

## **CABINET MEMBER FOR ADULT SOCIAL CARE AND HEALTH**

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

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

**Time: 9.30 a.m.**

### **A G E N D A**

1. To determine if the following matters are to be considered under the categories suggested, in accordance with Part 1 of Schedule 12A (as amended March 2006) 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 the previous meeting (Pages 1 - 6)  
Minutes of meeting held on 20<sup>th</sup> October, 2014
6. Health and Wellbeing Board (Pages 7 - 34)  
Minutes of meetings held on 27<sup>th</sup> August, 1<sup>st</sup> and 24<sup>th</sup> October, 2014
7. Representatives on Working Groups  
Obesity Strategy Group  
Rotherham Heart Town  
Tobacco Control Alliance  
Self-Harm and Suicide Prevention Group
8. White Ribbon Campaign (report herewith) (Pages 35 - 37)
9. Independent Mental Health Advocacy Service (IMHA) - 2015/16  
Commissioning Intentions (report herewith) (Pages 38 - 42)
10. The transfer of Independent Living Fund (ILF) support and funding to Local Authorities from 30 June 2015 (report herewith) (Pages 43 - 50)
11. Restructure of Enabling and Out of Hours Service (report herewith) (Pages 51 - 55)

12. Safeguarding Adults Annual Report 2013-2014 (herewith) (Pages 56 - 90)
13. Making Safeguarding Personal (report herewith) (Pages 91 - 95)
14. Vulnerable Adults Risk Management Report (herewith) (Pages 96 - 108)
15. Adult Services Revenue Budget Monitoring Report 2014/15 (report herewith) (Pages 109 - 114)
16. Waiver Rotherham Healthwatch (report herewith) (Pages 115 - 117)
17. Health Visiting and Family Nurse Partnership Development Funds - Section 7a Public Health Services - Proposals for Rotherham Services (report herewith) (Pages 118 - 121)
18. Crisis Care Concordat (report herewith) (Pages 122 - 130)
19. Exclusion of the Press and Public  
Resolved:- That, under Section 100A(4) of the Local Government Act 1972, the press and public be excluded from the meeting for the following items of business on the grounds that they involve the likely disclosure of exempt information as defined in Paragraph 3 of Part I of Schedule 12A to the Local Government Act 1972 (information relating to the financial or business affairs of any person (including the Council)).
20. Commissioning Framework for Domiciliary Care Tender 2014-15 (Pages 131 - 135)

**ADULT SOCIAL CARE AND HEALTH  
20th October, 2014**

Present:- Councillor Doyle (in the Chair) and Councillor Andrews.

Apologies for absence were received from Councillor Pitchley.

**H10.       DECLARATIONS OF INTEREST**

There were no Declarations of Interest made at the meeting.

**H11.       MINUTES OF THE PREVIOUS MEETING**

Consideration was given to the minutes of the meeting held on 22nd September, 2014.

Resolved:- That the minutes of the meeting held on 22nd September, 2014, be approved as a correct record.

**H12.       WORKPLACE HEALTH PROGRAMME**

Andy Turner, Workplace Health Advisor, Rotherham Public Health, reported on the Workplace Wellbeing Charter launched by Public Health England in June, 2014.

The Charter was a national framework for local Health and Wellbeing Boards to use as part of their work to address the health and wellbeing of adults. Utilising the national framework would allow the Authority to engage businesses and local Chambers of Commerce into making Rotherham's workforce healthier. It would contribute to improving the health and wellbeing of working age people through promoting the positive links between health and work and helping more people with health conditions to stay in or return to employment.

The Charter came in 3 levels each containing different standards to achieve. Each of the 3 levels would consider issues such as leadership, sickness management, awareness of alcohol and drug misuse, smoking, sexual health, mental health and stress, healthy eating and physical activity.

The assessment contained standards under each of the main areas that an organisation could address to improve the health and wellbeing of their employees. The purpose of the standards were to provide a guide as to what steps could be taken and give an indication of where an organisation may need to improve or where they were doing well. Under each area, the standards were separated into 3 categories:-

Commitment – the organisation had addressed each area and provided employees with the tools to help themselves to improve their health and wellbeing

Achievement – having put the building blocks in place, steps were being taken to actively encourage employees to improve their lifestyle and some basic interventions were in place to identify serious health issues

Excellence – not only was the information easily accessible and well publicised, but the leadership of the organisation was fully engaged

The categories were there to provide a general overview as to how an organisation was performing in each area.

The Charter assessments would be delivered by Rotherham Occupational Health Advisory Service as well as support for participating businesses. Early engagement would focus on supporting small/medium enterprises and businesses furthest from achieving the standards.

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

- Initial discussions with the Council's Human Resources regarding the Council's approach
- The risks associated with the initiative were the failure of businesses signing up to the Charter
- Support would be given in the employee's actual workplace at their convenience

Resolved:- (1) That Cabinet be requested to recommend to Council the adoption of the Workplace Wellbeing Charter.

(2) That Rotherham employers be supported in delivering the Workplace Wellbeing Charter as part of the Rotherham Public Health Workplace Health Service.

(3) That the report be referred to the Health and Wellbeing Board.

### **H13. ROTHERHAM REGIONAL INDEPENDENT PEER PERFORMANCE ASSESSMENT 2014 - ADULT SOCIAL CARE OUTCOMES FRAMEWORK**

Scott Clayton, Performance Improvement Officer, presented the outcome of the above Assessment which was carried out by the Association of Directors of Adult Social Services Standards and Performance Officers as part of the Yorkshire and Humberside Sector Led Improvement Model.

It was Rotherham's third independent assessment and clearly demonstrated a positive picture of Rotherham's direction of travel. It also illustrated how Rotherham compared with others in the region and its statistical neighbourhoods, the areas of strengths and areas for further

investigation. Rotherham had improved in 14 out of 18 national Adult Social Care Outcomes Framework (ASCOF) measures over the last 12 months and 16 over the last 2 years.

It was noted that the continuing budget pressures and drivers for efficiencies may have a negative impact on future performance; each efficiency proposal would set out the impact for customers and performance. The Care Bill set out a number of new requirements over the next 2 years and guidance was still being developed, however, the implementation may impact on performance.

The current issues regarding Child Sexual Exploitation and the Alexis Jay report may have a negative impact on the 2014/15 service user and carer surveys perception measures.

Discussion took place on the results with the following clarification/issues raised:-

- Performance Officers linked in with RDaSH with regard to the reporting of statistics e.g. mental health employment as well as the wider operational team to discuss what could/what was being done. However, it needed to be broader than just 1 organisation
- The Indicator as reported in the ASCOF only dealt with those 'higher needs' service users supported under the "Care Programme Approach" who were in paid employment. Additional support taking place that was not 'countable' within the ASCOF measure was not reflected.
- 15 Yorkshire and Humber authorities were part of the ASCOF rankings reflected in the report
- There had been engagement with Health colleagues, both at the hospital, CCG and RDaSH with regard to delayed transfers. Rotherham was still in the top 25% of all Councils but there had been a deterioration in performance. However, discussions had taken place and ascertained that RDaSH believed they were underreporting in an area

Resolved:- (1) That the report and the positive picture for Rotherham and the plans to address areas for further investigation be noted.

(2) That quarterly updates be submitted together with the performance monitoring reports.

#### **H14. THE GATE NEW REGISTRATIONS- SCREENING PILOT PROPOSAL**

Dr. John Radford, Director of Public Health, presented details of a proposed 2 year pilot scheme to provide an initial health assessment for vulnerable communities who had not yet registered with a GP.

The Gate Surgery specialised in supporting those who had difficulty accessing mainstream Health and Social Care Services. The Service would work flexibly and proactively across a range of complex and interlinked issues affecting adults and families at greater risk of or experiencing poor health, substance misuses, risk of neglect or sexual exploitation. It was essential that a clear health and safeguarding framework was development for assessment of the population group concerned and a strategy in place to limit the spread of infections and protect the most vulnerable from harm.

The proposed assessment would cover:-

- Identifying and reporting any safeguarding and social issues (including but not limited to language and learning needs/disability, risk of domestic abuse)
- Collecting a general medical history
- Baseline observations (height, weight, waist circumference, blood pressure, baseline bloods as required, children's growth pattern initial observation)
- Identification and treatment of any existing long term conditions requiring ongoing medication
- Bringing childhood immunisations/vaccinations up to UK schedule
- Risk assessment and testing as necessary for blood borne viruses (Hepatitis B, Hepatitis C, HIV), Syphilis and Gonorrhoea
- Tuberculosis testing was required
- Rubella susceptibility testing
- Identifying cervical cytology history/needs
- Contraception/LARC was required
- Onward referral to health services (e.g. health visiting and dental health services) and other support (English language lessons, living in the community training) as necessary
- Onward referral to Social Services as appropriate
- Introducing the new arrival to the different health services in Rotherham and appropriate use of them

If the individual had not registered with a GP already, a list of practices near their home would be provided. Confirmation of the assessment and a report would be given to the individual to pass to the general practice where they wanted to register.

Resolved:- (1) That the establishment of a 2 year screening pilot for people not registered with a GP be approved for those who registered at the Gate Surgery.

(2) That the funding of the pilot from non-recurrent savings in the ringfenced Public Health monies be approved.

(3) That a 6 monthly progress report be submitted to the Cabinet Member.

(4) That the report be referred to the Health and Wellbeing Board for information.

#### **H15. SUPPORTING PEOPLE FLOATING SUPPORT SERVICES COMMISSIONING INTENTIONS**

Claire Smith, Operational Commissioner, submitted a report regarding the 14 floating support services contracts which would be coming to an end on 31<sup>st</sup> March, 2015.

The Services had previously been commissioned through a competitive tender process in 2010/11 and commenced on 1<sup>st</sup> April, 2011 for 3 years with the option to extend for a further year subject to performance and quality.

The current overall cost of the 14 floating support services was £1,368,000 with a capacity of 2,033 at any one time.

Since 2011 the Supporting People Team had worked closely with Service providers to continue to make efficiencies as a requirement of the annual budget matrix exercise contributing to the Council's overall deficit. As at 1<sup>st</sup> April, 2014, a further £303,000 savings had been made across the 14 floating support services.

Commissioning activity to re-tender the floating support service had been suspended in order to ensure that provision reflected the Council's requirements to consider all options for effective, efficient, value for money services that were strategically relevant and only met the needs of the most vulnerable. In July, 2014, the Supporting People Programme was presented under the internal budget challenge process and proposals made to ensure that Council's directives were achieved as well as ensuring services were not duplicated and promoted prevention and early intervention.

