsorily conveyed under the MHA 1983 (11.3 MHA Code of Practice)

The Approved Mental Health Professional (AMHP) will take the lead in all matters relating to the conveyance of patients who are liable to be detained under the MHA 1983.

A properly completed application for the detention of an individual under the MHA 1983, together with the required medical recommendations, gives the applicant

(AMHP or Nearest Relative) the authority to convey the patient to hospital. They are authorised under the MHA to convey a patient to hospital or appropriate placement and therefore have all the powers of a police constable in respect of, and for the duration, of the conveyance of the patient.

When the AMHP is the applicant he/she has a duty to ensure that all necessary arrangements are made for the patient to be conveyed to hospital. Where an application for compulsory admission to hospital appears likely to take place, it is considered best practice to inform Ambulance Service in advance of the assessment

When the Nearest Relative is the applicant, the assistance of an AMHP should be made available, to give guidance and help on all aspects of conveyance and other matters related to the admission.

A patient will be conveyed to hospital in the most humane and least threatening way, consistent with ensuring that no harm comes to the patient or to others.

5.2 Who is authorised to convey the patient?

All patients subject to an application for admission to hospital or alternative placement under the MHA 1983 will be conveyed by the Ambulance Service using an appropriate vehicle and with suitably trained staff.
In situations where the risk of injury to patient or staff is likely, the assistance of the Police may be required. When called upon to assist, the attending officers will consult with other professionals as to the most appropriate method of transporting the patient to a place of safety, making a joint decision based upon a dynamic joint risk assessment (Appendix 3).

The detained patient should never be conveyed by private car.

If the patient is unlikely to or unwilling to move, the applicant should provide the people who are to convey the patient (including any ambulance staff or police officer involved) with written authority to convey the patient (Appendix 1)**.**
It is this authorisation, which confers on them the legal power to convey the patient against their will, using reasonable force if necessary, and to prevent the patient from absconding en route. Section 5 of the Mental Capacity Act provides powers to use reasonable force in order to act in the patients' best interests. It will be for the attending AMHP and other relevantly trained medical professionals to inform attending officers that the patient lacks the requisite capacity to make an informed decision about their proposed treatment. It will not be for attending police officers to make a capacity assessment. All such decisions should be appropriately documented. If officers are attending in circumstances whereby a warrant has been granted under Section 135 of the Mental Health Act 1983, then this grants powers to use reasonable force if required.

6. PROCEDURE/IMPLEMENTATION

6.1 AMHP responsibilities

6.1.1 <u>Risk Assessment</u>

Where the risk assessment conducted by the AMHP concludes that there is a threat of violence or harm or a risk that the patient will abscond, the AMHP will discuss whether the Police should be in attendance throughout the MHA assessment itself, and/or providing an escort in any subsequent conveyance of the patient to hospital. The risk assessment will be shared with Ambulance Service, Police, and other

colleagues and will be formally recorded (Appendix 3).

The AMHP should request the assistance of the Police if there is an assessed risk of violence during the assessment, conveyance, or admission process. The AMHP, upon acknowledging the need for a Mental Health assessment in the community, should carry out a risk assessment. If there are identified risks, then they should grade that risk in accordance with the attached flow chart (Appendix 6). Police assistance should then be requested from the Police Control Room by telephoning 101. (*this is the number for all police forces now and the call will be directed to the relevant force's control room*). The AMHP should quote 'Operation AMHP' to the call handler, together with the desired level of police support. This will then trigger the police action plan in place for such requests. The AMHP will be given an incident number for use when re-contacting the police. In the event of urgent and immediate assistance being required, then the AMHP should use the 999 system, giving as much information about the situation as is practicable in the circumstances.

If, following the initial request for police assistance, the attending AMHP requires further assistance, or if the situation develops or deteriorates, then the AMHP should re-contact the police, quoting the incident number.

In situations where an increased level of risk is identified prior to the assessment taking place, then the 'Additional Information for Police' sheets (Appendix 4) should be completed, with the information passed to the police. This will enable the rapid and appropriate deployment of resources to assist when required.

It is the AMHPs responsibility to conduct their own risk assessment. The Police will carry out their own risk assessment based upon this information, together with their own sources of information / intelligence in order to develop a deployment / assistance plan. Attending officers will carry out a dynamic risk assessment in consultation with the AMHP and other attending professionals, should they be deployed.

Where the Police have been urgently requested, due to an escalation of risk it would also be advisable to contact the ambulance service and upgrade the response so that there is an immediate ability to transport the patient.

6.1.2 Needs of the patient

The AMHP should ensure the needs of the patient are taken into account and give particular consideration to:

- The patient's wishes.
- The views of relatives or friend(s) involved with the patient.
- The views of other professionals involved in the application who know the patient.
- His or her judgment of the patient's state of mind, and the likelihood of the patient behaving in a violent or dangerous manner.
- Previous experience of conveying the patient.
- The impact that the use of a police vehicle may have on the patient's relationship with the community, to which he or she will return.

6.1.3 Arranging for the conveyance of the patient

As soon as it becomes clear that NHS transport is required, the AMHP should contact:

For Rotherham and Doncaster services:
Yorkshire Ambulance Service Emergency Operations Centre on 0300 330 0244.

For North Lincolnshire services:
East Midlands Ambulance Service ……

giving as much detail as possible (see Appendix 2).

NB: The AMHP should make it clear at this stage, to the emergency services call centre, as to whether the Police are or are not required to attend. The call centre staff will then pass this information to the Ambulance crew and advise if they can proceed directly to the address.

A patient's journey will be entered into the computer system, which will be assigned a unique incident number.

The AMHP may contact Ambulance Control at any stage giving the incident number, to update or discuss the progress of the incident.

If the admission is stopped at any stage it is the responsibility of the AMHP to contact Ambulance Control and cancel the journey.

Due to the complexity of some of the journeys, the discussion between the AMHP and Ambulance Control should make the exact circumstances of the situation completely clear.

If any difficulties arise, the AMHP should ask to be referred to the Emergency Operations Centre Team Leader.

6.1.4 Delegation of conveyance

The AMHP is permitted to delegate the task of conveying the patient to another person, such as personnel from the Ambulance Service or the Police. If the task is delegated, a form of authorisation should be given to the delegated person (Appendix 1).

If the AMHP delegates the conveyance of the patient she/he must be confident that the person accepting this responsibility is competent and fully aware of their responsibilities in relation to this task.

In exceptional circumstances, the AMHP may delegate the responsibility for conveying the patient to a professional worker other than an AMHP and not accompany the patient to hospital. The AMHP must contact the hospital accepting the patient and confirm the papers have been received. It is considered good practice to fax a copy of the papers to the receiving hospital prior the patient arriving there. If the delegated organisation encounters difficulty with the arrangements, it will need a means of contacting the AMHP. The AMHP will provide their contact details on the delegation form (Appendix 1).

6.1.5 Accompanying the patient during conveyance

It is good practice and generally expected that the AMHP will personally accompany, or follow the patient to hospital in their own vehicle. The AMHP retains ultimate responsibility to ensure that the patient is conveyed in a lawful, safe and humane manner, and must be ready to give the necessary guidance to those asked to assist.

The AMHP should take into account the needs of the patient and the views of the Nearest Relative, the Ambulance Service or the Police when deciding whether to accompany the patient to hospital in the same vehicle. If the patient would prefer to be accompanied by another professional or by any other adult, that person may be asked to escort the patient, provided the AMHP is satisfied that this will not increase the risk of harm to the patient or to others.

A decision should be reached by negotiation with the above, depending on individual circumstances.

6.1.6 Escorts for the conveyance

An escort should only be provided if needed and appropriate. This will depend on individual circumstances, and must be agreed between the AMHP, the Section 12 (2) MHA approved doctor, the GP (if present), personnel from the Ambulance Service and, where appropriate, the Police.

The escort could be the AMHP or, with the AMHPs agreement, any other adult, or another professional person. The escort must have an appropriate level of training to meet the patient's needs and welfare. This should not preclude the Nearest Relative exercising their right to accompany the patient. If the patient has been sedated a suitably trained professional should accompany him.

As a guide, the use of escorts should be considered in the following situations:

- Where the protection and/or support of both the patient and transport service personnel is required;
- Where the presence of a particular escort, e.g. relative, friend, nurse, social worker, will assist in the patient's conveyance to hospital.
- Where the presence of the Police is needed to prevent a breach of the peace or because the patient presents a physical risk to others.

If an escort is required the Ambulance Service will be unable to return the escort to their starting point and provisions should be made for them to arrange their own transport.

Where the AMHP/applicant is not travelling in the same vehicle as the patient the application form and medical recommendations should be given to the person authorised to convey, with instructions that they should be given to the receiving member of hospital staff.

6.1.7 Patients who have been sedated and require conveyance

If the patient has been sedated, the Ambulance Service will advise on the most appropriate vehicle to be used. In such circumstances the patient should be accompanied by a nurse, a doctor or a paramedic experienced in this area.

Where no nurse escort is available for a patient who has been sedated prior to transportation, a paramedic crew with advanced life support skills should be requested in case of adverse drug reaction, cessation of breathing, etc., with the attending clinician giving clear instructions at handover on likely adverse reactions and treatment required.

Please Note: The professional who administers the sedation should be prepared to provide the ambulance service with details of the medication given and the expected duration of its effect.

Only suitably qualified medical practitioners can prescribe medication and/or authorise and arrange any nurse escort. If the medical practitioner has to leave prior to the patient being conveyed to hospital he/she must ensure that the AMHP is informed of how to contact him/her or the duty psychiatrist in his/her absence. In the event of detention under S.4 MHA the assessing doctor will have this responsibility.

6.1.8 Medical Intervention

If it becomes apparent to the AMHP, Assessing Doctor/s or Ambulance Personnel that the patient requires immediate Medical intervention for his/her physical health then the Patient should be conveyed to the appropriate A&E department. It is the responsibility of the AMHP to follow the Ambulance to the A&E department in order to provide necessary information to the treating clinician.

6.1.9 Transfer of the patient into hospital services

In order to expedite the transfer of responsibility for the patient to the hospital, the AMHP should ensure that the receiving hospital is expecting the patient, and telephone ahead with expected time of arrival. The AMHP should ascertain the name of the person who will be formally receiving the admission papers.

The AMHP should arrive at the hospital at the same time as the patient and remain there until he/she has ensured that:

- The admission documents have been delivered, checked for accuracy and received, on behalf of the Hospital Managers.
- Any other relevant information (AMHP Outline Report) is given to the appropriate hospital personnel.
- The patient has been receipted into the care of the hospital.

6.2 Police Responsibilities

6.2.1 Police response

The Police will respond to a request for assistance where there is a threat of violence or harm to the patient, other persons or property, or a risk the patient will abscond. The AMHP and police will agree the most appropriate response to ensure the safety of all concerned - which may or may not require action by the police. The Police will ensure that any action they take is proportionate to the situation presenting. They will also, where this is not inconsistent with their duty to protect persons, or property, or the need to protect themselves comply with any directions or guidance given by the AMHP while the patient is being conveyed to hospital.
In the event that a patient absconds, then the police will respond according to identified risks and provide a tiered response accordingly. The police may apply their missing persons criteria and protocols to such circumstances. The police acknowledge that a person who absconds after they have been placed under a section of the Mental Health Act are classed as being ‘unlawfully at large’, unless advised otherwise by appropriate professionals.

Where an AMHP requests the assistance of the Police, this will be met as far as practicable. The Police will use their discretion on the number of officers to be deployed but their overriding duty is to protect the patient from harm to themselves or others. Where, for operational reasons, the Police find this difficult, there will be discussion between the Duty Inspector or Sergeant for the division concerned and the AMHP.

In exceptional circumstances where there is concern about the safety of the patient or other persons, a police vehicle may be used with the police and AMHP as an escort, if appropriate. If the patient is to be conveyed by the Police, for the safety of the patient and escorts the patient will be searched by the Police to identify if the patient has anything on their person that could cause harm or damage.

Where there is a risk of violence or harm to persons or property, and the police have conveyed the patient to hospital, the admission should be effected as efficiently as possible and the time spent by the Police in hospital should be restricted to the minimum required for safe transfer of responsibility.

6.3 Ambulance Responsibilities

6.3.1 Ambulance Response

When requested, the Ambulance Service has a duty to provide an appropriate vehicle and staff competent to manage the patient's presenting condition and convey the patient to hospital.

Staff employed by the Ambulance Service should, where it is not inconsistent with their duty, comply with any directions or guidance given by the AMHP.

If the crew of the vehicle provided by the Ambulance Service believes that by conveying the patient in their vehicle they would put themselves, the patient or other road users at risk, they may refuse to convey the patient and Police assistance should be requested.

The assessing doctors and AMHP need to agree the estimated time of the patient's arrival at the receiving hospital. The timeframe must be agreed between the AMHP and Ambulance Control and this will normally be within the agreed 2 hour response.

All patients detained under the Mental Health Act who require NHS transport to convey them to hospital are considered an 'emergency' in the sense of requiring transport within two hours.