The timescales for this piece of work would be approximately 12 months to facilitate a successful conclusion.

Concern was expressed that this had not been raised earlier and included as part of the 2015/16 budget process. It was noted that discussions would take place to ensure that a timetable was in place to coincide with the budget setting processes for commissioning of services.

Resolved:- (1) That an extension of the current floating support contracts be approved for a period of 6 months from 1<sup>st</sup> April, 2015, to 30<sup>th</sup> September, 2015, in order to meet the commissioning actions required.

(2) That a commissioning timetable be drawn up which would run parallel with the Council's budget setting process to avoid any further extension of contracts where possible.

**H16. SCRUTINY REVIEW: ACCESS TO GPs**

Dr. John Radford, Director of Public Health, reported on the response of NHS England, the GP Service Commissioner and Rotherham Clinical Commissioning to the above review.

At the time of the review, it had still been unclear as to what extent the Care Quality Commission and the GP Regulator would consider access under its new inspection regime. It was clear that this now formed a major part of the new inspections.

The CCG and NHS England would be developing a Rotherham based plan to improve healthcare in the Borough. Both NHS England and the CCG recognised the contribution the review would make to informing the “place based plan”.

Scrutiny Review Members had recognised the national and local pressures that impacted upon access to GPs. On the supply side there was reducing funding, shortages of GPs and nurses and premises that were not always suitable for the increasing range of services now delivered at GP practices. Patient demographics with a growing and ageing population, coupled with the prevalence of ill health and long term conditions and local deprivation in some areas meant increasing demand. This required adequate resourcing to ensure good access to services for all patients.

Resolved:- (1) That the response to the Scrutiny Review be noted.

(2) That the Health and Wellbeing Board ensure responsible agencies report progress to the Board.

(3) That Cabinet consider the route for future multi-agency Scrutiny Reviews.



**HEALTH AND WELLBEING BOARD  
27th August, 2014**

**Present:-****Members**

Councillor John Doyle	Cabinet Member for Adult Social Care ( <b>in the Chair</b> )
CI Richard Butterworth	South Yorkshire Police (representing South Yorkshire Police)
Tom Cray	Strategic Director, Neighbourhoods and Adult Services
Chris Edwards	Chief Officer, Rotherham CCG
Melanie Hall	Rotherham Healthwatch (representing Naveen Judah)
Dr. Julie Kitlowski	Clinical Chair, Rotherham CCG
Councillor Paul Lakin	Deputy Leader
Carol Stubbley	NHS England
Joyce Thacker	Strategic Director, Children Young People and Families Services

**Also in attendance:**

Tracy Clark	RDaSH (representing Chris Bain)
Miles Crompton	Policy and Partnerships
Kate Green	Policy Officer
Martin Havenhand	Rotherham Foundation Trust (representing Louise Barnett)
Michael Holmes	Policy and Partnerships
Shafiq Hussain	Voluntary Action Rotherham (representing Janet Wheatley)
Satvinder Rana	Local Government Association
Jasmine Swallow	Performance Officer
Sue Wilson	Performance and Quality Manager
Chrissy Wright	Strategic Commissioner, RMBC

Apologies for absence were received from Councillor Amy Rushforth, Chris Bain, Louise Barnett, Jason Harwin, Naveen Judah, Martin Kimber, Dr. John Radford and Janet Wheatley.

**S10. QUESTIONS FROM MEMBERS OF THE PRESS AND PUBLIC**

There were no questions from the press and public,

**S11. MINUTES OF PREVIOUS MEETING**

Resolved:- That the minutes of the meeting held on 2nd July, 2014, be approved as a correct record subject to the inclusion of the following addition:-

S5 (Better Care Fund) "Rotherham had no option but to conform to this request according to current information".

Arising from Minute No. S3 (Dalton and Treeton Health Centres), Carol Stubbley gave the following update:-

The former NHS Rotherham Board had approved, in principle, the development of new medical centres at Dalton and Treeton with tender processes to commence subject to funding being available and re-confirmation by the Board.

With regard to the Dalton Health Centre, all the legal and lease agreements had been signed on 19<sup>th</sup> August and contractors would be on site to commence the build at the end of September, 2014 with an estimated build time of 9 months.

The timescale with regard to the Treeton Health Centre was less clear at the present time. The next stage was to start work on a detailed project plan and time frame. An update would be given to a future meeting.

Arising from Minute No. S8 (Vaccinations and Immunisations), Dr. Kitlowski reported that a meeting had taken place with all the partners with regard to vaccinations and immunisations in pregnant women for influenza and whooping cough. The plan was to hopefully to implement it from 2015. An action plan would be submitted to the next Board meeting.

## **S12. INDEPENDENT INQUIRY INTO CHILD SEXUAL EXPLOITATION IN ROTHERHAM**

The Chairman referred to the recent publication of the above Inquiry report which had yet to be considered by the Council and partners.

He felt that the Board needed to be satisfied that the systems in place were as robust as possible and fit for purpose. Accordingly he proposed that all partners consider the report and report back to the Board.

Although it was the ultimate responsibility of the Rotherham Local Safeguarding Children Board there was the governance relationship between the 2 Boards. It was noted that the Safeguarding Board was to convene a special meeting to consider the report.

Resolved:- That the Chairman of the Rotherham Local Safeguarding Children Board be invited to a future meeting of this Board.

## **S13. COMMUNICATIONS**

### **Better Care Fund**

The Board considered 2 letters that had been received from the Departments of Health and Communities and Local Government and the BCF Programme Director, both dated 11<sup>th</sup> July, 2014, which gave a general update with regard to the funding and the new BCF Programme Team.

A further letter had since been received which gave much more detail and included the new updated guidance and deadlines for resubmitting plans.

**S14. BETTER CARE FUND**

The Chairman reported that the latest letter received from NHS England dated 25<sup>th</sup> July set out the changes to the Fund.

The most important change was that in relation to the previous £1bn Payment for Performance Framework which had now been revised so that the proportion linked to performance was dependent solely upon an area's scale of ambition in setting a planned level of reduction in total emergency admissions i.e. general and acute non-elective activity.

Nationally the assumption was that this would be in the region of a 3.5% reduction against the baseline detailed in the technical guidance. If this was achieved, it would equate to a national payment for performance pool of around £300M. The remaining £700M would be available upfront in 2015/16 to be invested in NHS commissioned out-of-hospital services. The detail would be subject to local agreement.

Although Rotherham had been selected as 1 of the fasttracked 15, it had been decided not to proceed due to the unknown/unquantified burden and the changes that were being made almost on a daily basis. The present scheme was significantly changed from what had originally been proposed.

The Fund had caused tensions between the Local Authority and CCG and it was important that lessons were learnt as a result. Locally there had been groundbreaking work around integration which the Fund had diverted the partners from and it was crucial that the partnership and direction of travel was not lost.

The submission now had to be submitted by 19<sup>th</sup> September which was before the next scheduled Board meeting.

The CCG had reduced its non-elective admissions by 10% during the last 2 years; its ambition was to maintain the non-emergency admissions at the 2008/09 levels. This was part of the 5 year plan which they had widely consulted upon. NHS England would be looking for a 5.8% reduction but the CCG would strongly argue that they had already achieved the reduction and making the case of maintaining that reduction.

It was proposed that the Task Group be delegated authority to complete and submit the application by the September deadline.

Resolved:- That, subject to no significant changes being made, the Task Group be delegated the authority to complete the submission and submit to NHS England by the 17<sup>th</sup> September, 2014, deadline.

**S15. HWB PEER CHALLENGE**

Satvinder Rana from the Local Government Association, reported that the Peer Challenge team would be on site from 9<sup>th</sup>-12<sup>th</sup> September.

Background work had been undertaken with the questionnaires previously supplied to members analysed. Statistics had been collated and documentation reviewed by the team.

Once on site, discussions would be held with Board members/stakeholders in the health and wellbeing system to ascertain how things were going. There was a suite of core questions in addition to the direction supplied on the type of things the Board wanted the team to focus upon.

It must be remembered it was not an inspection. The team consisted of practitioners i.e. someone from health and wellbeing, a Chief Executive from a Council, Director of Public Health etc. each bringing their experiences and feeding back on what they saw.

After the 4 days the findings would be fed back. There would be a presentation on the Friday morning followed by a report in 2 weeks later. The Board would have the opportunity to comment upon the report and, once signed off, would be published.

The Chairman encouraged members to be open about their experiences within the Board. It was hoped the Peer Challenge would be a constructive and positive process and provide recommendations to continued development.

All Board members would be invited to the presentation on the 12<sup>th</sup> September and requested that responses be provided to the invitation.

Resolved:- That the report be noted.

**S16. JOINT STRATEGIC NEEDS ASSESSMENT**

Chrissy Wright, Strategic Commissioner, submitted a report on the progress made in updating the Joint Strategic Needs Assessment (JSNA).

The JSNA was reviewed and revised at the end of 2011, however, a further refresh was required to meet Government guidance and a new online version developed and agreed in February, 2014. The JSNA process was a co-ordinated and consistent approach to data and information that had been validated and was evidence based.

All those who had contributed to the 2013 JSNA refresh were asked to provide any changes or additions to the information previously provided. In most cases the changes so far had been minor and the key issues emerging remain as previously reported.

Revised population projections now suggested that Rotherham would have 2,500 (1%) fewer residents by 2021 than previously projected. The reduction mainly affected people of working age whilst the expected numbers of older people aged 65+ and 75+ were slightly higher than previously projected. This illustrated the value of being able to update the JSNA so that new information could quickly be made available online.

A new requirement was for an Asset Register for the Borough such as physical community resources, leisure facilities and individual community resources. Compiling the Register had been a substantial piece of work but the information could be interrogated as required by the user to identify the resource sought. It was proposed that the Asset Register be used alongside the events and organisations information database on Connect to Support. The Register was in the process of being uploaded to the JSNA website.

Discussion ensued with the following comments made:-

- The document would become increasingly important particularly for commissioners as well as the move to more community-based services and integrated working
- Similarly the Asset Register for interested parties/communities linking into case management plans and single patient records so every locality knew exactly what resources each had in their community
- It was particularly important to understand what the voluntary sector had in place so it was essential it was refreshed on a regular basis. There were champions in each organisation whose responsibility it was to feed updated information through which would then feed into the Board 6 monthly updates
- VAR had a directory of 600 organisations which spelt out which provided what services in each area
- The JSNA featured in RDaSH's 5 year strategic plan of services
- A meeting had been arranged to discuss how Healthwatch and the public could feed into the process
- RFT had found it extremely valuable when producing their 5 year strategy

Resolved:- (1) That the progress made in relation to the updating of the Joint Strategic Needs Assessment and the establishment of the Asset Register be noted.

(2) That further updates be submitted twice a year (September and March) and by exception if so required.

**S17. COMMISSIONING PLANNING CYCLE**

Discussion ensued on the partners' commissioning cycles and the commitment made previously to share plans as soon as possible.

However, it was noted that all of the organisation's commissioning cycles were different. The CCG was about to start consultation with their GP members shortly with a view to getting draft plans out to stakeholders in November and formally to their Board in February, 2015.

It was suggested that by January, 2015, all organisations should have a draft commissioning plan.

Resolved:- That commissioning plans be submitted to the Board in January, 2015.

**S18. OPERATIONAL RESILIENCE IN 2014/15**

In accordance with Minute No. S4, Chris Edwards presented a report on Operational Resilience in 2014/15.

Following direction from NHS England, Rotherham CCG had set up a System Resilience Group which would build on the successful work in 2013/14 through the Urgent Care Working Group. The membership of the former Group had been widened to include a mental health provider (RDaSH).

The role of the Group was to inform and advise NHS England how it managed allocations on NHS waiting lists and System Resilience monies for Winter. It reported to NHS England and it was proposed that the minutes of the Group be circulated to the Board.

Discussion ensued on the Group with the following issues raised:-

- It was not just a change of name but change of tenure for the Group
- Need to ensure the representatives present had the delegated authority and, if unable to attend, the appropriate deputy attended
- Due to the short timescales that were normally associated with funding i.e. Winter pressures, decisions were needed within a few days not allowing representatives to take it back through their own governance structures
- Unrealistic tight timescales for important decision to be made for Winter Resilience Monies

Resolved:- That the minutes of the Group be circulated to enable Board members to gain an understanding of what was discussed at the meeting and, if required, a meeting be convened to discuss the matter further.

**S19. CUSTOMER CHARTER (EXPECTATIONS AND ASPIRATIONS WORKSTREAM)**

Sue Wilson (Performance and Quality Manager) and Jasmine Swallow (Performance Officer) presented a report setting out an overview of the consultation process undertaken to develop the customer standards, suggestions for monitoring performance and future plans for launching and embedding with employees and customers.

Initial consultation to identify the top priorities had narrowed the 36 Service standards to 15 priorities which had been further consulted on at the 2013 Rotherham Show. This had identified the top 5 promises which were the most important to customers/potential customers when accessing services across the Partnership. These were:-

‘Our Promises to you’ Customer Charter:

- We will make it easy for you to find out what services are available
- We will aim to be flexible if you need to meet with us
- We will actively listen to you and treat you with dignity and respect
- We will be honest about what we can do to help you
- We will ensure the services we provide are timely

It had also been suggested that a strapline within individual organisations’ version of the Customer Charter be included.

The concept of the design of the Charter was that the jigsaw pieces fitted together to provide a partnership commitment to promising and delivering against standards for customer service. There was a clear indication of who the Health and Wellbeing partners were which was reflected in the prominence of the logo, use of colours and each organisation’s logo within one jigsaw piece.

It was proposed that monitoring performance through annual satisfaction surveys be conducted at the Rotherham Show. It was anticipated that the baseline performance would be gained at the 2014 Show as part of a ‘You told us...We have...’ campaign. Monitoring activity would be co-ordinated through Performance and Quality at the Expectations and Aspirations Workstream Group with results reported to the Health and Wellbeing Board and communicated to the public.

A Communications and Marketing Plan was being developed to ensure the customer standards reached a wide audience, informing customers about the standards they should expect and demand when accessing services and providing consistent standards for employees to work to assuring the best customer service possible.

It was hoped that a formal launch would be held at the New York Stadium which would see the ‘jigsaw’ brought to life recreating the logo as an enlarged puzzle for the photo call.

There was also a further Priority 2 action within the work plan to develop generic customer care training. This would be a further opportunity to work in partnership to provide a co-ordinated approach to embed the single set of customer standards into working practices.

Each partner gave a brief report on their involvement in the workstream:-

- VAR – involved in the development of the Charter as well as its member organisations in the development of the Standards. There was nothing contained within it they would not be able to aspire to. The VAR Board and a number of VCS networks had supported and endorsed it
- SYP – consulted/contributed as part of the process and very supportive in relation to the Standards. Unfortunately, it was a county-wide organisation of which Rotherham was an element but would initiate work with officers and staff in terms of the Standards. Feedback was already being received from Your Voice Counts but the Charter would be used as a template to get more feedback and engagement from the public on the services delivered and to what standard they were delivered to
- RFT – meeting held with Chief Executive and Communications and Marketing Manager. There had been issues with regard to the NHS Constitution but since then it had been agreed and understood that the Standards were very much complimentary and supplementary
- RDASH – meeting held with representative of organisation and further work carried out during August. The Charter and Standards were similar to the organisation's set of values. It had not been through their governance process as yet
- CCG – some of the wording had been subtly changed to meet NHS guidance and would be used as a complimentary document
- CYPS – the Directorate had signed up to the Charter
- Healthwatch – had been part of the process and provided support at the Rotherham Show

Sue and Jasmine were thanked for their work in producing a fit for purpose and meaningful document.

Resolved:- (1) That the single set of customer Standards 'Our Promises to you' (Customer Charter) be approved and endorsed.

(2) That the partnership approach for monitoring performance, as set out in the report, be approved.



(3) That information be submitted regarding additional monitoring activities which single organisations could adopted.

**S20. DATE OF NEXT MEETING**

Resolved:- That a further meeting of the Health and Wellbeing Board be held on Wednesday, 1st October, 2014, commencing at 9.00 a.m. in the Rotherham Town Hall.

**HEALTH AND WELLBEING BOARD  
1st October, 2014**

**Present:-**

Councillor Doyle	Cabinet Member for Adult Social Care and Health <b>(in the Chair)</b>
Councillor Beaumont	Cabinet Member for Children and Education Services
Tom Cray	Strategic Director, Neighbourhoods and Adult Services
Chris Edwards	Chief Officer, Rotherham CCG
Jason Harwin	South Yorkshire Police
Fiona Jordan	NHS England (representing Carol Stubley)
Martin Kimber	Chief Executive
Dr. Julie Kitlowski	Clinical Chair, Rotherham CCG
Jason Page	Executive Lead, Referrals and Pathways, Rotherham CCG
Dr. John Radford	Director of Public Health
Dorothy Smith	Director of Schools and Lifelong Learning, RMBC

**Also in Attendance:-**

Richard Butterworth	South Yorkshire Police
David Hicks	Rotherham Foundation Trust (representing Louise Barnett)
Michael Holmes	Policy Officer, RMBC
Ian Jerrams	RDaSH
Shona McFarlane	Director of Health and Wellbeing, RMBC
Donald Rae	Special Education Needs and Disability Strategic Lead
Mark Scarrott	Finance Manager, RMBC
Janet Wheatley	Voluntary Action Rotherham
Chrissy Wright	Strategic Commissioner, RMBC

Apologies for absence were received from Councillor Emma Hoddinott, Chris Bain, Tracy Holmes, Naveen Judah and Carol Stubley.

**S21. QUESTIONS FROM MEMBERS OF THE PRESS AND PUBLIC**

There were no questions from the member of the public present at the meeting.

**S22. MINUTES OF PREVIOUS MEETING**

Resolved:- That the minutes of the meeting held on 27th August, 2014, be approved as a correct record.

Arising from Minute No. S15 (Peer Challenge), it was noted that the Peer Challenge had been deferred in light of the corporate governance inspection taking place. It would be arranged at some point in the future.

**S23. COMMUNICATIONS****Peer Challenge**

See Minute No. 22 above.

**Pharmaceutical Needs Assessment (PNA)**

Dr. John Radford, Director of Public Health, reported that a draft PNA had been produced in line with the statutory requirement for the Board to produce such a document before April, 2015.

A PNA was a tool required by NHS England to allow new pharmacies or changes in pharmacies across the Borough. It was a legal framework for pharmacies to enter the market place. This would be of particular importance in the town centre when the new emergency and urgent care centre at the Hospital opened and the maintenance of a pharmacy over that period.

The document would be circulated to Board Members as part of the 2 months consultation period with comments submitted to the Board. Once finalised and published there will be a process to update whenever required.

**CAMHS Strategy**

This item would now be discussed at the November Board meeting together with the Emotional Health and Wellbeing Strategy.

**Alex Jay Independent Inquiry**

A special Board meeting was to be held on 24<sup>th</sup> October at 1.00 p.m. to discuss the report.

**S24. BETTER CARE FUND**

Chris Edwards, CCG, reported that the Task Group had communicated via e-mail due to there being no significant changes to be made to the submission. A joint tele-conference had taken place with NHS England to provide external assurances.

No significant feedback had been received as yet but a report would be received as to whether NHSE's requirements had been met.

Resolved:- That the report be noted.

**S25. SOCIAL CARE SUPPORT GRANT 2014-15**

Shona McFarlane, Director of Health and Wellbeing, presented a report on the transfer to the Local Authority of the above Grant, details of the local allocations and the recommendations on how it could be spent for the 2014/15 financial year. NHS England would transfer £6.166M to the Council which included an increase of £1.351M from 2013/14.

Payment of the Social Care Support Grant was to be made via an Agreement under Section 256 of the 2006 NHS Act. The Agreement would be administered by the NHS England Area Team and would only pass over to local authorities once the Section 256 Agreement had been signed by both parties.

The Grant must be used to support Adult Social Care Services that delivered a health benefit. However, beyond that broad definition, NHS England wanted to provide flexibility for local areas to determine how the investment in Social Care Services was best used.

Guidance required NHS England to ensure that the local authority agreed with its local health partners on how the funding was best used. Health and Wellbeing Boards would be the forum for discussions between the Area Teams, CCGs and local authorities on how the funding should be spent. NHS England would make it a condition of the transfer that RMBC and RCCG had regard to the Joint Strategic Needs Assessment for their local population. It would also be a condition that RMBC demonstrated how the funding transfer would make a positive difference to Service users.