6.4 Restraint

In the process of conveying a patient to hospital any of the parties can use such force as is proportional and reasonable in the circumstances. Although it is not possible to be definitive as to what proportional means in practice, there should be consultation with the patient, the Nearest Relative and other professionals to assist in this judgement. Each situation must be assessed on its individual merits and be informed by the medical assessment(s) and the AMHP assessment.

All AMHP's must work in line with the RDASH Policy for the prevention and management of work related violence and aggression.

If physical intervention is necessary then the use of minimum force, acting under common law or if the patient lacks capacity then the MCA 2005 may be used to maintain the safety of the staff and others involved in the conveyance arrangements. Ambulance staff have not been trained in restraint and therefore they may be required to call Police assistance if necessary. The circumstances and reasons for doing this must be recorded in the Mental Health Act assessment documentation.

6.5 Geographical boundaries in relation to conveyance

Where it is necessary to use NHS transport services to convey the patient to hospital the responsibility lies with the area the journey arises. This is the situation for both NHS and private healthcare patients.
Where a privately funded patient is requesting admission to a particular private hospital, the patient will be responsible for the cost of the transport.

In the geographical area covered by RDASH, NHS transport services are provided by the Yorkshire Ambulance Service (Rotherham and Doncaster localities) and the East Midlands Ambulance Service (North Lincolnshire locality). The patient must be conveyed to a named hospital except in the case where bed availability dictates the use of a bed in another geographical area.

Where patients need to be conveyed longer distances because of a lack of, or suitability of, an appropriate bed locally, the Commissioners in whose area the journey arises remains responsible. Where the AMHP is the applicant in these circumstances, he/she has the duty to ensure that all necessary arrangements are made for the patient to be conveyed to the hospital and will consult closely with the Access Team or receiving inpatient staff.

Where police escorts and/or ambulance transport may be required for conveying patients longer distances, close co-operation between agencies will need to agree the most practical time and suitable way to achieve the conveyance.

6.6 Out of Area patients

For patients who originate from out of area (that is, beyond the geographical boundary covered by this policy and procedure) and require NHS transport to return them home, this remains the responsibility of their Primary Care Trust for that area.
A joint discussion with Ambulance Service should initially take place and focus on the patient's presenting issues and needs. Given that the Ambulance Service is normally involved in the transportation of patients locally, there maybe circumstances where such cases can be transported by the local Ambulance Service as an extra contractual referral and the costs will be fully met by the appropriate receiving authority. However in cases where the Ambulance Service is not able to provide this service staff should seek the services of a Private provider (i.e. Rapid and Secure) to facilitate this conveyance. The needs of the patient are paramount and there should be no delay in conveyance whilst discussions happen over funding, which can be dealt with retrospectively

6.7 Patients requiring specialist placements

For patients who require admission to a specialist hospital where the journey is deemed to be excessive and potentially detrimental to the patient's overall presentation at the time of assessment, consideration should be given, to admitting the patient to a RDASH hospital in the first instance and transfer should then be facilitated between hospitals under section 19 of the MHA 83.

NB: For those patients who are under the age of 18, a Tier 4 CAMHS bed should be sought either, during working hours by the Specialist Commissioners or out of hours by the Consultant on-call.

6.8 Other situations where conveyance will be required

6.8.1 Section 135 (1)

Where a member of the public has had a warrant served on them under s.135 (1) of the MHA 1983, and is required to be conveyed to a hospital subject to detention under the MHA 1983, or to a place of safety for the purpose of a full MHA assessment, the organisation of the conveyance arrangements will be the responsibility of the AMHP.

6.8.2 Section 135 (2)

Where a person who is liable to be detained in hospital has to be taken, or retaken, in the case where they have absented themselves from hospital and a warrant under s.135(2) of the MHA 1983 has been issued to a Police Officer to enter the premise by force. The most appropriate method of conveyance will be organised by a nominated member either of the hospital staff or in the case of a patient who is subject to Supervised Community Treatment (SCT) a staff member who knows the patient. There may be occasions where this conveyance is via the Ambulance Service.

Before the patient is conveyed the applicant should contact the receiving hospital to ensure that they are expecting the patient and provide an estimated time of arrival.

6.8.3 Section 17 / Supervised Community Treatment – non compliance

Where a patient is subject to S.17 MHA leave or supervised community treatment and is non-compliant with the care plan and needs to be returned to hospital, the Responsible Clinician, or other staff acting on his/her behalf, will need to decide the most appropriate form of conveyance. They will also be responsible for the co-ordination of the process to effect the patient's return or recall to hospital.

6.8.4 Supervised Community Treatment – recall

In the situation where a SCT patient is recalled to hospital it is the responsibility of the Responsible Clinician or the hospital managers to provide written authorisation to the most appropriate person to convey the patient -which could be to be any officer on the staff of the hospital to which the patient is to be recalled, any police officer or any AMHP.

7. TRAINING IMPLICATIONS

"There are no specific training needs in relation to this policy, but the following staff will need to be familiar with its contents: (Approved Mental Health Professionals South Yorkshire and Humberside Police personnel and Yorkshire and East Midlands Ambulance personnel and any other individual or group with a responsibility for implementing the contents of this policy).

As a Trust policy, all staff need to be aware of the key points that the policy covers. Staff can be made aware through: A number of a variety of means such as;

Trust wide Email	AMHP refresher Training
Team meetings	AMHP Specialist Meeting
Group supervision	One to one meetings / Supervision
Practice Development Days	Mental Health Legislation Training

The Training Needs Analysis (TNA) for this policy can be found in the Training Needs Analysis document which is part of the Trust's Mandatory Risk Management Training Policy located under policy section of the Trust website.

8. MONITORING ARRANGEMENTS

- **Monitoring and Review**

The effectiveness of the local conveyance arrangements will be formally reviewed on an annual basis. This annual review will be undertaken by the Mental Health Legislation Group, convened and chaired RDASH Mental Health NHS Foundation and reported through to relevant Council Senior Management Teams and relevant partners.

Area for Monitoring	**How**	**Who by**	**Reported to**	**Frequency**
Implementation	Dissemination	Social Work Consultant / Mental Health Act Manager/ in partnership with SY& H Police and YAS and EMAS	MHLC	3 monthly
Compliance with content of policy particular attention being given to waiting time	Through AMHP report	Social Work Consultant / MHA Manager	MHLC who will ensure that any recommendations made will be forwarded on to partner organisations	3 monthly
Any Incidents which identify issues or concerns relating to implementation of this policy	Issues or concerned will be reviewed and recommendation will be made	Social Work Consultant / MHA Manager/ Liaison officers from SY & H police and YAS &EMAS	MHLC who will ensure that any recommendations made will be forwarded on to partner organisations	As required

9.1 Privacy, Dignity and Respect

Central to any aspect of care delivered to adults and young people aged 16 years or over will be the consideration of the individuals capacity to participate in the decision making process. Consequently, no intervention should be carried out without either the individuals informed consent, or the powers included in a legal framework, or by order of the Court Therefore, the Trust is required to make sure that all staff working with individuals who use our service are familiar with the provisions within the Mental Capacity Act. For this reason all procedural documents will be considered, if relevant to reflect the provisions of the Mental Capacity Act 2005 to ensure that the interests of an individual whose capacity is in question can continue to make as many decisions for themselves as possible.	**Indicate How This Will Be Achieved.** *All individuals involved in the implementation of this policy should do so in accordance with the Guiding Principles of the Mental Capacity Act 2005. (Section 1)*

The Mental Capacity Act	**Indicate how this will be met**
The NHS Constitution states that all patients should feel that their privacy and dignity are respected while they are in hospital. High Quality Care for All (2008), Lord Darzi's review of the NHS, identifies the need to organise care around the individual, '*not just clinically but in terms of dignity and respect'*. As a consequence the Trust is required to articulate its intent to deliver care with privacy and dignity that treats all service users with respect. Therefore, all procedural documents will be considered, if relevant, to reflect the requirement to treat everyone with privacy, dignity and respect, (when appropriate this should also include how same sex accommodation is provided).	*All individuals involved in the implementation of this policy should do so in accordance with the Mental Health Act Code of Practice – Chapter one*

10. LINKS TO OTHER TRUST PROCEDURAL DOCUMENTS

Policy for the prevention and management of work related violence and aggression
Mental Capacity Act Policy
Procedure on the receipt and scrutiny of section papers

11. REFERENCES

Statutory Framework:

- Mental Health Act 1983 as amended by the Mental Health Act 2007
- Police & Criminal Evidence Act 1984
- Criminal Law Act 1995
- Human Rights Act 1998

Guidance:

- Mental Health Act – Code of Practice 2008 (*particularly chapter 11*).
- Police & Criminal Evidence Act 1984 – Codes of Practice
- European Convention on Human Rights – specifically Articles 2, 3, 5, 10, 14

Definitions used in this document:

- The Mental Health Act 1983 as amended by the Mental Health Act 2007
- Local Social Services Authority: Section 145 (1)
- Approved Mental Health Professional: Section 145 (1)
- Community Treatment: Section 17A
- Nearest Relative: Section 26 (3) Patient

Case law:

- There is no recent case law of relevance to this policy and procedures.

12. APPENDICES

APPENDIX 1	–	Delegation Of Authority To Convey
APPENDIX 2	–	Information required by Ambulance Service during booking
APPENDIX 3	–	Risk Assessment
APPENDIX 4	-	Additional information to be provided when requesting Police Assistance
APPENDIX 5	-	Risk Assessment Options
APPENDIX 6	-	Conveyance Flowchart

APPENDIX 1

DELEGATION OF AUTHORITY TO CONVEY

Delegation of Authority to Convey a Patient to a Hospital under the Mental Health Act 1983 as amended by the Mental Health Act 2007

…..…… (Name of Patient)

…..……

…..……

I, ……. (Your name)

have made an application for the admission of the above patient to:

…..…… (Name of Hospital or Registered nursing home)

…..……

I am an *Approved Mental Health Professional/the Nearest Relative (**delete as appropriate)* within the meaning of the Act.

I delegate my authority to convey the patient to the above hospital to:

…..…… (Name)

You may use reasonable restraint to achieve the objective of conveying the person to hospital but you should use the least restriction possible whilst ensuring the patient's and other person's safety.

Signed: …..…… (Your signature)

Of: …..…… (Address on forms)

…..……

Contact mobile telephone details if you need to speak with me about this delegation arrangement: …..……

Date authority issued: …..……

Date authority expires: …..……

APPENDIX 2

Do not disclose this number to members of the public.

Press 1 for a life threatening emergency or 2 for a 1 to 4 hours response.

Press 1 to have your call dealt with as a medical emergency, e.g. chest pain, difficulty breathing or O/D.

In exceptional circumstances where a two hour response would be detrimental to the patient then answer “No but with lights & sirens” which will prompt an ambulance response within 30 minutes. AMHPs are asked to balance the safety implications of a blue light response against the risk to their patient when considering this option.

The following additional information will be required:

- Patient name, age, date of birth and gender.
- Address ambulance is to attend.
- Address patient is to be conveyed to.
- Name and contact telephone number of the person making the booking.
- Does the patient require any assistance e.g. a wheelchair or stretcher.
- Does the patient require Medical Intervention?
- Is the patient ready to travel immediately?
  - Has the paperwork been signed?
  - Are the police required or present on scene?
  - Has sedation been given, and what is its expected duration of effect?

Rotherham Doncaster and South Humber NHS Foundation Trust

Yorkshire Ambulance Service NHS Trust

An Aspirant Foundation Trust

APPENDIX 3

Risk Assessment

Has there been any recent (12 months) violence towards others?	**Y / N**	What happened?	**Low Medium High**
Have there been any recent attempts at self harm?	**Y / N**	What?	**L/M/H**
Recent police involvement?	**Y / N**	What? When?	
Any evidence that person is reliant upon or uses intoxicants (legal or otherwise)?	**Y / N**	What? How?	**L/M/H**
Uncharacteristic behaviour?	**Y / N**	Witnessed by who? What?	**L/M/H**
Risk of abuse/ exploitation by others?	**Y / N**	Witnessed by who? Suspicion or belief?	**L/M/H**
Any safeguarding issues? Risk to others or self?	**Y / N**	Evidence?	**L/M/H**
Identified health care issues eg medical complaints or surgery (ie pacemaker)	**Y / N**		**L/M/H**

Risk:	Low	Medium	High
Violence			
Challenging Behaviour			
Resistive Behaviour			
Absconding			
Suicide			
Self Harm			

APPENDIX 4

Additional information to be provided when requesting police assistance

Type of premises (house/flat etc) & precise address	
Where in the property does the person live? (ground floor/front bedroom/first floor)	
How many rooms? Condition of rooms? Hygiene? Living standards?	
Does anyone else live there or is likely to be there? Who? Relationship to person?	
How is access to the property gained? (communal entrance/Key code/Phone entry)	
Have measures been taken to facilitate access? Key? Family/Neighbour/Landlord assistance?	
Is there access to the rear of the premises?	
Is the address fortified? (Substantial locks? Security gate? Barred windows?)	
Are there any weapons in the house (other than normal household items)? If so, what?	

APPENDIX 5

Risk Assessment Options

Option 1

Atlas Court create an RWD incident. Pass to the relevant duty Sergeant on patrol for their attention and information only. Previous Incidents at address, Police National Computer and local intelligence checks to be carried out at discretion of supervisors.

Option 2

Incident created. Police National Computer and local intelligence checks carried out on address and nominal details given. Previous incidents checked. The Duty Sergeant to liaise, where appropriate, with the AMHP and internal colleagues to make a decision on the deployment of SYP.

Option 3

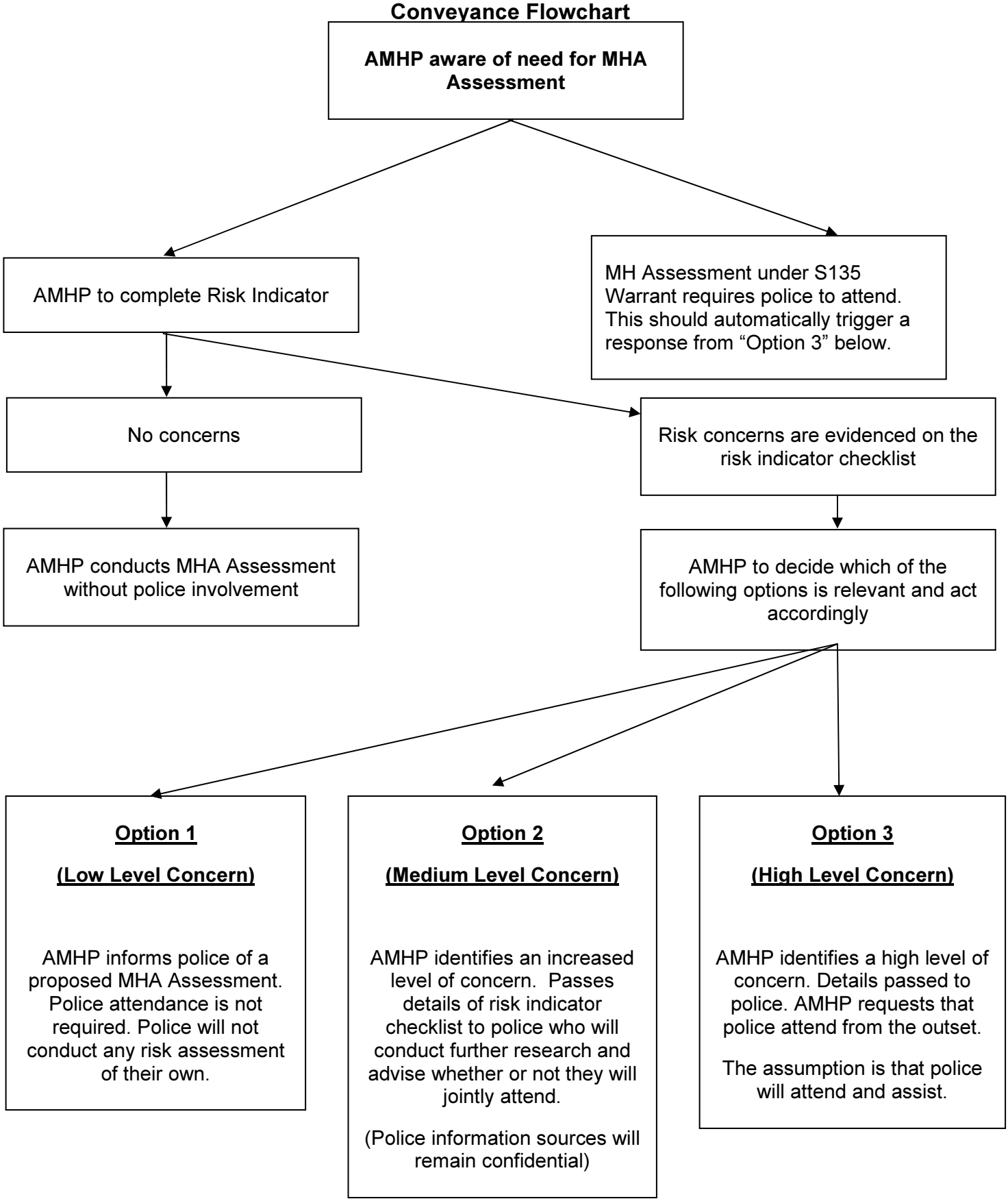
Incident created. Police National Computer and local intelligence checks carried out on address and nominal details given. Previous incidents checked. The Duty Sergeant to liaise, where appropriate, with the AMHP and internal colleagues to make a decision on the deployment of SYP.

Liaison with Force Incident Manager/Duty Inspector may be required to make decisions on resources deployed and any specialist resources. May require a police risk assessment to be carried out.

Expected outcomes to be discussed and agreed, together with incident command structures and individual roles. If level of concern is sufficiently severe, then AMHP should give consideration to a S135 Warrant application.

APPENDIX 6

Conveyance Flowchart



ROTHERHAM BOROUGH COUNCIL – REPORT TO MEMBERS

1.	**Meeting:**	**Cabinet Member for Adult Social Care**
2.	**Date:**	**21st October, 2013**
3	**Title:**	**LAC (DH) (2013) 2 – Armed Forces Independence Payments – Treatment in the Financial Assessment for Charging**
4	**Directorate:**	**Neighbourhoods and Adult Services**

5 Summary

This circular provides guidance on the treatment of Armed Forces Independence Payments when carrying out financial assessments in order to calculate how much someone should pay towards their accommodation charges.

6 Recommendation

- **Members agree to disregard Armed Forces Independence Payments entirely when calculating non residential care charges for former armed forces veterans, in line with the statutory disregard which applies when calculating residential care charges**

7 Proposals and Details

7.1 From 8th April 2013, Personal Independence Payments will replace Disability Living Allowance for eligible working age claimants.

7.2 The mobility component of Disability Living Allowance is excluded by legislation from being taken into account in the financial assessment for charges. The mobility component of Personal Independence Payments should also be disregarded.

7.3 From 8th April 2013, Armed Forces Independence Payments will begin to replace Disability Living Allowance for veterans.

7.4 Unlike a Personal Independence Payment, an Armed Forces Independence Payment is not divided into daily living and mobility components. However, the total amount of the payment is the same.

7.5 For residential care charging, under the National Assistance (Assessment of Resources) Regulations 1992, Armed Forces Independence Payments should be fully disregarded in the financial assessment.

7.6 For Non residential care charging, as set out in "Fairer Charging Guidance", councils may choose to disregard Armed Forces Independence Payments entirely, in recognition of the contribution made by armed forces personnel injured whilst on active duty.

7.7 Should the Council decide not to disregard the Armed Forces Independence Payment in full we must disregard an amount equivalent to what would be disregarded from a Personal Independence Payment.

8 Finance

The frequency of occurrence is negligible; therefore the potential impact of this is likely to be minimal.

9 Risks and Uncertainties

The Council would be viewed as recognising the contribution made by armed forces personnel injured whilst on active duty should they choose to disregard the payment in its entirety.

10 Policy and Performance Agenda Implications

No Implications

11 Background Papers and Consultation

11.1 Fairer Charging for Home Care and other non-residential social services issued by the Department of Health.

11.2 Local Authority Circular (DH) (2013) 2 dated June, 2013 (attached).

Contact Name: Gillian Buckley Operational Manager Revenue and Payments
Ext 34019
E-mail Gillian.buckley@rotherham.gov.uk

ROTHERHAM BOROUGH COUNCIL – REPORT TO MEMBERS

1.	**Meeting:**	**Cabinet Member for Adult Social Care**
2.	**Date:**	**21st October, 2013**
3.	**Title:**	**Safeguarding Adults Annual Report 20012-2013**
4.	**Programme Area:**	**Neighbourhoods and Adult Services**

5 Summary

The Rotherham Safeguarding Adults Board (SAB) produces an Annual Report of safeguarding adult's activity. SAB ratify this report for publication to all Partner agencies represented at SAB and for publication on the Council website. The report is also presented to Cabinet Member for Health and Social Care and presented at Adult Social Care and Health Scrutiny Panel.

6 Recommendations

- **That the attached Safeguarding Adults Annual Report 20012-2013 be presented for information to Cabinet Member for Adult Social Care.**

7 Background Information

Safeguarding Adults "No Secrets" DoH 2000 states that "The multi-agency management committee should undertake (preferably annually) an audit to monitor and evaluate the way in which their policies, procedures and practices for the protection of vulnerable adults are working". This has now been passed to the role of the Safeguarding Adults Board, this will be the 5th Annual Report produced on behalf of the Board.

8 Proposal

The report will be published to all Partner agencies represented at SAB and on the Council website in pdf. That the attached report will be presented to:

- Cabinet member for Health and Social Care on 21 October 2013
- Safeguarding Adults Board on 20 November 2013
- Adult Social Care and Health Scrutiny Panel on 6 November 2013

9 Finance

The costing is £500 for the design and artwork.

10 Consultation

The proposed schedule of presentations will ensure that all relevant officers and partners have had full consultation regarding the contents of the report prior to publication.

11 Risks and Uncertainties

A delay in consultation and publication should the report not be approved.

12 Performance Agenda Implications

Corporate Priority 2 - Protecting our most vulnerable people and enabling them to maximise their independence.

Corporate Priority 4 - All areas of Rotherham are safe, clean and well maintained.

NAS Service Plan 2013-14 -Vulnerable people are protected from abuse, ASB and crime is reduced and People feel safe where they live

13. Background Papers and Consultation

- Safeguarding Adults “No Secrets” DoH 2000.
- I&DeA Adult Safeguarding Scrutiny Guide April 2010.
- “OSC’s should, as a minimum, expect to review an annual report of the Safeguarding Board and the performance data collected by it”.

Contact Name: Sam Newton
Service Manager Safeguarding Adults.

Tel: 01709 382121
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Rotherham Safeguarding Adults

Annual Report 2012/13

Rotherham Safeguarding Adults

People of Rotherham are able to live a life **free from harm** where all organisations and communities:

- **Have a culture of zero tolerance of abuse**
- **Work together to prevent abuse**
- **Knows what to do when abuse happens**

What does zero tolerance mean in Rotherham?

We work continually for justice for victims of abuse to achieve the best possible positive outcomes for those who have been abused, ensuring their future safety and reducing the risk of similar abuse being repeated to others.

In the last 12 months we supported over 1500 people in Rotherham to feel safer.

Since 2007 we have worked hard to raise awareness of adult abuse in Rotherham and year on year the number of people who report abuse happening has continued to rise.

All 1565 people were responded to and made safe within 24 hours of contact.

After people were made safe we thoroughly investigated 264 cases as there was an indication that significant abuse was taking place.

All 264 people had a protection plan in place to protect them and prevent further abuse.

Protection plans ensure as far as possible that any abuse stops, and any further harm is prevented.

Following investigation 67 people were found to have been abused. We put in place ongoing support for these people to protect them from further abuse, where appropriate.

The action we take when we find abuse has taken place:

- **when staff are involved, staff are suspended from work.**
- **police are called in to investigate to see if a crime has taken place.**
- **services are changed or put in place to provide additional support.**

We put in place a protection plan to support every victim of abuse, to make sure they are safe as far as possible and to ensure abuse did not happen again. We reduced the amount of repeat abuse by 35%.

- **When abuse is substantiated we ensure that victims are safe and the perpetrators are dealt with. In substantiated cases this results in strong recommendations that the perpetrator of abuse is reported to the appropriate regulatory/professional body (who determine appropriate action which may mean 'vetting' and 'barring').**
- **We have clear expectations that providers suspend and investigate and take appropriate disciplinary action (including dismissal) against any staff members alleged or proven to have abused someone.**
- **All perpetrators were reported to the Police for consideration of criminal prosecution.**
- **2 perpetrators were given prison sentences.**

MELTON COURT CARE HOME CLOSURE ON HOLD DUE TO OWNERSHIP TALKS

The care home's 21 residents had been given 10 days to move out due to lack of management.

Council and CQC hold talks to reach a solution for residents to remain in the home

When abuse occurs or poor standards are evident we take swift action. Last year:

- **9 care homes were failing to provide good care – we set deadlines for improvement through Special Measures Improvement Plans, monitored and held providers to account for their care practice in order to improve standards. Our intervention helped keep around 300 residents in those homes safe.**
- **A further 25 care homes and 3 domiciliary care providers were helped to improve standards through jointly agreed action plans. Through tackling these poor standards we supported over 2,000 council funded or self funding people to live in their own homes and be safe.**
- **All new placements to 4 care homes were suspended – this means that we were not prepared to admit someone to a care home where standards were not being met. We worked with the homes until we were satisfied that they met our standards before allowing new placements to be made again.**
- **Council staff were sent into one home to ensure that people were safe through difficult management and ownership issues and while improvements were being made. Our every day on-site presence supported 18 people to be safe and get the standard of service they need.**
- **We carried out quality assurance visits on all regulated homes and services in Rotherham working with Age UK and Speak Up Advocacy Services to ensure the customer voice and experience of these services is part of that assessment.**

These measures and interventions in each case led to an improvement in standards of care and safety and resulted in it not being necessary to terminate any contracts this year.