The Fund would be overseen by a robust joint governance framework which supported achievement of the following:-

- Reduction in emergency admissions
- Reduction in delayed transfers of care from hospital
- Proportion of older people still at home 91 days after hospital discharge into rehabilitation
- Number of re-admissions to hospital within 30 days of discharge

It was proposed that the Grant be used to support existing Services and Transformation Programmes where such services or programmes were of benefit to the wider health and care system:-

- Additional short term residential care places or respite and intermediate care
- Increased capacity for home care support, investment in equipment, adaptations and telecare
- Investment in crisis response teams and preventative services to avoid hospital admission
- Further investment in reablement services to help people regain their independence

The appendix to the report submitted set out the proposed spending programme.

Discussion ensued on the proposed spending programme with the following issues raised:-

- Would consideration be given to the individuals entering the criminal justice system as part of the Mental Health Service?
- Was there sufficient funding for the development of community based Dementia Care
- RDaSH would be evaluating their triage project which had been running in conjunction with the Police

Resolved:- (1) That the programme of expenditure set out in the report be approved.

(2) That the development of a light-touch performance framework for the Grant be approved.

(3) That as part of the Board review, the processes and sub-groups be reviewed together with the appropriateness of the memberships.

## **S26. PERFORMANCE MANAGEMENT FRAMEWORK**

Dr. John Radford, Director of Public Health, presented the current position on the reporting framework for 6 Priorities of the Health and Wellbeing Strategy drawing attention to:-

- Reducing hospital admissions due to alcohol related illness – activity had worsened. Although it reflected an increase in hospital admissions it was not an accurate figure. The CCG were carrying out work to understand the issues and had a pilot in place to reduce alcohol related hospital admissions
- Discussions were taking place with South Yorkshire Police regarding the number of FPN waivers which resulted in attendance at binge drinking courses – it was believed that the number was higher than reported
- The trend in terms of healthy life expectancy in Rotherham was improving. There were issues in relation to childhood obesity and very high levels of inactivity in Rotherham than elsewhere in the country

Discussion ensued with the following issue raised/clarified:-

- There was poor dental health in children of 2-5 years. Public Health England had been asked to submit a report setting out the trends. It again raised the issue of fluoridation and persuading parents to give their children water/milk rather than sugary drinks

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

(2) That a report be submitted to a future Board meeting in relation to the trends associated with Priority 2 particularly relating to reduced hospital admissions due to alcohol related illness, the number of FPN waivers and children's dental health.

(3) That future performance management reports highlight any indicators off target together with the reasons for such performance.

## **S27. HEALTHWATCH ROTHERHAM**

Further to Minute No. 88 of 26<sup>th</sup> March, 2014, Chrissy Wright, Strategic Commissioning Manager, reported that the contract for Healthwatch Rotherham had terminated with Parkwood Healthcare Ltd. on 31<sup>st</sup> August, 2014, and the contract commenced with the social enterprise Rotherham Healthwatch Ltd. on 1<sup>st</sup> September.

Rotherham Healthwatch would continue to deliver the service under the same terms and conditions as the previous provider using the original specification for the service and the existing staffing arrangements. All existing staff had been transferred to Rotherham Healthwatch Ltd. under TUPE regulations.

The report also set out performance for the first half of the year as well as future work for the remainder of the year.

As of yet it was not known whether there would be Government funding post-March, 2015. If funding was forthcoming it was the intention to recommission the social enterprise.

Discussion ensued with the following issues raised/clarified:-

- The contract was currently until April, 2015
- Healthwatch had also work on the Mental Health Review and the SEND Review
- The social enterprise had been fully aware of the risk of the possibility of no further funding when the contract had been signed
- The decrease in the number of volunteer hours and volunteers used during July

Resolved:- (1) That the setting up of the social enterprise Rotherham Healthwatch Ltd. be noted.

(2) That the termination of the contract with Parkwood Healthcare Ltd. and the transfer of the rights and obligations of the Healthwatch Rotherham Service to Rotherham Healthwatch Ltd. be noted.

(3) That the progress achieved be noted.

(4) That further updates be submitted in due course.

(5) That the reduction in the number of volunteer hours and volunteers used be referred to the Chief Executive of Rotherham Healthwatch Ltd. for comment.

(6) That the Board's congratulations be conveyed to those concerned in achieving social enterprise status and wished well for the future.

## **S28. VACCINATIONS AND IMMUNISATIONS FOR PREGNANT WOMEN**

Further to Minute No. S11. Dr. Julie Kitlowski, CCG, reported that agreement had now been reached and that midwives would be trained to give vaccinations but not until next year.

David Hicks, TRFT, stated that there were issues around training, resources and the timing of when vaccinations were due, however, it was the Trust's intention to implement the programme next year.

An action plan would be drawn up. It was imperative that any barriers to implementation were raised so agencies could work together and agree a way forward.

Fiona Jordan, Screening Officer, NHS, reported that a lot of work was carried out with GP practices and the hospital emphasising the need to increase the uptake of the Pertussis. There was a need to ensure that all pregnant women were offered the vaccination by their GP or midwife and that the statistics were captured of those who refused the offer. Weekly e-mails were sent to practices to reiterate the message.

Resolved:- That an update be submitted to the next Board meeting.

## **S29. DIABETIC RETINOPATHY SCREENING**

Jacky Mason, NHS England, reported that the NHS Diabetic Eye Screening Programme had been introduced to reduce the risk of vision loss in people with Diabetes. Everyone with Diabetes who was 12 years of age or over should have their eyes screened once per year to check for signs of Diabetic Retinopathy.

The joint Barnsley and Rotherham Programme was commissioned in 2007 and provided by Barnsley Hospital Foundation Trust. In line with the national trend, the diabetic population in Barnsley and Rotherham was increasing year on year. It currently had 27,707 registered patients 25,906 of which were eligible for screening. Those not eligible were managed in line with the national programme guidance and reviewed and validated every 3 months to ensure they still met the exclusion/suspension criteria.

The programme was currently commissioned on behalf of Public Health England via NHS England South Yorkshire and Bassetlaw Area Team to the national service specification for Diabetic Eye Screening.

Programme performance was reported nationally on a quarterly basis and also into the quarterly Programme Board. Any performance issues were escalated to the SYB Screening and Immunisation Advisory Group NHS England Public Health Commissioning Local Delivery Group and South Yorkshire Commissioners Group.

The programme in Rotherham was currently underperforming in some areas. These were being monitored by an action plan with a monthly update submitted to the SYB Screening and Immunisation Team.

The combined programme update was currently above the Public Health Outcomes Framework standard of 70% but below the stretch achievable target of 80%. Each individual programme showed a similar picture. In attempting to address, patients who had DNA had been surveyed and some of the findings acted upon including offering clinics at evenings and weekends.

All cancer and non-cancer screening programmes were subject to an external quality assurance review. The Barnsley and Rotherham review was planned for October, 2014 and would be the first programme in SYB to be quality assured in this manner.

Resolved:- That the report be noted.

### **S30. SPECIAL EDUCATIONAL NEEDS AND DISABILITY TRANSFORMATION**

Further to Minute No. 107 of 4<sup>th</sup> June, 2014, Donald Rae, Special Education Needs and Disability Strategic Lead, presented an update on the implementation of the Reforms to support children and young people with special educational needs and a disability.

The 'In It Together' event held on 4<sup>th</sup> July, 2014, had attracted over 500 parents and young people who were able to gather information from education, health and care providers and attend workshops to discuss how best to introduce a more personalised approach/how the new assessment model was developing. It is expected that it will become an annual event not least to ascertain the views of children, young people and parents about Rotherham's SEND Local Offer website.

The 2 key tasks required to be in place by 1<sup>st</sup> September had been met i.e.:-

- Rotherham's SEND Local Offer Website ([www.rotherhamsendlocaloffer.org](http://www.rotherhamsendlocaloffer.org)). The site aimed to provide as much information as possible within the site and not a link to other sites



- New assessment system for those with special educational needs and disability bringing together separate systems for early years, schools and colleges. SEN Statements and Learning Difficulty Assessments had been replaced by Education Health and Care Plans and a timetable had been published showing how the Statements would transfer to the new EHC Plan

The report also set out a range of actions that had been agreed by the Special Educational Needs and Disability Transformation Commissioning Group. Whilst some of the actions would be delivered quickly others were more long term reflecting that the transformation of services would take up to 3 years.

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

- The new working practice was much more focussed on what was best for the parent and the young person particularly those aged 16-25 years.
- A further major change was how the plans the plans were reviewed, how schools were involved, care professionals working in a different way and how the plan was progressing particularly as a young child became a young person
- The new model had to have the parent and young person at the heart and deliver what they wanted
- There had been implications for the training and supporting of staff
- The new care plans included input from all professionals that represented the needs of the individual
- The CCG was fully engaged with the new way of working
- There was an issue that health data tended to be 4-5 years out of date but work was taking place on how to gather information through the health system much earlier so that babies with complex needs and the implications thereof were known throughout the system
- The Joint Strategic Needs Assessment had a particular section containing all the SEND details and was monitored as part of the regular scheduled updates
- Rotherham's SEND Local Offer website was continually updated with any links to organisations of interest some of which were suggestions from parents. There was a danger of putting too many onto the website but if it came from a recommendation it was included
- The website had been built on the same platform as Connect to Support
- The new system allowed a much more open assessment with regard to how resources would be allocated and how much was available

Resolved:- (1) That the progress made be noted.

(2) That an update be submitted in 12 months.

**S31. DATE OF NEXT MEETING**

Resolved:- (1) That a special meeting be held on Friday, 24<sup>th</sup> October at 1.00 p.m.

(2) That a meeting of the Health and Wellbeing Board be held on Wednesday, 12th November, 2014, commencing at 1.00 p.m. in the Rotherham Town Hall.