This report sets out the extensive partnership work we have undertaken in the last 12 months to ensure that Rotherham people are safe and when abuse happens we take action. The case studies provide real life stories of how Safeguarding Adults in Rotherham is making a real difference.

Introduction from the Independent Chair of Rotherham Safeguarding Adults Board: Professor Pat Cantrill

Rotherham Safeguarding Adults Board exists to serve the population of Rotherham who because they are older people, or have mental health problems or learning disablities have difficulty protecting themselves from people who might abuse them physically, emotionally, mentally, sexually or financially.

To do this the Safeguarding Board has a strong focus on partnership working, and through this partnership approach hopes to ensure that vulnerable adults are able to live their lives free from abuse, whilst maintaining their independence and well being. The Safeguarding Adults Board brings together representatives of all the key statutory agencies whose expertise may be needed to put things right when they have gone wrong.

This annual report sets out the work of the partner agencies who have a shared responsibility for the safeguarding of vulnerable adults in Rotherham. It identifies facts and figures about the volume of referrals that are received from different sources. Reading it we must remember that each statistic represents a person or a family who are struggling to keep safe or to get good care.

Most carers provide excellent care and most communities are respectful of their more vulnerable members but for some this is sadly not so. Adults at risk can face abuse and hostility, neglect or cruelty, whether this is the taunting of a disabled person by local children or the rough handling by a care worker. Occasionally the abuse is more planned and deliberate and these are cases that shock the public and that cause fear and concern to older people and people with mental health or learning disabilities.

This report confirms the fact that Rotherham Borough Council and partner agencies take abuse and neglect seriously and follow up cases rigorously.

When people trust any of the staff working in agencies with their concerns or complaints, we ensure they are referred to the responsible safeguarding team who can conduct an investigation, take steps to keep vulnerable people safe and if necessary to act against a person who has harmed a vulnerable adult or a service that has failed in its duty of care. The annual report has statements made by each of these agencies about their work over the past year and the report identifies that whilst the task is complex each agency is committed to making sure the right action is taken.

During the last year we have faced challenges of reorganisation and changes to the way services are commissioned, delivered and overseen and these changes will continue to impact on services during the next year.

We all know that there are cuts in the funding available to provide services and that despite these there is support for new ways of trying to offer services that improve choice and accessibility while also being cost efficient and flexible. The Safeguarding Adults Board tries to "stay ahead of the game" by anticipating any ways in which people might be made more vulnerable than they need to be, and by

building safeguards into new systems. However we have to find the right balance between being too interfering and at the other end of the spectrum, turning the other way when some very vulnerable people are out of their depth. Of course we don't always get it right, but we are always learning and facilitating people to make the right decisions through training and raising awareness.

Ultimately the test of our work lies not in the figures assembled here but in whether vulnerable people living in Rotherham feel safe in their homes, when they receive care, when they move about their community and in their workplaces and leisure activities.

I would like to thank everyone who during the year has worked so hard to provide services to some of the most vulnerable people in Rotherham, not least the Safeguarding Adults Team for their commitment, dedication and high levels of achievement.

Rotherham Adult Safeguarding Board believes that everyone has the right to:

- **live their life free from violence and abuse.**
- **be protected from harm and exploitation.**
- **independence, which involves a degree of risk.**

We take the safety of older people and people with disabilities very seriously whether that means protecting them from one-off instances of abuse or from more pervasive and longstanding failures in care. Their rights to citizenship and dignity are jeopardised if we do not act on their behalf when they are abused or denigrated. The Board's job, as evidenced in this report, is to work together, across all agencies, but we also need the public to be our 'eyes and ears' to make these Safeguards the best that we can.

Message from the Safeguarding Adults Champion: Councillor Pat Russell

Safeguarding Adults remains our number one priority. The Council and the Rotherham Safeguarding Adults Board has a continued commitment for Rotherham to be one of the safest places in the country. I am pleased to share with you our achievements for 2012-2013 which show how we have all continued to help keep people safe from all types of abuse and protected as far as possible from avoidable harm. It is important that the People of Rotherham are able to live a life free from harm and the whole community understands that abuse is not acceptable and that it is 'everybody's business'. Councils have a responsibility in relation to safeguarding adults who are defined as vulnerable. As a Council member I am Safeguarding Adults Champion and sit on the Safeguarding Adults Board and I am committed to contributing to the work of the Board to ensure safeguarding adults is given sufficient priority to improve outcomes for vulnerable adults.

Rotherham Safeguarding Adults Review 2012/13

The Rotherham Safeguarding Adults Board's vision is that **"Every vulnerable adult in Rotherham will live a full life as safely and independently as possible and live a life free from abuse and neglect"**. The Board is fully committed to ensuring Rotherham will be one of the safest places in the country by ensuring that:

- Adults who are vulnerable are protected from abuse.
- All organisations and the wider community work together to prevent abuse, exploitation or neglect.
- Where abuse does occur, to support the individual to feel safe and reduce the risk of further abuse to them or to other vulnerable adults.
- Staff in organisations across the partnership are confident that they have the knowledge, skills and resources to enable them to prevent abuse or to respond to it quickly and appropriately.
- The whole community understands that abuse is not acceptable and that it is **'everybody's business'.**

We promised to achieve the following in 2012/13

- Raise public awareness of safeguarding vulnerable people. **Alerts up by 29%**
- Sustain our commitment to respond to every safeguarding concern within 24 hours. **100% achieved**
- Continue to work closely with all providers and the Care Quality Commission to ensure all providers raise standards in care homes. **Abuse in care homes down by 12%**
- Ensure all providers immediately address issues where they fail to meet essential standards. **9 contracting default notices were applied, 314 substantiated contract concerns, 4 care homes had placements suspended due to safeguarding concerns.**
- Increase the number of people who feel safer as a result of the services they receive. **All people who reported that they "don't feel safe" in the Adult Social Care Survey were contacted personally.**
- Improve outcomes for customers experiencing domestic abuse through integrating the response within Safeguarding Adults Service. **Domestic abuse service fully integrated and embedded within safeguarding adults.**
- April 2013 sees the responsibility for DoLS in hospitals transferring from the local Primary Care Trust to the Local Authority. Rotherham MBC and NHS Rotherham will ensure the smooth transition of responsibility. **Fully achieved.**
- Deliver a protected learning safeguarding event aimed at all GPs. **The proposed Safeguarding event for Primary Care took place as planned in November 2012, 700 delegates attended.**

This report highlights the significant work undertaken by the Board in this year. It demonstrates the real and substantial improvements which have been put in place and how we have been successful in ensuring prompt and effective response to and prevention of adult abuse, whilst also delivering the greatest possible protection to Rotherham's most vulnerable citizens. We wish to reiterate our commitment to instilling a zero tolerance of abuse culture across the whole community. When allegations of abuse have been made we have responded quickly to protect individuals with **100% of all alleged abuse responded to within 24 hours.** Our culture and approach to partnership working ensures that vulnerable adults receive the outcomes they want, making a significant positive difference to individual's lives. All people who reported that they "don't feel safe" in the Adult Social Care Survey were contacted personally. Their concerns did not relate to adult safeguarding, however they were all supported and given the information and advice they required to enable them to feel safer.

Our awareness campaigns are crucial to ensuring that we actively promote the understanding and awareness of the safeguarding adults agenda. This is reflected in a year on year increase in people alerting abuse and this year we have seen a further 29% increase in concerns of abuse being reported.

We are committed to ensuring robust arrangements are in place so that all staff in Residential and Nursing Care establishments are trained to recognise and report any safeguarding concerns. We have further strengthened our links with the Care Quality Commission improving communication and information sharing. As a result, this year there has been a further 12% decrease in abuse taking place in Residential and Nursing care. This decrease has occurred year on year, and is evidence of the effectiveness of the Board's commitment to ensuring safeguarding awareness is raised, there is zero tolerance of abuse and an insistence in driving up standards of care.

The Safeguarding Adults Investigation Team remain focused on ensuring that people are safe and perpetrators of abuse are held to account and brought to justice. A clear result of this is that they held 264 strategy meetings and this ensured robust and effective protection plans were in place for the victim. 227 case conferences were held and abuse was substantiated in 30% of these cases. Details of the activity of this team are evidenced in Appendix 1 of this report.

The Domestic Abuse Service is now fully integrated and embedded within the Safeguarding Adults service which has enabled Independent Domestic Violence and Advocacy Service (IDVAS) to respond to 424 referrals and supported 344 victims at Multi Agency Risk Assessment Conferences (MARAC). This service continues to advocate on behalf of high risk victims of Domestic Violence.

The work of the Board is critical in ensuring the development of a capable, confident and skilled workforce. 1800 people have been trained as part of the Bronze to Platinum Training Program across all partners.

Adult Safeguarding is governed by statutory guidance **"No Secrets"** issued by the Department of Health in 2000, which gave Social Services lead responsibility to co-ordinate the development of the local multi agency framework, policies and procedures. **All** statutory agencies are expected to work in partnership with each other and with all agencies involved in the public, voluntary and private sectors to protect vulnerable adults from abuse. 2012-13 has been a challenging year for many of the organisations on the Board as a result of internal changes triggered by either new legislative or statutory guidance, or driven by the need to make financial savings. Such challenges will continue to face all partner organisations over the next few years but all Board members have acknowledged that safeguarding vulnerable adults from abuse continues to be a fundamental priority and they will continue to be involved in this essential work.

This report will demonstrate how this has been achieved through examples of real life stories and highlights of key achievements.

Key Partnership Contributions 2012/13

Safeguarding Adults Service:

- Undertaken a review of the safeguarding team and introduced a performance management framework strengthening the process to respond in a timely manner to all alerts by creating a Principlal Social Work role and Duty officer.
- Introduced a protocol for virtual strategy meetings and case conferences.
- Developed a Local Authority Designated Officer (LADO) protocol.
- Integrated the Contract Compliance Officers into the safeguarding service, to strengthen links and collaborative working with contracting, to raise standards and to ensure all services we commission or deliver meet required standards.
- Strengthened our relationship with the Care Quality Commission and introduced monthly information sharing meetings.
- The Safeguarding Investigation Team have undertaken 264 investigations into alleged abuse.

Case Outcome:

X was a gentleman with profound sensory impairment who lived with his father. X disclosed at work that he was being physically abused by his father and that his sister was financially abusing him. Following initial enquiries the safeguarding social worker in collaboration with assessment and care management, sign language interpreting service and the Police worked with x to facilitate a place of safety, where he remains free from abuse.

Mental Capacity Act & Deprivation of Liberty Safeguards (DoLS) Service:

- Following the recommendations from a Serious Case Review, links have been forged with Children's and Young Peoples Services and in particular the Safeguarding Childrens Board to identify the training and development needs of the workforce.
- A review has been undertaken of the quality assurance and authorised signatory processes to ensure the reports submitted by DoLS assessors would stand the scrutiny of the Court of Protection.
- The Court of Protection team have increased their workload by 26% over the past year of providing financial management services to vulnerable adults, whilst at the same time receiving a satisfactory internal audit and with no additional resources.
- Work continues with Mental Health services by providing advice and training on the interface between the Mental Health Act and Mental Capacity Act to ensure patient rights are protected.

Case Outcome:

X is 69 years old and has a diagnosis of Korsakoff's dementia. The professionals involved in his care felt that he was unable to look after himself safely at home. X was considered to lack the mental capacity to decide where he should live and he was placed in a residential care home. X although judged to lack capacity was still able to object to being placed in residential care, so the care home applied for a Deprivation of Liberty Safeguards (DoLS) authorisation.

The Council granted an authorisation for a short period of time and appointed him an advocate from the local Independent Mental Capacity Advocacy Service (IMCA) as he had no one else who lived close by who could offer him regular support and representation. The advocate appealed through a solicitor to the Court of Protection to challenge the DoLS authorisation. The Court of Protection, employed the services of an Independent Psychiatrist who found that X did have the mental capacity to make his own decisions about where he should live. X decided to remain in residential care but requested a move and now lives closer to his family in the South of England.

Domestic Abuse Service:

Since 2011/12, the Safer Rotherham Partnership's Independent Domestic Violence and Advocacy Service (IDVAS) and Domestic Abuse Coordination have been integrated within Safeguarding Adults, and this has ensured that domestic abuse in Rotherham is seen as a local safeguarding priority throughout 2012/13.

IDVAS

- Received 424 referrals
- Supported 344 MARAC cases

Domestic Abuse

- With support from the Safer Rotherham Partnership, sustained the funding of the Rotherham Independent Domestic Violence Advocacy Service for a further year.
- From March 2013, the Safer Rotherham Partnership has responded to the change in definition of Domestic Abuse to ensure, alongside the 3 other Community Safety. Partnerships in South Yorkshire, the support of 16 – 18 year olds of victims who are direct victims of Domestic Abuse.
- Commenced a Domestic Homicide Review (DHR), on behalf of the Safer Rotherham Partnership.
- Delivered 12 Multi Agency Domestic Abuse training events (4 x Awareness Raising (module 1) and 5 x MARAC workshops (module 3)), and, with the Rotherham LSCB, delivered 3 Domestic Abuse from a Child's Perspective (module 2).

thank you for Bev ,Cheryl and team without them I wouldn't be in the place I am

Customer Compliment

Regarding Cheryl, Bev, Domestic Abuse team

Case Outcome:

A client who worked in a professional environment approached the IDVAs for support. The client had 3 children and fled, with them, to Rotherham from the client's violent and abusive partner. Whilst here, the perpetrator harassed the client and the IDVAs supported the client through Civil court proceedings to obtain a non-molestation order and Residence order. Once this was imposed, the perpetrator then harassed the client through third parties and the IDVAs then supported the client in dealing with agencies whilst they investigated complaints made against her by the perpetrator. As a result of this type of harassment, the client decided the family would be safer moving on to another part of the country and the IDVAs supported the client to access refuge support away from Rotherham.

Joint Learning Disability Service:

- Appointed Safeguarding Lead Social Worker.
- Continued successful multi disciplinary joint screening and investigations through the integrated Health and Social Care Learning Disability teams.
- Use of Vulnerable Adult Risk Management Model process and raising this as good practice for the department.
- Implemented Winterbourne Concordat in relation to out of area placements in hospital settings.

Case Outcome:

X is a 55 year old man who is blind and has a learning disability. He has been able to maintain an independent lifestyle with a care package of 24 hour support into his own home. He is completely reliant on support staff to take him to the bank to withdraw money. The financial anomalies between his bank statement and record of expenditure were picked up at his annual review by his social worker. This was referred for full safeguarding investigation into financial abuse of X. Utilised Mental Capacity Act to demonstrate to Police that service user had capacity to press charges. Progressed to police investigation and perpetrator gained six month criminal conviction.

The Rotherham NHS
NHS Foundation Trust

Rotherham NHS Foundation Trust:

- Adopted and implemented the train the trainers program PREVENT strategy within existing resources.
- Delivered CQUIN standards and achieved significant progress against safeguarding standards.
- Achieved Board of Directors approval for an additional substantive role to support safeguarding adults.
- Recognised and brought together the processes related to safeguarding issues in respect of pressure ulcers.
- Developed a training needs analysis which identifies level of safeguarding training required.
- Safeguarding Vulnerable Adults arrangements within The Rotherham NHS Foundation Trust (TRFT) were subject to an unannounced CQC inspection on 13th August 2012. No concerns in respect of services were identified. Within the same year CQC carried out a planned inspection regarding the detention of Mental Health patients where there is not a Mental Health Unit, TRFT were found to be compliant with requirements.

Case Outcome:

X was a patient in a Hospital following a hip operation. During their stay on the ward concerns were raised regarding inappropriate restraint and managing people with dementia care needs on the general wards. There was a joint investigation with health. On completion of the investigation a case conference was held, allegations of abuse were substantiated.

Whilst X's experience in hospital was not positive the investigation benefitted from positive joint working between safeguarding and the Hospital and identified several areas for improvement and lessons learned related to the care of people with dementia on the general wards. As part of the case conference it was recommended that there would be on going action taken between health and social services to look at a more personalised approach to the care needs of individuals on the ward including information regarding Deprivation Of Liberty safeguards and to develop a working flowchart which would enable staff on the wards to recognise issues related to "wandering behaviour" and look at least restrictive approaches to managing these including those that may be at high risk of falls. Additionally to encourage a more proactive approach to ensure that appropriate discharge planning takes place and happens within an appropriate time frame. It also identified some staff member's lack of understanding regarding mental capacity and agreement was reached that more appropriate training would be completed with staff.

NHS Rotherham (Commissioning Services):

NHS Rotherham

- Rotherham Primary Care Trust (PCT) ceased to exist on the 31 March 2013 and Rotherham Clinical Commissioning Group (RCCG) became a statutory organisation on 1 April 2013. The groundwork for the relationship between the RSAB and the CCG has been firmly laid during the transition and lead up to this major change in NHS commissioning. Rotherham CCG is led by GPs and other clinicians and is responsible for commissioning most local healthcare services (not Primary Care). The focus remains on improving outcomes and driving up standards of care for the population as a whole, but with an emphasis on tackling health inequalities.
- There is now a ratified Commissioning Safeguarding Vulnerable Clients Policy for use by CCG staff.
- Rotherham CCG undertook its first joint Safeguarding Annual Report 2012; this report provided an overview of key issues and activities taking place across the health

economy in relation to safeguarding children and vulnerable adults. The annual report evaluated the safeguarding contributions of health providers in Rotherham namely The Rotherham NHS Foundation Trust (TRFT) and Rotherham Doncaster and South Humber Mental Health NHS Foundation Trust (RDaSH). In addition the expectations of Rotherham Local Safeguarding Childrens Board (RLSCB) and Rotherham Safeguarding Adults Board (RSAB) were incorporated into Rotherham CCG reporting and planning process.

- The proposed Safeguarding event for Primary Care took place as planned in November 2012. Almost 700 delegates attended, the main areas covered were Public Protection, Early Help, Suspicion v Allegation and Death Review Process.
- The CCG has benchmarked the organisation against the NHS England "Safeguarding Vulnerable People in the Reformed NHS Accountability and Assurance Framework".
- RCCG has engaged with the other CCGs across South Yorkshire and Bassetlaw and the Area team of NHS England to work collaboratively as a safeguarding forum.
- GPs in Rotherham, with the support of Rotherham CCG, undertook a safeguarding self assessment (June 2012). 95% of GP Practices provided evidence of their self assessment to Rotherham Safeguarding Adults Board. This self assessment complies with aims of CQC outcome 7 to ensure that patients can expect health care services to meet Essential Standards of Quality and Safety, to protect the safety and respect the dignity and rights wherever care is provided. The resulting report provides assurance that RCCG has benchmarked individual GP Practices against expectations highlighted in No Secrets and the CQC Essential Standards of Quality and Safety Outcome 7.
- With regard to the February 2013 Francis Report (report of the public inquiry into the failings identified at the Mid Staffordshire NHS Foundation Trust), the CCG is currently taking stock of the implications of the 290 recommendations made in the report.
- Safeguarding reports have been scrutinised at the monthly CCG Governing Body (and during the transition also at the NHS South Yorkshire and Bassetlaw Board).
- The CCG are recruiting a safeguarding adults lead nurse to support the work of the CCG.

Rotherham, Doncaster and South Humber Mental Health NHS FoundationTrust (RDaSH):

- We have embedded the new model of the Safeguarding Vulnerable Adults Service Provision. There are now three Safeguarding Adults Lead professionals who provide advice and support to staff throughout the Trust.
- The quarterly Quality Improvement Report has continued to be produced throughout 2012/13 and provided to the Trust's Board of Directors and to all Local Safeguarding Adults Partnership Boards, providing assurance to key stakeholders about the quality of safeguarding services in RDaSH.
- An audit has been conducted on the implementation of the Safeguarding Adults Policy across the Trust, measuring how the Trust is performing against its goals.
- A specific section was included in the Trust's Safeguarding Adults Policy in order to incorporate the implementation of the government's 'Prevent Strategy'.
- We have continued to review, develop and implement the training matrix for safeguarding adults. In addition, we have monitored compliance of training at all levels for safeguarding by Business Divisions, demonstrating links to the training needs analysis. Further, the Learning and Development Team now facilitate the

delivery and monitoring of appropriate training programme.

- Supervision for practitioners working directly with vulnerable adults has been provided.
- Support has been provided throughout the Trust on the implementation of the recommendations in the 'Transforming care: A national response to Winterbourne View Hospital' report with regard to Safeguarding Adult practice.
- There is a Named Safeguarding Adults Lead Professional with responsibility for each of the 5 localities served by the Trust. Each Lead Professional has developed strong operational links with the Business Divisions within those locality areas and works in partnership with the staff to implement the Safeguarding Adults Policy and practice.
- This has resulted in the increased early detection and notification of safeguarding concerns and has identified areas of good practice within the Trust and supported services to improve standards of care where necessary.

South Yorkshire Fire and Rescue Service:

- SYFR Annual Policy & Procedure Review & Update Feb 2013 now include more detailed information on the Mental Capacity Act, Serious Case Reviews and Domestic Homicide Reviews.
- The numbers for internal safeguarding alerts for adults have been increasing for SYFR across South Yorkshire. In 2010/11 there were 42, 2011/12 there were 49 and 2012/13 there were 54. The majority were related to fire risks linked to self neglect and resulted in referral for services or management.
- Our (single agency) Introductory Basic Awareness programme (Stage 1) is now almost complete. Additional multi agency training for Advocates and an annual update for Group Managers is ongoing and a 3 yearly Update & Refresh Programme is being developed. There will be an initial assessment using the online Common Induction Standards in Safeguarding Module (Stage 2) which will inform the 3rd stage which will be delivered through Case Study workshops to embed safeguarding into practice.
- A missed opportunity for SYFR to share information where there are significant fire safety issues within a Care Home has been identified and arrangements have now been made to address this gap.
- Technical Fire Safety, when serving enforcement notices will also inform (from March 2013) the Local Authority Safeguarding/Contracts and CQC where an Enforcement Notice is served on a Care Home. A further alert will follow if the responsible owner/manager does not take action to comply with the corrective measures. SYFR will continue to pursue through the legislative process, but Safeguarding/Contracts are able to factor in any fire safety risks into their own audit and risk assessment process.
- SYFR has signed up to both the National and the Yorkshire & Humberside Regional Dementia Pledge. One of the activities on the Action Plan is to raise awareness for frontline staff and training is to be piloted with our Community Safety teams this summer.

Case Outcome:

In response to recommendations from an IMR conducted as part of a Serious Case Review, linked to a Fire Fatality and increasing complex risk factors, SYFR has developed a more detailed and effective risk assessment tool for Home Safety Checks. In line with this change the policy has been rewritten and all frontline staff received training. The changes are focused on identifying specific vulnerabilities and related risks together with direction toward the most appropriate actions required to address the risks. A raft of observations and questions direct the assessor to identify those that are at increased risk of having a fire or unable to respond and evacuate in the event of a fire. From this referrals are made into the Community Safety Team who then liaise with the most appropriate agency.

South Yorkshire Police:

- The introduction of a dedicated Adult Protection Officer and Detective Sergeant to act as a single point of contact for Rotherham Adult Safeguarding and Adult Social Care.
- A more efficient and timely review of safeguarding alerts.
- A more efficient and timely decision making process.
- An increase in Police attendance at strategy meetings.
- The delivery of Safeguarding Adults training to all front line Police Officers attending the Street Skills training programme in order to improve the quality of submissions and raise awareness in respect of definitions and legislation.
- The introduction of the Vulnerable Persons Unit to monitor and collate information relating to those adults who are vulnerable but not as defined by Safeguarding Adults (No Secrets).

Case Outcome:

Referral from Police regarding X who was alleging she was paying her landlord in kind with sexual favours. X wrote a letter to British Gas explaining this arrangement and British Gas had contacted the Police. The lady was living in an RMBC flat in poor condition and presented as very withdrawn. Safeguarding involved other agencies Police, Housing, Mental Health and Learning Disability Services. A place of safety was arranged for the lady who was placed in specialist residential services. Further work was undertaken with X until she felt the confidence to live independently and safely once more.

Rotherham Voluntary and Community Sector:

- The Voluntary and Community Sector, through the Adult Services Consortium, has continued to show its commitment to Adult Safeguarding across the Borough by contributing to the work of the Adult Safeguarding Board via its nominated representatives.
- 3 nominated representatives attend the Safeguarding Adults Board to provide a voluntary and community sector perspective on developments. They also provide a liaison function between the wider sector and the Board to keep VCS organisations up-dated on safeguarding issues, and encourage and support their contribution to this important area of work.
- Representatives from the VCS are from SCOPE, Age UK and Action for Children to reflect different service user groups' perspectives to the Board.
- VCS organisations have contributed to the Safeguarding Board as partners, for example taking part in Adult Safeguarding Week and as alerters and referrers where concerns are identified.
- Individual VCS organisations have also continued their work internally in respect of their own policies and procedures for Safeguarding, linking in to the wider Safeguarding Procedures in the Borough.

Case Outcome:

Speakup has run two Peoples Parliaments for People with Learning Disabilities and or/autism from across Rotherham. 49 attended the first forum and 79 people attended the second. Both forums have looked at; What is abuse, different types of abuse, who could abuse you, where abuse could happen, what to do if you have been abused, who to talk to, where to go for help and the Rotherham SIR Scheme. People had the opportunity to watch some drama and take part in interactive group workshops to discuss their ideas. Everyone who came to the forum received an easy read guide to reporting safeguarding in Rotherham and information on the SIR Scheme. In addition Speakup has been heavily involved in inspection work for the CQC following the Winterbourne scandal. Our self-advocates with learning disabilities have inspected several homes across the country to ensure the people who live there are safe.