**HEALTH AND WELLBEING BOARD**  
**Friday, 24th October, 2014**

**Present:-**

Councillor Doyle	Cabinet Member, Adult Social Care and Health <b>In the Chair</b>
Councillor Beaumont Robin Carlisle	Cabinet Member, Children and Education Services Rotherham CCG (representing Chris Edwards)
Tom Cray	Strategic Director, Neighbourhoods and Adult Services
Jason Harwin	South Yorkshire Police
Councillor Hoddinott Shafiq Hussain	Deputy Leader Voluntary Action Rotherham (representing Janet Wheatley)
Naveen Judah	Healthwatch Rotherham Ltd.
Martin Kimber	Chief Executive, RMBC
Carol Levell	NHS England Commissioning Body (representing Carol Stubbley)
Dr. John Radford	Director of Public Health

**Also Present:-**

Steve Ashley	Chair, Rotherham Local Safeguarding Children's Board
Chris Bain	RDaSH
Warren Carratt	Service Manager - Strategy, Standards & Early Help
Shona McFarlane	Director of Health and Wellbeing, RMBC
Phil Morris	Safeguarding Children and Families
Paul Theaker	Operational Commissioner

Apologies for absence were received from Louise Barnett and Carol Stubbley

**S32. QUESTIONS FROM MEMBERS OF THE PRESS AND PUBLIC**

There were no members of the press and public present at the meeting.

**S33. RESPONSE TO THE ALEXIS JAY REPORT ON CHILD SEXUAL EXPLOITATION IN ROTHERHAM**

At the request of the Chair, each partner reported as to the governance taking place within their organisation and what their respective priorities were in response to the findings of the Jay report:-

**Rotherham Local Safeguarding Children Board**

The Board Chair, Steve Ashley, reported that the Board was at the early stages of preparing an action plan in response to the Jay Report although the CSE Sub Group has incorporated the recommendations into its action plan. The outcome of the recent inspection from Ofsted was awaited and would impact upon the action plan currently being compiled. Urgent areas of work being undertaken were:-

- Auditing - the auditing process that the Board undertook to reassure itself that partners were fully engaged. There were now extra resources to increase the amount of auditing carried out. A thematic audit process had been put in place where audits would be repeated over a period of time until satisfied that the Board and partners were fulfilling its function e.g. auditing had commenced on cases where contact had been made through the “front door” and those that were determined “no further action required” as to whether those decision were correctly made. The findings would be reported on a monthly basis.
- Building contact with all the communities in Rotherham. Work had been commissioned as to how that would take place recognising that all partners were engaged in some form of community liaison so as to avoid duplication. There was a need to get on with this work urgently.
- The Board had considered the recommendations and has submitted a report requesting the development of a Needs Assessment and Commissioning Plan for a Post-Abuse Support Service. The Jay report had clearly highlighted that there could be anything up to 1,400 victims and it had been the original intention to try and identify as many as possible. However, this was not thought to be a practical course of action so there was a need for support to be available for when victims came forward. It was also important that there were plans and support in place for those victims who were now over the age of 18 and not just for current children and young people who were victims of CSE.
- There had been dialogue between the Chairs of the Safeguarding Adults Board and Local Safeguarding Children Board to ensure that they are working together to support young people through transition to adulthood.. It is imperative that any individual receives appropriate services throughout their lives and continued into adulthood.

### **Public Health**

Dr. John Radford reported on the overall provision that partners had put into place for post-abuse support.

- Needs Assessment – work was underway with the CSE Group and a set of indicators developed with the Framework of Need placed within the JSNA. The work would give an indication of need in the medium term as well as an indication of service performance in relation to people accessing that need. Performance measures in terms of waiting times for services and ensuring people were getting the services were required. Work was underway currently and would feed into the JSNA.
- A summary of the activity being undertaken currently in relation to the response to CSE. The interim Police and Crime Commissioner had invested an additional £80,000 for Independent Domestic Violence

Advisors.

- Allocation of funding:-  
 £20,000 to GROW to increase the capacity to support victims over 16 years of age in a family context  
 £20,000 to Rotherham Women's Counselling Service/Pit Stop for Men to increase specialist counselling  
 £20,000 to increase the CSE Small Grants Fund established in August, 2014, administrated by South Yorkshire Community Foundation  
 £49,000 additional capacity currently being commissioned through the voluntary sector through a tender process with a further £11,000 held in contingency  
 £53,000 allocated to Youth Start to increase capacity to support 7-25 year olds post-abuse support service  
 £200,000 allocated by the CCG to provide additional capacity to RDaSH
- Understanding from the CCG that there was a clear pathway for the referral for men/women with embedded sexual disfunction to be referred through to the specialist centre in Sheffield for counselling. The specialist psychiatric support could be accessed through a GP with no barriers to the service.
- Public Health would co-ordinate all services including the CCG, RDaSH etc.
- Funding had been allocated to the various services and it could be identified what the funding was for and what those services could and could not provide. For children it was clear that the referral was through a single point of access and that pathway needed to be cascaded to the NHS, Local Authority and voluntary sectors so everybody was clear.
- The second task was much more complex and needed to be done with some urgency and that was to establish a correct pathway through the system because people would vary in their need. Some adults would want recourse to justice and would require referral through SARC; some would need a pathway to individual counselling; some would need drug and alcohol services relating to sexual health issues
- "1 size fits all" may not be the best method of tracking to see where victims went and where they received the best access to services.

#### **RDaSH**

- Some of the CCG resources provided was to look at existing Service users who felt confident enough to disclose and ascertain how the Service was supporting them in their core services, how it responded to presenting new cases, ability to provide an immediate and fast

track response, monitoring the ongoing needs of individuals and interfacing with the Services already provided.

- There was a responsibility to support staff not only with regard to refresher training but how to respond in circumstances where an existing Service user may start to disclose issues not previously mentioned.
- All were being taken forward in conjunction with the CCG.
- Experience of those currently seeking support of the Service showed that the clients would decide when and where they sought support and resources needed to be flexible enough to provide.

### **RMBC Commissioning**

- The CSE Group has tasked the Head of Integrated Youth Support Service to look at co-ordination in terms of the immediate need from the “front door” to those services in terms of young people and adults.
- Youthstart funding for 1-1 counselling for young people.
- There would be a co-ordinator for both children and young people and adults coming through and speedily referred to the right Services.
- As part of the commissioning exercise, the starting point was an understanding of what post-abuse support could be provided and having a map of service provision.
- The map could be shared with partners to ensure there were no gaps in provision
- The JSNA needed to be strengthened in relation to CSE.

### **CYPS**

- A commissioning group had been established and building on the work referred to above in terms of co-ordination. It would also pick up on the voice and influence of victims, needs analysis, pulling information together from Services and had been given extra funding with a view to commissioning appropriate support as from 1<sup>st</sup> April, 2015.
- 1 of the biggest delivery vehicles with regard to prevention was Universal Services and Schools had been carrying out direct work with Y8 children to raise awareness of CSE and organised safeguarding sessions in all Rotherham schools. They were fully engaged and understood the referral process. CSE was also part of the tool kit.

**NHS England**

- Acknowledgement centrally that there had been some confusion around commissioning particularly for ongoing therapy services for adult victims.
- Input had been provided to the DoH for inclusion into a national report with regard to ongoing therapeutic support for adults.
- The DoH wanted some steer for commissioning arrangements on the new commissioning framework coming out next year.
- In the short term Margaret Kitchen had pulled together a Health Steering Group and the information gathered on the action plan would be followed to inform the work the CCG were carrying out

**CCG**

- Fragmentation of Health Services – it was the responsibility of the CCG refresh plan to put in place a plan which organisations could check the response for other organisations who can steer where resources lay
- If the Board had a criteria by which it assessed the submitted 2015/16 commissioning plans it could check that they addressed the totality of what was required for evident CSE

**South Yorkshire Police**

- Work needed to progress quickly.
- Although the funding was in place for additional Independent Domestic Violence Advisors there were a limited number of advisors nationally for the demand.

**Healthwatch Rotherham Ltd.**

- Healthwatch had an escalation process that it adhered to depending upon the severity of the case presented. In the first instance it would be referred to Safeguarding and then look at the other agencies.
- It could be escalated outside of the Borough dependent upon the severity if more than support was needed.

**Voluntary Action Rotherham**

- The information from the Jay report had been disseminated and considered by members and the Voluntary and Community Sector Consortia.
- A number of meetings had been arranged for organisations to understand the Jay report and provide support provided to post-abuse

victims. As a result of those meetings GROW and SYWS had waiting lists and increased demand.

- As well as the work looking at intermediate needs the organisation, from feedback from voluntary and community organisations, was clear about where the soft intelligence had been reported to, how it was being received, confidence of some of the victims coming forward and how they were being supported by the organisation. Accordingly, clarity was required on those pathways.
- Working with the Safer Rotherham Partnership and the Council in terms of CSE community awareness raising sessions. There was a programme of sessions that would be rolled out across the Borough.
- A conference around CSE awareness raising was to be held on on 4<sup>th</sup> November specifically targeted at voluntary and community organisations in Rotherham.
- Community cohesion and community engagement work with partners across the piste to support community engagement across all local communities.

#### **Rotherham College**

- There had been a full review of all safeguarding procedures and CSE awareness raising training. Dedicated work had been carried out around identification and introduction to the College to ascertain if there was more that the College could do to identify any historical cases and raise awareness of the issues around CSE.
- It was an important transition from childhood and College had a roll to play.

Discussion ensued with the following issues raised/clarified:-

**Given the list of funding being provided, how/who would monitor to ensure that the services were available and that victims were accessing them? The worst thing that could happen was partners leaving the meeting thinking funding was going into the services and working on an assumption that they turned themselves into services that victims needed and used. Would the Health and Wellbeing Board be responsible for monitoring and compiling an action plan illustrating what was available, how many victims the Services could deal with and ensure that the right services were being provided/used by victims?**

The funding had been allocated to groups as a short term measure. Work was needed to identify those organisations that had seen an increase of referrals since the publication of the Jay report and were responding to that need. It was very clear that there needed to be longer term planning for all partners.



**The funding was very short term and there was a need to identify organisations that had seen an increase in the number of referrals since the publication of the Jay report and were responding to that need. It was clear that there needed to be longer term planning for all partners. What would the services look like post-April, 2015?**

Currently it was not known who the victims would have the confidence in to make a disclosure and if they did, making the assumption that that Service could help for a particular period of time. As things progressed there would be more experience and the ability to advise as to which service had much better outcomes than others.

**Was there somewhere GPs could ring in to take advice about the different referrals routes?**

For existing victims of CSE the point of contact should be the Referral Team in CYPS which GPs were aware of. An area that would be reviewed and developed very quickly was the appropriateness and feasibility of a central point of contact for anything to do with a wide range of issues.