Commissioning. Policy and Performance Services:

All contracted providers of care and support are:

- Monitored throughout their contract term for compliance with the Safeguarding Adults Policy and this clause is reviewed annually in conjunction with the Safeguarding Team.
- Compliance includes ensuring that the programme of mandatory Safeguarding Adults training for all staff employed by their organisations is in place and current.
- Agencies responsible for recruiting care staff are required to take steps to apply the necessary checks via the Disclosure and Barring Service who carry out a Criminal Records check.
- Obliged to attend provider forums where Safeguarding Adults themes are discussed.
- Expected to foster an atmosphere of openness which is supportive of staff who wish to disclose concerns regarding care delivery without fear of reproach. They must have a Whistle-blowing Policy in place which is applied and shared with staff.
- The Commissioning Team, located within Neighbourhood and Adult Services Directorate, and the Contract Officer and Contract Compliance Officers, who work at the interface between Commissioning, Assessment and Care Management and Safeguarding are dedicated to ensuring high standards of service provision from external providers of care and support services.
- Contracting concerns received regarding care homes and community and home care services are logged, triaged and prioritised by the Contract Compliance Team and forwarded if appropriate to Safeguarding Adults Team.

Quality Assurance Schemes

RMBC's 'Home from Home' (in partnership with Age UK Rotherham and Speak Up Rotherham) and 'Home Matters' are established high profile programmes to assure quality in provision of care and support by registered Rotherham providers. These programmes allow people who are seeking to use services, and their families, the opportunity to access comparative information about services.

The last fully completed round of Home from Home reviews in older peoples' homes resulted in 1 home receiving a rating of Gold, 18 were rated Silver, 16 were rated Bronze and 2 were unrated.

Care Homes from 2013/14 are rated Adequate, Good or Excellent (replacing the previous Gold, Silver, Bronze). A premium payment is paid to homes in the older people's sector that receive a rating of Good or Excellent. Community and Home Care Providers are rated as Outcomes Met or Outcomes Exceeded. Completed reports are published on the Council's Website.

Action taken with provider

A default notice is served if the provider fails to perform the contract as per the contract terms and conditions and service specification. Should the provider fail to remedy the breach(es) within a reasonable time the contract can be terminated as per the terms and conditions. 9 contracting default notices were applied in 2012/13, two of which involved an imposed temporary suspension of placements. Areas of concern included record keeping, Mental Capacity Act usage, staff training, lack of clinical policies and procedures, infection control, equipment and environmental issues, safeguarding, standard of meals.

During 2012/13 there were 150 substantiated contract concerns involving 11 of the 14 Domiciliary Care providers in the context of over 600,000 hours delivered in the year.

In Residential and Nursing Care Home Services, 428 contracting concerns were received in the year. 294 were investigated and 164 of these were substantiated. 134 remain open and under investigation. 86 of the concerns received had also involved an alert to the Safeguarding Team.

Suspensions of placements are either voluntary or mandatory and can be invoked either through Safeguarding or as a result of a breach of contract resulting in a default. Suspensions may be in place whilst a safeguarding investigation takes place or whilst the provider is in default. In 2012-2013 there were 4 care homes who had placements suspended due to safeguarding concerns.

Case Outcome:

Care home X is a privately owned (single owner) residential care home situated in Rotherham providing residential care for 24 residents. Information came to the attention of the Care Quality Commission (CQC) that prompted an investigation into the registered owner of care home X resulting in X being temporarily unregistered. As a direct result RMBC suspended all new placements and served a default notice against their contract.

The investigation into the registered owner by CQC resulted in CQC making the decision that the owner was not fit to be a responsible person of a care home and a non-urgent notice of deregistration was served. As a result of this action by CQC the Local Authority were not able to do business with X as a provider of residential care as the service was no longer legal. The Local Authority had no option but to instigate the Home Closure Protocol and begin the process of transferring residents from X into alternative care homes. Recognising that the closure of a care home is an extremely traumatic event every effort was made to minimise the impact of this for the residents of X and their families. Our primary aim was to make sure that the needs of residents and their families were met and that efficient and effective actions were taken in response to individual circumstances and needs. The Local Authority had a presence in the care home throughout offering support to residents, their families and staff within the home, taking a proactive approach working with CQC to seek alternative solutions to closure. Some residents chose to take the opportunity to transfer to alternative care homes however most residents and their families decided to remain to see if the home could be saved. Finally a new provider came forward and the home could remain open.

Learning and development

- We standardised training materials for courses at bronze, silver and gold levels against the national safeguarding adults' capability.
- We refreshed the e-learning bronze level module and introduced a new module 'Alerter update' at silver level to enable workers to update their knowledge and skills.
- We introduced new training courses at gold level - Safeguarding Adults Form 1 Training and Provider Managers' Roles in Safeguarding Adults Investigations - to support professionals and management roles.
- We introduced a course place cancellation charge and no-show policy to improve attendance levels at courses and make the best use of limited financial resources.
- We maintained our 2011/12 position that we do not have waiting lists for Silver level training and place availability matches bookings.
- We delivered training to over 1,800 learners maintaining the levels set in 2012/13.
- We continued to respond to training requests to address compliance issues in establishments and services not meeting standards by providing bespoke training.

Case Outcome:

Morrison Facilities Services and Willmott Dixon Partnerships - Rotherham's Council's housing repairs and maintenance contractors. The contractors have been supported through the Council's Contract & Service Development and Learning & Development teams to access the Board's bronze and silver level training and development courses. This was a new initiative! The Contract & Service Development team recognised that the Council's contractors came into contact with vulnerable adults in their day-to-day work and wanted to ensure that they could respond to safeguarding adults concerns. An approach was made to both contractors about up-skilling their workforce, who welcomed the opportunity to access the training offered at bronze and silver levels. Over 300 workers completed the bronze level training and 27 managers the silver level.

"Willmott Dixon is in partnership with Rotherham MBC, as such its employees see themselves as representatives of both organisations. They can sometimes be the only representatives to have direct face to face contact with vulnerable people. It is great to know that our employees are now better trained to identify these situations and take the appropriate action"

"In partnership with the council, Morrison has always supported safeguarding by highlighting issues that we come across to RMBC. By putting all our staff through the Bronze Safeguarding Adults training we have raised awareness of safeguarding and what our staff should look out for whilst they are going about their everyday business. Our managers and resident liaison staff also completed the Silver Safeguarding training for an increased awareness and to give them the knowledge and tools to sensitively communicate any safeguarding issues to the relevant people. Having done the Bronze and Silver training myself I can vouch for its effectiveness. The way in which the Silver course was delivered to a mixture of RMBC officers, Morrison and WDP staff will help build the partnership and strengthen relationships."

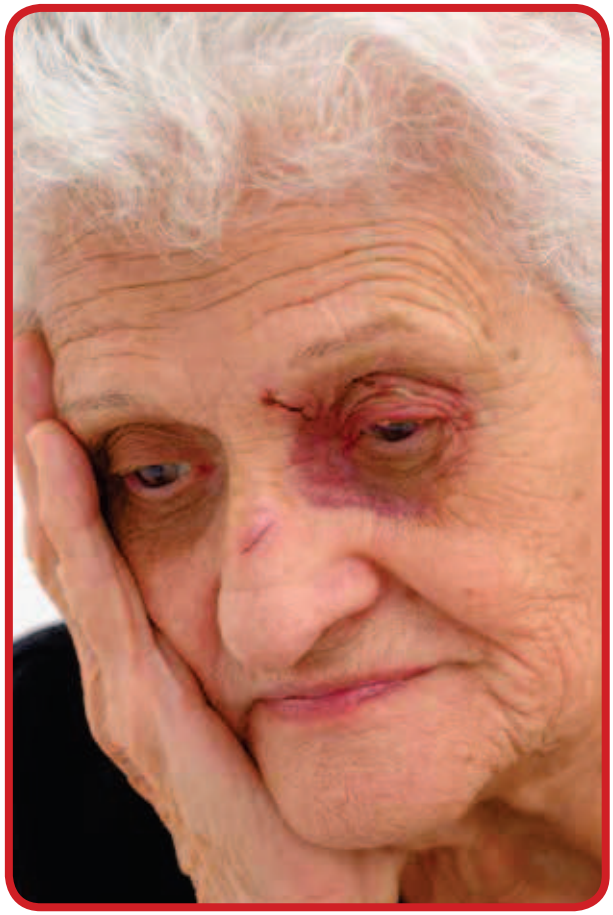
Key Partnership Contributions 2012/13

Safeguarding Adults Service:

Throughout 2012/13, the Safer Rotherham Partnership made considerable progress in tackling Crime and Anti-social Behaviour across the borough.

During that period South Yorkshire Police recorded 16,103 crimes in the borough of Rotherham, which was a 3% reduction/532 fewer crimes than in the previous year, despite the difficult economic conditions. Additionally 4,203 fewer Anti-Social Behaviour incidents were recorded by South Yorkshire Police in Rotherham compared to the previous year, a reduction of 20%.

- **Recorded Crime fell by 3%**
- **Domestic Burglary increased by 3%**
- **Theft of motor vehicles fell by 11%**
- **Theft from motor vehicles fell by 2%**
- **Criminal Damage fell by 8%**
- **Violence Against the Person increased by 3%**
- **Public Order offences fell by 8%**
- **Drug Offences fell by 3%**



The Safeguaring Social Worker was very supportive during the investigation, we appreciate the prompt response to our concerns

Customer Compliment
regarding staff from Safeguarding Adults Team

This year's campaign had the key message:

"Neglect; prevention is better than cure."

Rotherham Safeguarding Adults Board's annual awareness week was held from 9th to 16th July 2012.. We targeted all aspects of neglect including prevention of self-neglect linking the event with 5 Ways of Wellbeing, **http://neweconomics.org/publications/five-ways-to-wellbeing**

Providers of care either in a care home or community based service were invited to take part in this awareness week. Providers were provided with a resource pack and embraced this event by promoting the theme within their service.

Tackling Neglect

Following a case conference which substantiated neglect within a care home the family thanked all professionals involved, in particular the safeguarding Social Worker and Contracting Compliance Officer stating:

"We didn't know people like you existed we are reassured that you are looking out for our family and taking these issues very seriously".

Looking Forward

2013-14 will see a strategic review and self-assessment of the Board to ensure vulnerable people are protected from abuse. Amongst Rotherham Safeguarding Adults Board's priorities for the coming year are:

- To develop a Safeguarding Adults Strategy that empowers people to protect themselves and their carers through effective risk management in personalisation of their care.
- To deliver the RASB strategy through a Performance Management Framework, holding partner agencies to account through robust governance arrangements and quality assurance processes.
- To review the constitution and governance of the RSAB in line with National and Local priorities.
- RSAB will adopt a Safeguarding Adults Charter and a partnership agreement of commitment.
- Ensure lessons are learned and recommendations implemented from serious case reviews to prevent abuse and safeguard vulnerable adults across Rotherham.
- To align the interface between Children and Adult Safeguarding, with cross representation at a strategic and operational level to ensure a holistic view across the safeguarding agenda.
- To further develop multi-agency information sharing systems, empowering practitioners to identify and prevent abuse from occurring where possible through integration of 'reportable concerns' and be fully informed about their responsibilities regarding the sharing of information between agencies for the purpose of safeguarding activities.
- To engage and support local communities through cultural change to be the eyes and ears of safeguarding, raising awareness and promoting safeguarding adults work, reporting concerns and speaking up for people who may not be able to protect themselves and ensuring everyone involved in safeguarding is clear about their role and responsibilities.

APPENDIX 1
Key Facts and Figures

A total of 1,565 alerts were reported through the new Safeguarding Adults reporting process.

The table below illustrates how all elements of Safeguarding Adult's activity, from the initial alert has increased. During 2012/2013 there has been a continued public and professional awareness raising campaign, and a focus on staff training particularly in the residential and nursing sector. There is a continued commitment to a culture that does not tolerate abuse and knows what to do when abuse happens. This has contributed to a better public and professional understanding of the signs and symptoms of abuse and to the mechanisms for reporting concerns. As anticipated this has resulted in a further increase in the number of safeguarding alerts by 29%.

Older People's Services have consistently recorded the greatest number of safeguarding alerts with 74% of all alerts. However, once again this year there has been an increase in those from other vulnerable adult groups which reflects an increasing awareness in these services.

Number of alerts 2012 – 2013

In total there were 1,565 Alerts made to Safeguarding Adults

Physical & Sensory Disability, Frailty, other vulnerability		Learning Disability		Mental Health		Substance Misuse		**Total**	
18-64	**65+**	**18-64**	**65+**	**18-64**	**65+**	**18-64**	**65+**	**18-64**	**65+**
293	**1014**	**47**	**12**	**62**	**134**	**3**		**405**	**1160**

The strategy meeting/discussion is a crucial stage in the safeguarding process as it determines which organisation is best placed to lead the investigation. The strategy meeting/discussion also identifies how the investigation will be conducted and how the investigators will report on their findings. A strategy meeting should only be called when the threshold for 'significant harm' has been met.

The table below indicates an increase in strategy meetings convened in year to those in 20012/2013.

Number of strategy meetings convened 2012 – 2013

264 Strategy Meetings/discussions held across all services compared to **319** in 2011/2012

All alerts that progress to a strategy meeting are called 'referrals'. There has been a decrease in referrals, which shows of all alerts, those meeting threshold of significant harm is reducing.

The South Yorkshire Safeguarding Adults Procedures are very clear regarding when a case conference should be held on completion of a safeguarding investigation. This year's figures reflect a substantial increase in the number of investigations that culminate in a case conference. This indicates that the procedures are being applied appropriately and consistently across all service user groups to ensure that there is a recorded outcome for all investigations regardless of whether the abuse was substantiated or not.

Number of case conference convened 2012 – 2013

227 Case Conferences convened across all services compared to **89** in 2011/2012

Review of alerts April 2012 – March 2013

Who alerted?

Alert

An alert is a feeling of anxiety or worry that a Vulnerable Adult may have been, is or might be, a victim of abuse. An alert may arise as a result of a disclosure, an incident, or other signs or indicators.

Referral

A referral is the same as an Alert however it becomes a referral when the details lead to an adult protection investigation/assessment relating to the concerns reported.

Source of alert		
Alerter:	**2011/2012**	**2012/2013**
Residential/Nursing Care	186	301
Relative	73	112
Health – Community	36	60
Health – Hospitals	71	91
Health – Mental Health Staff	3	15
GP	0	16
Domiciliary Care	96	162
Alleged Victim	13	15
Neighbours/Public/Friend	12	14
Social Care Staff	160	264
Police	207	131
Housing	5	9
Ambulance	11	20
Anonymous	90	67
Other Local Authority	6	19
Other Source*	181	269

*__Other source__ refers to a variety of sources e.g. Probation, Prison, Employment, the Care Quality Commission schools and other agencies and the Voluntary and Community Sector.

If we make a direct comparison between the number of 'alerts' reported in 2012/2013 from the previous year there has been a continued rise in the number of alerts from Professional and other organisations. This increase is due to the success in raising awareness across all organisations and agencies which indicates there is less reliance on waiting for the victim, family, friends, and public to alert.

Who was the subject of the alert?

Alleged victim

Approximately 66% of all alleged subjects of safeguarding concerns, who were referred into the Safeguarding Adults procedure in Rotherham in 2012/2013 were female, this remains consistent with previous year's figures.

The age of the alleged victim also remains consistent as reported in previous years, once again showing the highest category of alleged victim remains older people. Whilst there is a decrease in those under the age of 65 years as a % of total alerts the number of alerts in reported abuse on adults under 65 years has increased by 7%.

Gender of alleged victim

	2011/2012	2012/2013
Female	64%	66%
Male	36%	34%

Age of alleged victim

	2011/2012	2012/2013
Over 65 years	69%	74%
Under 65 years	31%	26%

It is significant that the majority of alerts received regard alleged victims from a White/British background. This does not reflect Rotherham's diverse cultural mix; however this is reflective of the ethnicity of residents living in permanent care in Rotherham, where the highest percentage of alerts originates.

4.1% of the total number of alerts during 2012/2013 concerned alleged victims from BME communities; this remains consistent with the previous year.

At alert "unknown or refused" ethnicity has increased again this year. However, this is reduced by 88% at the point of referral. This demonstrates the effectiveness of information gathering at referral stage.

Ethnicity of alleged victim

	2011/2012	2012/2013
White/British	1056	1406
White/Irish	6	5
Asian/Pakistani	24	22
White/European	5	13
Asian/Other	6	4
Asian/Indian	2	0
Black/Caribbean	5	0
Black/African	4	5
Other Black Background	8	2
Dual Heritage	0	8
Other Ethnic Groups	13	6
Refused	10	94

Review of referrals andinvestigations April 2012 – March 2013

What were the categories of alleged abuse investigated?

Categories of alleged abuse 2011 - 2012						
Neglect	Physical	Financial/ Material	Psychological	Institutional	Sexual	Discriminatory
52%	12%	12%	8%	14%	2%	0%

Categories of alleged abuse 2012 - 2013						
Neglect	Physical	Financial/ Material	Psychological	Institutional	Sexual	Discriminatory
54%	17%	13%	7.5%	3.5%	4.5%	0.5%

Last year's annual awareness week directly targeted Neglect which is reflected in the 2% increase in this category, however this category of abuse is consistently the highest every year, this year accounting for over 50% of all investigated abuse. However institutional abuse has significantly reduced by 10.5% which reflects the on-going work to raise standards and to ensure all services we commission or deliver meet required standards.

What was referred?

Who was the alleged perpetrator?

Relationship of alleged perpetrator to alleged victim		
	2011/2012	**2012/2013**
Residential/Nursing Care Provider	62%	46%
Family	15%	13%
Other vulnerable adult	0%	2%
Health/Care Worker	3%	7%
Neighbours/Public/Friend	0%	3%
Domiciliary Care Provider	6%	11%
Day Care	0%	1%
Stranger	1%	0%
Other	13%	17%

Setting of alleged abuse		
	2011/2012	2012/2013
Residential/Nursing Care Home	65%	53%
Own Home	23%	35%
Hospital	6%	7%
Public Place	0%	0%
Alleged Perpetrator's Home	1%	0%
Day Care	0%	1%
Other	5%	4%

Consistent with the figures for 2011/2012 the highest numbers of alleged victims in 2012/2013 were living in Residential/Nursing Care and the alleged perpetrator of the abuse was either an identified person paid to care for them, or the care provision as a whole by allegedly neglecting their residents' care needs.

There has been a further 12% decrease in abuse taking place in Residential/Nursing care, this decrease has occurred year on year, this reflects the robust arrangements that are in place to ensure that all staff in Residential/Nursing Care establishments are trained to enable them to feel confident to recognise and report any safeguarding concerns they become aware of. The continued 'Home from Home' initiative, has ensured safeguarding awareness is raised and also is ensuring a rise in Care Standards.

There is a 12% increase in abuse taking place within the victim's own home - given that abuse by family has decreased - this increase would be attributable to the increase in alerts from Domiciliary Services.

Review of referrals and investigations April 2012 - March 2013

What were the outcomes?

The conclusion of the Safeguarding Adults case conferences

Of the 1565 Safeguarding Adults alerts received in 2012/2013 227 culminated in a Safeguarding Adults case conference compared to 89 in the previous year.

This is due to the adherence to the South Yorkshire Safeguarding Adults Procedures and the increased quality control of all safeguarding investigations by the Safeguarding Adults Team Manager. This year the number of safeguarding alerts that were closed (no further action) prior to a strategy meeting being convened was 1301 out of the 1565 (83%). This indicates that the original alert did not meet the threshold of 'significant harm' or the alleged victim did not meet the definition of a 'vulnerable adult' as defined in 'No Secrets' (Department of Health 2000):

'The definition of a vulnerable adult is - a person aged 18 or over who is or may be in need of community care services by reason of mental or other disability, age or illness and is or maybe unable to take care of him or herself, or able to protect him or herself against significant harm or exploitation'.

Outcomes of Safeguarding case conferences			
227 Case Conferences held regarding individuals			
Abuse Substantiated	**67 (30%)**	Abuse Not Substantiated	**159 (70%)**

In 2012/2013 67 case conferences were substantiated (on the balance of probability). This compares to 79 substantiated in 2011/2012.

These figures overall show us that although we are encouraging more people to alert us of possible safeguarding concerns, we are more successful at reducing substantiated abuse at case conference.

Allegations regarding physical abuse and neglect have consistently been the highest categories of alleged abuse referred into the safeguarding process. This perhaps reflects the visible signs and symptoms of these forms of abuse which can be observed by those having contact with the vulnerable person. Other forms of abuse rely more heavily perhaps on the alleged victim telling someone about the abuse and we are aware that vulnerable people are often unwilling or unable to raise a concern themselves.

Mental Capacity Act and Deprivation of Liberty Safeguards

Background

The Deprivation of Liberty Safeguards (DoLS) were introduced on the 1 April 2009. Since this time the Rotherham service has evolved to the point where we now have a permanent Mental Capacity Act and Deprivation of Liberty Safeguards Coordinator administering DoLS applications to the Local Authority and the PCT. The post sits within the Safeguarding Adults Unit. Rotherham has 11 qualified Best Interest Assessors which is an increase of 3 over the past 12 months.

Ongoing Work

Work remains ongoing in terms of education and training around DoLS for both staff and providers. This is clearly reflected in the increase in referrals as highlighted in the table below.

In terms of the requests received this year, a break down of this is as follows:

Mental Capacity Act and Deprivation of Liberty Safeguards 2012/2013			
Referrals Received by RMBC	37	Referrals Received by NHS Rotherham	9
Authorised Referrals by RMBC	29	Authorised by NHS Rotherham	1

Compared to the requests made in 2011/2012:

Mental Capacity Act and Deprivation of Liberty Safeguards 2011/2012			
Referrals Received by RMBC	38	Referrals Received by NHS Rotherham	8
Authorised Referrals by RMBC	24	Authorised by NHS Rotherham	4

Training and development

The year saw further delivery of a range of bespoke and specialist Safeguarding Adults training events, as well as the continued availability of e-learning.

This table summarises attendance at all courses as compared to last year:

Safeguarding Adults training attendance (excludes e-learning)			
	2010/2011	**2011/2012**	**2012/2013**
Local Authority	310	249	552
Independent Sector	495	1072	894
Health	415	508	363
Voluntary Sector			
Police/Probation	28	0	3
Service users/carers	0	13	2
Students	35	32	7
Other	5	16 (Councillors)	8 (Councillors)
Totals	**1288**	**1890**	**1829**

Safeguarding Adults Report

List of abbreviations used:

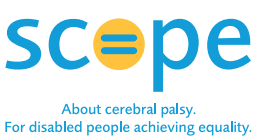
CQUIN	Commissioning for Quality and Innovation
DoLS	Deprivation of Liberty Safeguards
IDVAS	Independent Domestic Violence and Advocacy Service
IMR	Independent Management Review
IMCA	Independent Mental Capacity Advocate
LADO	Local Authority Designated Officer
MARAC	Multi Agency Risk Assessment Conference
PCT	Primary Care Trust
RCCG	Rotherham Clinical Commissioning Group
RDaSH	Rotherham Doncaster and South Humber (Mental Health NHS Foundation Trust)
RLSCB	Rotherham Local Safeguarding Children Board
RSAB	Rotherham Safeguarding Adult Board
SIR	Safe In Rotherham
SYFR	South Yorkshire Fire and Rescue
TRFT	The Rotherham NHS Foundation Trust
VCS	Voluntary and Community Sector
WDP	Willmott Dixon Partnerships


Rotherham
ageUK


Rotherham Doncaster and
South Humber
NHS
NHS Foundation Trust


South Yorkshire
POLICE


South Yorkshire
Fire & Rescue


scope
About cerebral palsy.
For disabled people achieving equality.


RDaSH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To change


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ROTHERHAM BOROUGH COUNCIL – REPORT TO MEMBERS

1	**Meeting:**	**Cabinet Member for Adult Social Care**
2	**Date:**	**Monday 21 October 2013**
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 August 2013.

The forecast for the financial year 2013/14 at this stage is an overall overspend of £1.819m, against an approved net revenue budget of £72.807m. The main budget pressure areas relate to slippage on a number of budget savings targets including continuing health care funding and implementing the review of in-house residential care.
A range of management actions are currently being developed by budget managers to bring the forecast overspend in line with the approved cash limited budget and progress will be shown in future reports.

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 £72.807m. Included in the approved budget was 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:-

Division of Service	**Net Budget**	**Forecast Outturn**	**Variation**	**Variation**
	£000	£000	£000	%
Adults General	1,782	1,774	-8	-0.45
Older People	29,444	30,413	+969	+3.29
Learning Disabilities	23,527	24,037	+510	+2.17
Mental Health	5,004	4,760	-244	-4.88
Physical & Sensory Disabilities	5,280	5,920	+640	+12.12
Safeguarding	729	766	+37	+5.08
Supporting People	7,041	6,956	-85	-1.21
Total Adult Services	**72,807**	**74,626**	**+1,819**	**+2.50**

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 slippage 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 are currently being developed 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 (-£8k)

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

Older People (+£969k)

- Overspend on In-House Residential Care due to slippage on implementation of budget savings target due to extended consultation (+£364k) and recurrent budget pressure on residential care income (+£73k).
- Recurrent budget pressure in Direct Payments over budget (+£597k). However, client numbers have reduced (-27) 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 (-£211k) based on current level of service. However, there is an over spend on Independent sector home care (+£765k), which has experienced an increase in demand since April (+61 clients).
- An over spend on independent residential and nursing care (+£345k) due to an additional 11 admissions in August. Additional income from property charges is reducing the overall overspend.
- Forecast under spend at this stage in respect of Community Mental Health budgets due to planned slippage in developing dementia services in order to reduce overall overspend (-£90k).
- Under spend on carers services due to vacancies and slippage in carers breaks (-£75k).
- Slippage on recruitment to vacant posts within Assessment & Care Management and Community Support plus additional income from Health (-£605k).
- Forecast saving on in-house day care (-£49k) due to vacant posts and moratorium on non-pay budgets.
- Overall under spend on Rothercare (-£84k) due to slippage in service review including options for replacement of alarms.
- Other minor under spends in other non pay budgets due to moratorium on non essential spend (-£21k).