**How did the work fit in with the work of the Vulnerable Adults Risk Management Group?**

In the weeks immediately following the publication of the Jay report, Adults Social Care front door, Assessment Direct, had become very much more alert to the issues. When clients presented with complex needs the assessment now went beyond the presenting issues and through that process had started to identify those they believed could be victims of CSE. Furthermore, 2 very experienced Social Workers had been identified who would work in the Vulnerable Persons Unit so when referrals came through Assessment Direct and referred to the VPU, they would be risk assessed beyond the presented need. They could act as Key Workers and able to refer clients on to support more appropriate to their need and actually support them as they accessed the services such as SARC, GROW, Homeless Teams, RDaSH, DWP etc.

In the past young adults, 18-25 years, would have been assessed through Assessment Direct and the "signs" may not have been spotted. A more thorough assessment was now conducted to try and ensure that was not the case and appropriate case work and support was provided.

Since the additional staff had been placed in the VPU 17 clients potentially requiring further support services had been identified. It was important that this fed into the JSNA not just need for the services already identified but where there were gaps in service provision and lead to improved commissioning.

It was early days and it needed to fit into the emerging strategy. A proposed Vulnerable Adults Risk Management Framework was to be submitted to Cabinet Member.

**It was key that the funding followed the victim and the support of**

**their choice. It was also essential that older teenagers did not fall through the gaps when they crossed over from Children's Services to Adult Social Care. Were the Services flexible enough to deal with that?**

The importance of the funding following the victim was acknowledged but also, as the processes were developed, it would be equally as important to establish where the best outcomes were and assist the client in assessing whether or not a different service would be better for them.

**Was there sufficient capacity in the voluntary sector?**

No organisation was saying they were fully resourced and had all the resources they needed, however, it was important that the resources should follow the victims. Agencies needed to understand who the victims were and their needs to ensure they were being signposted to the most appropriate service. More information was required in terms of the post-abuse victim, the current work and the preventative work. The Voluntary and Community Sector did a lot of preventative work on how CSE occurred and how it could be prevented.

The Safeguarding Board made training available free at the point of access and had trained officers from the voluntary and community sector who delivered CSE training. E-learning was also available.

**Were all Rotherham schools actively engaged?**

Every school in Rotherham was engaged in the CSE agenda and their safeguarding responsibilities. Should a school not engage it would be escalated quickly and also referred to the Safeguarding Children's Board.

**With regard to Schools and the preventative agenda, what was contained in the CSE training and did it include online grooming?**

In addition to the direct work from the CSE Team, the Healthy Schools Adviser worked to embed the DHSE curriculum which covered sexual relationships. To also assist, every secondary school had a Police Officer who work across the 16 secondary schools and were on site to provide advice and support to the teaching staff.

The arrangement also included MyPlace etc.

Over the age of 10, Crucial Crew was part of Rotherham School's curriculum of which internet safety formed part of.

**Were there arrangements in place for those children who were not in school?**

The Education Welfare Service was a key partner in terms of being the "eyes" for those children at risk of CSE. 1 of the Team Leaders was a CSE Champion. There were also links with the Elective Home Education Team who would assess situations where children were being taught in the home environment rather than in school. There was no such legal concept as a part-time timetable and the Series Case Review outlined the dangers of children being out of school on a part-time basis. A lot of work

was carried out in Schools to identify where that practice was in place and to challenge that. The advent of Academisation was more problematic when the Authority was not part of the reporting structure, however, the Education Welfare Officer support function still existed and they were challenged.

The new Director of Safeguarding had successfully secured agreement for a dedicated post in the Safeguarding Team to have oversight of Missing Children and Runaways which was an area the Police had been looking at for some time.

**When would a report be submitted on pathways?**

It was hoped that a document would be available by the end of the following week on the structures of Services and contact numbers.

Other work in terms of the JSNA and the Needs Assessment would take a little longer but hopefully by the end of November.

It was noted that the governance arrangements would need to be considered by the CSE Sub-Group initially.

**It had been stated that CSE should be more prominent in the Board's priorities. Did the Board need to add a 7<sup>th</sup> priority or highlight that Safeguarding was a priority, of which CSE was prominent, that ran through all 6 priorities?**

- The Board should give it prominence, not as an activity, but ensure that it was clear through the commissioning strategy that commissioning against the JSNA which identified CSE as a key priority for Service delivery.
- The Board should identify a unique contribution it could make and capable of being held to account for it. It was important that outsiders could see what had been delivered and construct a governance that the dynamic relationship contributed to the outcomes it needed to achieve
- CSE would be a thread running through the Health Commissioning Strategy from what was identified in the JSNA and various parts of the commissioning i.e. Children's, Mental Health and Safeguarding.

The additional functions of the Board also needed to be highlighted.

**Was the Protocol between the Rotherham Local Safeguarding Children Board, Health and Wellbeing Board and the Children, Young People and Families Strategic Partnership still relevant?**

It was fit for purpose and compliant with Working Together 2013 statutory guidance. However, it needed to be very clear who held who to account. Steve Ashley stated that the Local Safeguarding Children CSE was the statutory responsibility of the Local Safeguarding Children's Board which would be much more aggressive in terms of holding the agencies who are members of the LSCB to account. The relationship between the two Boards had to be stronger and, although the Board may not wish to add a

further priority, it was suggested that a formal statement be included when the Health and Wellbeing Strategy was reviewed of the intention for CSE to be one of the major priorities over the coming year.

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

(2) That discussions take place between the Chairs of the Health and Wellbeing and Local Safeguarding Children Board with regard to the way forward.

(3) That the Needs Assessment and Pathways document be distributed to all partners by e-mail once completed.

(3) That the Health and Wellbeing Board's website be updated as a matter of urgency.

**S34. DATE OF NEXT MEETING**

Resolved:- (1) That a meeting of the Health and Wellbeing Board be held on Wednesday, 12th November, 2014, commencing at 1.00 p.m. in the Rotherham Town Hall.

<b>ROTHERHAM BOROUGH COUNCIL – REPORT TO CABINET MEMBER</b>
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<b>1.</b>	<b>Meeting:</b>	<b>Cabinet Member for Adult Social Care and Health</b>
<b>2.</b>	<b>Date:</b>	<b>17 November 2014</b>
<b>3.</b>	<b>Title:</b>	<b>White Ribbon Campaign</b>
<b>4.</b>	<b>Directorate:</b>	<b>Neighbourhoods and Adults Services</b>

## **5. Summary**

The White Ribbon Campaign Award is for Towns to demonstrate their commitment to the aims of the White Ribbon Campaign (WRC). To achieve White Ribbon status requires a commitment by partners across Rotherham Borough to involving men in sending a clear message that Domestic Abuse against women will not be tolerated. In particular involving men in preventative activities, addressing and altering social norms that lead to violent behaviour against women, increasing awareness on the issue and providing services aimed at reducing domestic abuse. The WRC claims that by mobilising men the anti-violence against women and girls (VAWG) message increases in effectiveness and reach and mobilises the entire local community under the goal of ending violence against women and girls.

An action plan, demonstrating the towns commitment to reducing domestic abuse, has been developed with the Partnership Violent Crime Forum and Domestic Abuse Priority Group (DAPG).

On the 30<sup>th</sup> October 2014 the plan was approved as ‘Excellent’ by the White Ribbon campaign Director and Rotherham has been provided ‘White Ribbon Status’.

## **6. Recommendations**

- **Cabinet Member endorses and supports partnership commitment to achieving the aims of the White Ribbon Campaign.**
- **The work is driven by Chief Inspector Ian Womersley inconjunction with the DAPG and Partnership Violent Crime Forum.**
- **A joint media strategy is developed between RMBC, Police and RUFC.**
- **RMBC celebrate the White Ribbon Status with the flying of a White Ribbon flag during the International WRC period 25<sup>th</sup> November to 10<sup>th</sup> December 2014.**

## **7. Proposals and Details**

Rotherham joins over 40 towns and local authorities who have gained the nationally recognised WRC Town Award. The Award demonstrates our commitment to reducing violence against women and girls.

Every year three million women and girls experience rape, domestic abuse, sexual exploitation, forced marriage, stalking and honour crimes in the UK. The vast majority of this violence against women is perpetrated by men. Violence Against Women continues to increase across Rotherham and the perception of such violence is even greater following recent high profile events.

The campaign raises awareness that most men are not violent towards women, but many of them ignore the problem, or see it as something which doesn't have anything to do with them, it advocates that men need to join women and women's organisations in taking action to end the problem. This campaign is about men saying it to other men.

The action plan developed by the Borough has been created in conjunction with many private and public partners. The partners involved include: South Yorkshire Police, RMBC, RUFC, Integrated Youth Support Services (IYSS), YMCA, Licence Watch, Interchange, Door Security, NHS Hospital and Doctors Surgery, Wilmott and Dixon, Street Pastors, Apna Haq and the Community Rehabilitation Company. Seven managers from these partners have put themselves forward as White Ribbon Ambassadors for Rotherham.

A number of events and campaigns have been planned from November 2014 onwards including: IYSS 'Rock against DA', RUFC v Blackpool 'Dedicated White Ribbon match', NHS 'White Ribbon Community Corner', All Licensees and Door Security conducting promotional events, Wilmott and Dixon displaying WRC van stickers and a wide media campaign across partners and communities.

The plans also build on the innovative work being driven through Rotherham Police and DAPG to reduce the reoffending of DA perpetrators, through an offender management programme. With reductions in reoffending of over 75% this work is being rolled out across SYP and has been shared with the College of Policing.

## **8. Finance**

The cost of application to become a White Ribbon Town and purchase of WRC merchandise has been approved through JAG.

## 9. Risks and Uncertainties

Domestic abuse is a key priority across the partnership and one of the four identified priorities of SRP. By not ensuring increased awareness of Domestic Abuse and healthy relationships we will find it difficult to:

- Evidence that Domestic Abuse features in strategic frameworks
- Increase confidence of the Public in reporting Domestic Abuse and accessing support
- Evidence its compliance with the Home Office's national agenda to Eliminate Violence Against Women and Girls
- Evidence or commitment to the "Prevent" agenda – "We will make it more difficult for domestic abuse to happen"

## 10. Policy and Performance Agenda Implications

Community Strategy -Support the most vulnerable in our communities

The Performance Management Framework and Action Plan for Domestic Abuse

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

"We will work with partners and communities including local businesses to ensure that they have an increased awareness of Domestic Abuse and healthy relationships so that they can respond appropriately regardless of the level of risk, domestic or non-domestic setting and any form of abuse e.g. "honour" based abuse, forced marriage, harassment, stalking, sexual violence etc."

## 11. Background Papers and Consultation

- Domestic Abuse Strategy: Violence Against Women and Girls
- Performance Management Framework and Action Plan for Domestic Abuse

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Police Chief Inspector  
(Chair Partnership Violent Crime Forum)

<b>ROTHERHAM BOROUGH COUNCIL – REPORT TO MEMBERS</b>
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1	<b>Meeting:</b>	Cabinet Member for Adult Social Care and Health
2	<b>Date:</b>	17 November 2014
3	<b>Title:</b>	Independent Mental Health Advocacy Service (IMHA) - 2015/16 Commissioning Intentions
4	<b>Directorate:</b>	Neighbourhoods and Adult Services

## 5. Summary:

- 5.1 The IMHA (Independent Mental Health Advocate) service was previously commissioned via a Primary Care Trust (PCT) competitive tender process in 2010 to cover the Rotherham and Doncaster area using special grant funding from the DH. Contract commencement was 1<sup>st</sup> October 2010 for 3 years with the option to extend to June 2015 subject to performance and quality.
- 5.2 The current combined envelope for the contract is £116,100.00, and the Rotherham commitment is £52,028.
- 5.3 The DH transferred IMHA Grant funding from NHS bodies to Local Authorities in April 2013. The former PCT contract was novated across to the Local Authorities (Rotherham and Doncaster) at that time, and Rotherham MBC took the commissioning role for the partnership. Following the extensions allowed, the current contract is due to end on 30<sup>th</sup> June 2015.
- 5.4 The Council will not receive confirmation from the DH that it intends to continue to fund this service in 2015/16 until December 2014, though there is a high likelihood that it will remain a priority for DH.
- 5.5 This paper explains the circumstances that relate to the IMHA service in paragraph 7, and outlines a number of critical actions to be taken before a tender can be progressed.
- 5.6 In consideration of these, this paper recommends an extension to the existing contract to 30<sup>th</sup> September 2015.

## 6. Recommendations

Cabinet Member is asked to:-

- **Note the content of the report.**
- **Approve the extension of contract by as detailed in 9.1 to 30<sup>th</sup> September 2015.**



## **7. Background**

### **7.1 Independent Mental Health Advocacy Service**

An IMHA (Independent Mental Health Advocate) is a specialist type of mental health advocate, granted specific roles and responsibilities to undertake duties under the Mental Health Act 1983, and funded through a DH special grant (Local Reform and Community Voices Grant). IMHAs help 'qualifying patients' understand the legal provisions to which they are subject under the Mental Health Act 1983, and the rights and safeguards to which they are entitled. Commissioning arrangements should, as far as possible, ensure that IMHA services are operationally independent of health and social care providers. IMHA activity is recorded on a DH database and reported independently to DH.

7.2 A contract for IMHA Services was first commissioned via a PCT competitive tender process in 2010, to cover the Rotherham and Doncaster area. The service was new in 2010, and uptake and awareness has developed slowly over the period of the contract. Contract commencement was 1<sup>st</sup> October 2010 for 3 years with the option to extend for a further 1 year and 9 months, subject to performance and quality.

7.3 IMHA funding was transferred from Rotherham PCT and Doncaster PCT in April 2013, and the contract was novated to Rotherham MBC, which assumed the lead commissioning role. Following the extensions allowed, the contract is due to end on 30<sup>th</sup> June 2015.

7.4 There was a delay in commencing re-tender of this service due to the need to establish funding continuation and partner funding intentions, and also to identify the responsible body for commissioning of IMHA services at secure mental health units including Wathwood Hospital, which is in the Rotherham borough.

7.5 The Performance and Contracting Team at Nottinghamshire Health Care confirmed in September that they will commission IMHA services at Wathwood Hospital as part of their regional specification for MH secure units.

7.6 Since 2013 the Commissioning Team has monitored the IMHA service, provided by Cloverleaf:

- Over 3 years the IMHA service in Rotherham has seen a rise in the number of IMHA referrals, and this was reflected in an increased allocation by DH from April 2013.
- Referrals to the Doncaster service follow a similar pattern.
- There is capacity within the contract to respond to non-statutory advocacy requests, and the ratio of activity is 90% IMHA referrals, to 10% generic mental health advocacy referrals.
- Better Care Fund principles, embedded in the Rotherham submission in September 2014, require the Council and RCCG to take into account the mental health needs of people using services: to make services available for people presenting to NHS services in emergencies, and to ensure that

services which support people with mental health problems are protected. The current IMHA service is well placed to measure the impact of the BCF reforms on mental health service users and to give a valuable independent view on the transition to new arrangements.

- The current provider is of the view that the IMHA service provides a valuable bridge to advocacy access for 'non-qualifying' patients who might otherwise receive no independent advocacy support.
- The current service is highly valued by customers and well regarded by the Mental Health Trust (Rotherham and Doncaster NHS Foundation Trust, which is the main referral source).
- It is expected that funding specific to this service will be available from DH in future years but this will not be confirmed until December 2014. Doncaster MBC are unable to commit to tender a new service until this time.
- RMBC Commissioners are reviewing the need for both IMCA (Independent Mental Capacity Advocacy) and IMHA services following the 'DoLS Supreme Court Judgement in March 2014 and will need to tailor future provision to meet the increased demand.

#### **Summary of IMHA Activity (Rotherham)**

	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014 to date</b>
<b>Referrals</b>	300	314	342	415

## **8. Considerations**

- 8.1 The existing IMHA contract expires in June 2015. Best practice requires us to give reasonable notice of our commissioning intentions, as the service provides a specialist function and requires trained and qualified personnel.

Before the service can be re-commissioned the following will be considered:

- Need to confirm strategic and financial commitment by DH to this service – by December 2014.
- Analysis of the current and projected IMHA activity and general mental health advocacy activity across the whole health and social care community and in the context of the Better Care Fund Action Plan and the Care Act implementation - and the principles of “parity of “esteem”; and “no health without mental health”.
- The feasibility of amalgamating neighbouring IMHA services, including those that deliver to low/medium/secure services and specialist hospitals to create a sub-regional service.
- The need to reconfigure local services based on the emerging picture of increased need.

## **9. Recommendation**

9.1 Cabinet Member to formally waive Council Financial Regulations and allow extension of the current IMHA contract for a period of 3 months from 1<sup>st</sup> July 2015 to 30<sup>th</sup> September 2015. This would allow a full 12 month commissioning exercise:

- Analysis of current provision (need/demand/gaps analysis) and factor in the requirements of the Better Care Fund Work Programme
- Joint work on establishing need with Rotherham CCG and other partners.
- Consider options for amalgamation of provision sub-regionally – using existing mental health commissioning networks.
- Benchmarking of activity and demand with other LAs.
- Formal and in-depth consultation with service users
- Complete Equality Analysis
- Development of revised and enhanced service specifications
- Tender process – PQQ, ITT, Evaluations.

9.2 It is recognised that commissioning through partnership arrangements with other LAs or health partners, and/or commissioning for highly specialist or complex services can extend the procurement time by 3-6 months. We need to work with Rotherham CCG; the Mental Health Trust; Doncaster MBC; and Doncaster CCG to optimise the service specification and allow for a good response to tender.

9.3 The timescale for this work will be around 12 months.

## **10. Finance**

10.1 The cost of the block contract is £106,412.60 with an overall envelope allowing the purchase of additional activity up to £116,100 p.a.. The Council contribution is £52,028.

10.2 The Council receives income from the DH: Local Reform and Community Voices Grant for this service; and receives income from Doncaster MBC of £54,384.60 - £64,072.00 p.a. depending on the need to pay for additional activity.

10.3 The Council needs to seek confirmation that the funding will be available from DH and that Doncaster are committed to work in partnership commit to fund its element of service in a refreshed Memorandum of Agreement.

## **11. Risks and Uncertainties**

11.1 Failure to deliver IMHA services effectively will leave the Council in breach of its current statutory duty to provide formal and specialist advice to people detained under MHA 1983.

11.2 Failure to provide effective specialist mental health advocacy services that align with the BCF Work Programme may lead to failure to achieve published outcomes.

- 11.3 Failure to provide effective specialist mental health advocacy services during transition to the Care Act will leave the Council in breach of its future statutory duties.
- 11.4 Failure to appropriately procure services, with formal approval from Cabinet Member to waive, will breach the Council Financial Regulations and Standing Orders.

## **12. Policy and Performance Agenda Implications**

Services contribute to the Corporate Plan:

- CP4 Helping people to improve their health and wellbeing and reducing inequalities within the borough.
- CP2 Protecting our most vulnerable people and families, enabling them to maximise their independence.

They are also linked to the following Council Strategies:

- Health and Wellbeing Strategy
- Better Care Fund Action Plan
- Care Act Implementation

## **13. Background Papers and Consultation**

Contract Information can be viewed on request.

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<b>ROTHERHAM BOROUGH COUNCIL – REPORT TO CABINET MEMBER</b>
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1	<b>Meeting:</b>	Cabinet Member for Adult Social Care and Health
2	<b>Date:</b>	17 November 2014
3	<b>Title:</b>	The transfer of Independent Living Fund (ILF) support and funding to Local Authorities from 30 June 2015
4	<b>Directorate:</b>	Neighbourhoods and Adult Services

## 5 Summary

The Independent Living Fund (ILF) was established by the Government in 1988 as a charitable trust. It makes payments to disabled people on low incomes who have to pay for personal care – it is the forerunner of Direct Payments and personal budgets. The maximum ILF award is £475 per week.

The Government originally announced its intention in 2013 to close the ILF from April 2015 and transfer funding and responsibilities to Local Authorities. The closure programme was stopped, however, due to a Court of Appeal ruling regarding the Government's administration of the process. This has now been resolved and in March 2014 the relevant Minister announced that the ILF would close on the slightly later date of June 30<sup>th</sup> 2015 and a new closure programme would be launched with immediate effect.

There are currently 105 Rotherham ILF users (the ILF has been closed to new applicants since 2010 and the number of recipients has, therefore, decreased slightly each year since then). 62 people are known to the Learning Disability Service; the remainder are known to other adult social care teams. This change to ILF funding now requires local authorities to determine their policy on this matter prior to implementation of the changes in 2015.