Learning Disabilities (+£510k)

- Overspend on independent sector residential care budgets due to 3 new admissions in July and shortfall on CHC income (+£169k). Work is ongoing regarding CHC applications and an internal review of all high cost placements.
- Forecast overspend on Day Care (+£343k) due to slippage on implementation of day care review including increase in fees and charges, plus recurrent budget pressure on the provision of external transport.

- Forecast overspend in independent sector home care (+£98k) due to increase in demand and slippage in meeting budget savings.
- High cost placements in independent day care is resulting in a forecast overspend of +£74k. Pressure reduced since last month 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 £90k.
- Slippage on developing Supported Living schemes plus additional funding from health is resulting in a forecast under spend (-£132k).
- Efficiency savings on SLA's for advice and information and client support services (-£60k).
- Lower than expected increase in demand for direct payments (-£50k).
- Planned delay in recruiting to vacant posts within Assessment & Care Management (-£22k).

Mental Health (-£244k)

- Projected over spend on residential care budget (+£61k) 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 (-£369k).
- A net reduction of 3 clients in July and additional income is reducing the overall budget pressure on Direct Payments (+£23k).
- Minor overspends on employees budgets due to lower staff turnover, additional overtime and agency cover (+£41k).

Physical & Sensory Disabilities (+£640k)

- Continued Pressure on Independent Sector domiciliary care (+£270k) due to a continued increase in demand for service.
- Further increase in demand for Direct Payments (+ 10 clients), forecast overspend (+£624k).
- Under spend on community support (-£62k) 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 (-£83k).
- Reduction in contract with independent sector day care provider (-£16k).
- Under spend on equipment and minor adaptations budgets (-£69k).
- Forecast efficiency savings on contracts with Voluntary Sector providers (-£24k).

Safeguarding (+£37k)

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

Supporting People (-£85k)

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

7.1.3 Agency and Consultancy

Actual spend on agency costs to end August 2013 was £216,978 (no off contract), this is a significant increase compared with actual expenditure of £100,184 (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 August 2013 was £162,845 compared with £133,477 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 CABINET MEMBER

1.	**Meeting:**	**Cabinet Member for Adult Social Care**
2.	**Date:**	**21st October, 2013**
3	**Title:**	**LAC (DH) (2013) 2 – Charges for Residential Accommodation – Crag Update**
4	**Directorate:**	**Neighbourhoods and Adult Services**

5. Summary

5.1 This circular notifies Local Authorities of inflationary increases to personal expenses allowance, capital limits and savings disregards which are used when carrying out financial assessments in order to calculate how much someone should pay towards their accommodation charges.

5.2 It also contains alerts to the Local Authorities on their responsibilities in applying a number of charging policy issues.

5.3 These are statutory requirements; no decision is required, there are minimal financial implications and therefore this report is for information only.

6. Recommendations

- **That the Cabinet Member receive this report and note its content.**

7. Proposals and Details

7.1 The Personal Expenses Allowance – Inflationary increase

The personal expenses allowance is to increase from £23.50 to £23.90 per week from 8th April 2013. This applies to all service user's who are resident in a care home and receiving help from local authorities to meet the cost of the accommodation.

7.2 Capital Limits – No inflationary increase

The capital limits are to remain unchanged at £14,250 (lower capital limit) and £23,250 (upper capital limit).

7.3 Savings Disregard – No Inflationary Increase

The savings disregards are to remain unchanged at up to £5.75 per week for individual supported service users, and up to £8.60 per week for couples.

7.4 Introduction of Earnings Disregard in the Financial Assessment for Residential Care - Policy change, minimal impact

The introduction of a disregard of earned income in the financial assessment for residential care. This is to encourage those in residential care to pursue employment opportunities if they are able to do so. It also brings residential charging policy into line with that for non residential. The frequency of occurrence is negligible; therefore the potential impact of this is likely to be minimal.

7.5 Guidance on the Treatment of Armed Forces Independence Payments in the Financial Assessment for Residential Care– Policy Alert, no impact

With effect from 8th April 2013 Armed Forces Independence Payments will begin to replace Disability Living Allowance for veterans; the payments should be fully disregarded in the financial assessment for residential care whereas only the mobility component of Disability Living Allowance is disregarded. The frequency of occurrence is negligible; therefore the potential impact of this is likely to be minimal.

8. Finance

These are generally inflationary linked increases and policy reminders the impact of these is likely to be minimal.

9. Risks and Uncertainties

There are no risks in adopting the changes outlined in this circular.

10. Policy and Performance Agenda Implications

No Implications

11. Background Papers and Consultation

11.1 Charging for Residential Accommodation Guide issued by the Department of Health.

11.2 Local Authority Circular (DH) (2013) 2 dated June, 2013 (attached).

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Department of Health

Local Authority Circular **LAC(DH)(2013)2**

To: The Chief Executive
County Councils } England
Metropolitan District Councils }
Shire Unitary Councils }
London Borough Councils
Common Council of the City of London
Council of the Isles of Scilly

Copy to: The Director of Social Services
Chief Executive - Care Trusts
Chief Executive - Strategic Health Authorities

Date: June 2013

CHARGING FOR RESIDENTIAL ACCOMMODATION

1. Summary

This circular:

I. Sets out the revised Personal Expenses Allowance (PEA) of £23.90, which came into force on 8th April 2013.

II. Reminds councils that the capital limits remain at their current level (i.e. lower capital limit £14,250 and upper capital limit £23,250).

III. Confirms that the savings credit disregards remain at their current level (i.e. up to £5.75 per week for individual supported residents in receipt of savings credit and up to £8.60 per week for couples).

IV. Confirms the introduction of a disregard for earned income in the financial assessment for residential care charging with effect from 8 April 2013.

V. Provides guidance on the treatment of Armed Forces Independence Payments in the financial assessment for charging.

VI. The future of charging arrangements

The Annex to this circular contains fuller details.

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VII. A revised Charging for Residential Accommodation Guide (CRAG) is being issued at the same time as this circular.

VIII. A revised edition of "Fairer Charging Policies for Home Care and other non-residential Social Services" providing updated guidance on how local authorities should design their non-residential charging policies is being issued ate the same time as this circular.

2. Action

This circular is issued under section 7(1) of the Local Authority Social Services Act 1970.

3. Enquiries

Enquiries about this circular should be made by email to:
SCPI-ENQUIRIES@DH.GSI.GOV.UK

Further copies of this Circular may be obtained from Department of Health, PO Box 777, London SE1 6XH, Tel. 0870 155 5455 or Fax 01623 724 524. Please quote the code and serial number appearing on the top right-hand corner.

Current circulars are now listed on the Department of Health website on the Internet at: www.dh.gov.uk/letters. Full text of recent circulars is also accessible at this site.

Department of Health

ANNEX TO THE CIRCULAR

I. PERSONAL EXPENSES ALLOWANCE (PEA)

Legal basis

1. The PEA is the weekly amount that councils must, in the absence of special circumstances, assume residents need for their personal expenses. The PEA is specified in regulations made under section 22(4) of the National Assistance Act 1948 ("the 1948 Act"). This amount is uprated each April, usually in line with the increase in average earnings.

2. The PEA applies in relation to all persons whose accommodation is arranged by a council under Part 3 of the 1948 Act, including residents of care homes with nursing on the premises, residents of council run homes and homes run by the private and voluntary sector.

New PEA amount from 8th April 2013

3. The Regulations were amended to provide for PEA to increase from £23.50 to £23.90 with effect from 8th April 2013. Paragraph 5.002 of CRAG has been amended accordingly.

4. This is slightly larger than the usual formula increase (40p per week rather than 35p per week). This is because DWP made a number of increases to benefits from April 2013. For example, basic state pension will increase by 2.5%.These changes should result in a gain for councils in income from charging.

5. The intention of the above formula increase in PEA is to enable residents to keep some of the increase they are receiving in benefits, for their personal use. The increase to PEA has been set at a level that is expected to keep broadly constant the proportion of care home costs met from charges on residents.

The purpose of the PEA

6. The PEA is intended to allow residents to have monies for personal use. Councils, providers of accommodation and residents are again reminded that the PEA should not need to be spent on aspects of board, lodging and care that have been contracted for by the council and/or assessed as necessary to meet individuals' needs by the council or the NHS. Councils should therefore ensure that an individual resident's need for continence supplies or chiropody is fully reflected in their care plan. Neither councils nor providers have the authority to require residents to spend their PEA in particular ways and, as such,

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should not do so. Pressure of any kind to the contrary is extremely poor practice. See LAC(2002)11 for fuller guidance.

II. CAPITAL LIMITS

Residential care charges

7. As set out in LAC(DH)(2011)1, in the context of the Spending Review 2010, the capital limits will continue to remain at their current level, £23,250 for the upper capital limit and £14,250 for the lower capital limit.

8. The intention is to help protect the level and quality of social care services by enabling councils to raise additional revenue to pay for these services, from residential care charges. This extra revenue should help ensure councils can maintain the existing quality and quantity of social care.

9. The Spending Review 2010 covers Government spending up to April 2015. We do not envisage any increase to the capital limits before April 2015. However, the Department will continue to monitor the effect of not increasing the limits.

Home care charges

10. With respect to charging for home care, savings and capital should be treated no less generously than under the rules for assessing residential care charges. Councils should note that the capital limits set out in this circular apply automatically as minimum requirements for home care charges.

III. SAVINGS CREDIT DISREGARD

11. LAC 2003(22) mentioned the introduction of a new savings credit disregard from October 2003, in response to the introduction of Pension Credit.

12. From April 2013, DWP increased the state pension by 2.5% in line with the usual formula (the so-called ‘triple lock’) and increased the pension credit standard minimum guarantee (SMG) by the increase in the cash value of the basic state pension, about £2.70 or 1.9%. This is about 0.3% more than suggested by the usual formula, which for the SMG is average earnings. To fund this, there was an increase in the savings credit threshold and an associated reduction in the maximum savings credit.

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13. However, as mentioned above (paragraph 4), DWP is making a number changes which should result in a gain for councils in income from charging. Therefore, Ministers have decided to make no change to the savings disregards. These remain unchanged at up to £5.75 a week for individual supported residents aged 65 and over, and up to £8.60 a week for couples.

IV. DISREGARD FOR EARNED INCOME

14. As announced in the White Paper "Caring for our future", in order to support more disabled people into employment, so that society and the economy can benefit from their skills and talents, from April 2013, income that people earn in employment are exempt from residential care charges. This is intended to help encourage those in residential care to pursue employment opportunities if they are able to do so. It also brings residential charging policy into line with that for non-residential charging.

15. As acknowledged in the White paper, this disregard is a New Burden on local authorities and additional funding of £2.7 million has been allocated to cover the cost.

V. ARMED FORCES INDEPENDENCE PAYMENTS

16. With effect from 8 April 2013, Armed Forces Independence Payments (AFIPs) will begin to replace Disability Living Allowance for veterans in receipt of a Guaranteed Income Payment under the Armed Forces Compensation Scheme.

17. For residential care charging, under Paragraph 4A of Schedule 3 to the National Assistance (Assessment of Resources) Regulations 1992, AFIPs are fully disregarded in the financial assessment for charging.

18. For non-residential care charging, as set out in Paragraph 33 of the revised "Fairer Charging Guidance", Councils may choose to disregard AFIPs entirely, in recognition of the contribution made by armed forces personnel injured whilst on active service. However, if they do not they should disregard an amount equivalent to what they would disregard from a PIP.

VI. THE FUTURE OF CHARGING ARRANGEMENTS

19. The Department of Health is working through the implications for social care charging of Welfare Reform – in particular the move to Universal Credit – Funding Reform and the planned social care legislation. We are liaising with the Department for Work and Pensions and relevant stakeholders in developing and modernising the charging arrangements.

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20. We anticipate a transitional period. This takes account of the introduction of Universal Deferred Payments Agreements, planned for 2015; the introduction of the capped cost model and the extended means test, planned for 2016; and Welfare Reform, which is not due for completion before 2018. Revised regulations and guidance will be issued periodically, during this period, as we work through the transition to the new arrangements.

VII. REVISED CHARGING FOR RESIDENTIAL ACCOMMODATION GUIDE (CRAG)

21. A revised CRAG is being issued at the same time as this circular. The revised CRAG is available on the UK.GOV website at [add link].

VIII. REVISED EDITION OF "FAIRER CHARGING POLICIES FOR HOME CARE AND OTHER NON-RESIDENTIAL SOCIAL SERVICES"

22. A revised edition of the "Fairer Charging Guidance" is being issued at the same time as this circular. The revised Guidance is available on the UK.GOV website at [add link].

23. The changes to the Guidance at to reflect alterations to benefits as a result of Welfare Reform. DWP has published analysis of the potential impact of Welfare Reform on people with protected characteristics. This can be found on the GOV.UK website at:

https://www.gov.uk/government/publications/welfare-reform-bill-2011-equality-impact-assessments-general-introduction

https://www.gov.uk/government/publications/universal-credit-equality-impact-assessment

https://www.gov.uk/government/publications/disability-living-allowance-reform-equality-impact-assessment

https://www.gov.uk/government/publications/social-sector-housing-under-occupation-equality-impact-assessment