## 6 Recommendations

- **That Cabinet Member considers the options available for the administration of ILF following the 2015 transfer to the Local Authority and recommends endorsing Option C together with maintaining the necessary support for Supported Living.**

## 7 **Proposals and Details**

All ILF users have received information about changes in their future funding. In recent months ILF administrators have been jointly reviewing each user with a social worker from the Local Authority to give clear information about their future funding. It is expected that all these reviews will be completed by the end of this calendar year.

ILF policies on deciding funding packages are different to Fairer Access to Care Services (FACS) criteria. Frequently the ILF pays for 'desirable' elements of care whereas FACS cannot. There are also significant differences between ILF rules on user contributions to support packages and Fairer Charging.

It is likely that many ILF users will face a reduction in support funding if FACS was applied across the total care package. In many instances users have received high levels of ILF funding for desirable, rather than essential, elements of support.

There are 33 people with a learning disability in supported living schemes, however, who receive ILF funding for a significant proportion of their care package. To continue in supported living the ILF funding will need to be replaced by revenue funding from the Local Authority.

### **Two examples of how ILF money is used**

#### *Carl – living in the community with his family*

Carl is 47 years old and has learning and physical disabilities. He lives with his elderly mother who is now in poor health. He goes to a day centre for 5 days per week and has 84 nights of respite care. He also receives £400 from the ILF each week. This pays for 54 hours of support at £7 per hour and 2 nights of support at £30. He contributes £38 to his ILF package (half of his DLA care).

Although some of the 54 hours funded by ILF are for Carl's personal care, a significant proportion are for recreational and community activities. His current indicative budget is £769 and the cost of his day and respite services is £756. At least some of his ILF package could therefore be seen to be 'desirable' not 'essential'.

#### *Peter- supported living tenant*

Peter is 42 years old and has learning and physical disabilities. He has lived in a supported living scheme for 10 years as both his parents were in poor health. He goes to a day centre 5 days per week. He receives £470 from the ILF each week and contributes £87 towards his ILF package (half of his DLA care and his Severe Disability Premium as it is in payment).

The Learning Disability Service funds £220 towards Peter's care in the supported living scheme and his ILF monies pay the remaining cost. His current indicative budget is £803. If ILF was not in payment the Learning Disability Service would have to fund the full supported living cost.

### **Options appraisal**

*For customers in the community*

**Option A** - Replicate existing funding packages by replacing ILF with a Direct Payment. Customers will be happy and this would be relatively easy to administer. However this would replicate what is already a two tier system and there may be challenges from customers who did not previously receive ILF money.

**Option B** - Replicate existing funding packages but agree a phased reduction over a fixed period. There are likely to be fewer complaints and customers can make a more gradual adjustment to the loss of funding. However this is potentially a very complex administrative process for the Local Authority.

**Option C** – Assess everyone under FACS criteria and award funding accordingly. Whilst this is probably fairer it will cause hardship and/or some significant readjustments of lifestyle for some very disabled people and their carers. Complaints are likely to be high.

*For people in supported living schemes*

To allocate an appropriate amount into the Supported Living Budget to allow these placements to continue. The alternative would be significantly more costly and inappropriate residential care placements.

## **8 Finance**

The total Rotherham ILF income for the 105 people is approximately £2 million per year. ILF users also typically contribute £35 – 90 per week towards the cost of their support packages, based on ILF rules, not Fairer Charging rules.

Currently the ILF offsets the supported living budget of the Learning Disability Service by approximately £830,000 pa. In addition, supported living tenants contribute about £144,000 pa towards their ILF packages. It is unlikely that they would pay this level through Fairer Charging and therefore any reduction in client contributions would lead to additional costs to the LA of approximately £40,000. This will need factoring into forthcoming reviews of Supported Living scheme costs. However, it may be that potential reductions in other care packages (if Option C is adopted) would offset any additional costs in Supporting Living.

The funding for ILF will be transferred to Local Authorities from 1 July 2015 and indications are this will not be a ring fenced grant. The level of funding will be based on 2014-15 allocations adjusted by approx 5% to take account the estimated reduction in clients.

## **9 Risks and Uncertainties**

Transfer funding from the ILF will not be ring fenced to Adult Social Care. Each Local Authority will be able to decide themselves how the funding is distributed. As a result any customers losing ILF are potential complainants to the Local Authority about changes to their funding.

Any reduction in funding to an ILF claimant will impact upon their lifestyle. ILF users are people with significant needs who require high levels of support. Potentially there will be cases presented to the local media which may be damaging to the reputation of the Local Authority.

ILF recipients will be facing these potential changes to their funding at the same time as the Welfare Reform changes have begun impacting upon their overall benefits. There some customers who are also facing reductions in their respite care provision and some leisure or employment support services from MENCAP as a consequence of RMBC's need to make savings this financial year.

Some customers and/or their carers may seek to challenge reductions in funding through the legal process.

## **10 Policy and Performance Agenda Implications**

How the Local Authority decides to communicate its policy regarding the transfer of ILF funding to customers will need careful consideration. To date, the only information ILF customers have received has been from the ILF itself. They are awaiting the Local Authorities policy on this transfer. There is now an urgency to formulate this policy to avoid confusion and allow preparation for customers and services alike.

Social workers will absorb ILF reviews with the normal annual review. This will make reviews potentially more challenging and thus be a more time consuming process.

Any increase in formal complaints and/or legal challenge will be costly in staff time.

## **11 Background Papers and Consultation**

- ILF Website: [www.dwp.gov.uk/ilf](http://www.dwp.gov.uk/ilf)
- Includes transfer information and booklets for customers
- 'Transfer review programme: Code of practise' – as agreed by ILF, ADASS and LGA.



**12 Examples of potential impact of changes on customers attached.**

Document with examples attached.

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**Examples of use of ILF monies****C**

C is 47 years old and has severe learning disability, cerebral palsy and quadriplegia. He lives with his elderly mother who is now in poor health and cannot provide any of his care. He goes to a day centre for 5 days per week and has 84 nights of respite care funded by the LA. He does not have any Continuing Health Care needs. Family also currently provide a high level of informal support, and his sister is his ILF support worker.

His ILF funding pays for an additional 54 hours of support and 2 nights of support. The ILF worker also provides transport to/from his day service.

C therefore receives a total of 188 nights respite per year paid by the LA and the ILF; this is 3 or 4 nights per week.

**Impact:** On information gathered it would seem likely that without the current level of support C would be unable to remain at home with his mother, and alternative support would be required.

It is estimated that the LA would need to take on 100% of the ILF funding.

Current LA contribution for C	ILF package	Estimated Future LA contribution if no ILF
£471.72	£473.50	£945.22

**W\***

W is 44 and has a learning disability. He lives with his parents. The long term family plan is for him to live with his sister in the future. He goes to a day centre 5 days per week, and has a Direct Payment to have respite one night per week at his sister's home, as well as 6.5 hours from a PA to support recreation and leisure. He does not have any Continuing Health Care needs.

His ILF funding pays for an additional 30 hours of support and one respite night at his sister's per week. In addition the ILF fund 112 hours of support for 3 weeks a year, during day centre closures.

W therefore receives a total of 94 nights respite per year paid by the LA and the ILF; this averages at almost 2 nights per week.

**Impact:** On information gathered it is not felt that the current level of support would be reasonably offered by the LA. Based on the level of need identified, the package would need to be reduced. This would impact on W's current life style; however the package also needs to support parents' employment, so there would need to be some increase in funding from LA.

It is estimated that the LA would need to take on 50% of the ILF funding.

Current LA contribution for W	ILF package	Estimated Future LA contribution if no ILF
£357.53	£286.01	£ 500.53

**L**

L is 27 and has a learning disability, autism and epilepsy. She lives with her parents who both work. She goes to a day centre 5 days per week and has respite for 38 nights per year funded by the LA. She also has a Direct Payment of £56.25 per week for a PA. She does not have any Continuing Health Care needs.

The ILF pays for an additional 30 hours each week to support leisure activities.

Impact: It is felt that the 30 hours of support from ILF would need careful examination and some may be eligible to be provided by LA. This is because both parents work and have stated that without current levels of support, they do not think they could manage to continue to support her. The impact to L would be less leisure activity support outside day services.

It is estimated that the LA would need to take on 75% of the ILF funding.

Current LA contribution for L	ILF package	Estimated Future LA contribution if no ILF
£374.27	£422.84	£691.13

**J**

J is 26 and has a learning disability and Prader-Wili syndrome (a life threatening eating disorder). Due to this he needs constant support and supervision. He lives with his parents, and younger siblings. He has a Direct Payment for 10 hours of community support and activity costs, and 70 nights of respite (with 1:1 support, 36 hours over 10 weeks) per year funded by the LA. He does not have any Continuing Health Care needs.

The ILF pays for 29 hours of support each week from a specialist service. The support enables J to access community facilities, social/leisure opportunities and to support him in his work placement.

Impact: Without the full care package there would be a significant impact on J's quality of life and his parent's ability to continue to care for him. Alternative specialised support would need to be sought.

It is estimated that the LA would need to take on 100% of the ILF funding.

Current LA contribution for J	ILF package	Estimated Future LA contribution if no ILF
£610.11	£488.36	£1,098.47

**M**

M is 43 and has a learning and physical disability. She lives with her mother. She goes to a day centre 4 days per week and has 34 nights of respite per year funded by the LA. She does not have any Continuing Health Care needs.

The ILF pays for 14 hours of support per week for access to community and carer support.

Impact: It is felt that the 14 hours of support would need careful examination and not all may be eligible to be provided by the LA; there may need to be some minor increases in funding from the LA to support the carer. She feels that without the additional support the impact on both their lives would be great. The impact to M would be fewer leisure activities outside day services.

It is estimated that the LA would need to take on 25% of the ILF funding.

Current LA contribution for M	ILF package	Estimated Future LA contribution if no ILF
£349.50	£306.55	£426.13

## P

P is 37 and has a learning disability. He lives with his mother. He goes to a day centre 5 days per week and has 59 nights of respite per year funded by the LA. He does not have any Continuing Health Care needs.

The ILF pays for an additional 35 hours of support per week.

Impact: It is felt that the 35 hours of support from ILF would need careful examination and most may not be eligible to be provided by LA. His mother has stated that the above package is the only way she can continue to support P. If support is reduced the impact on P would be fewer leisure activities outside day services, and he may possibly need alternative support.

It is estimated that the LA would need to take on 75% of the ILF funding.

Current LA contribution for P	ILF package	Estimated Future LA contribution if no ILF
£513.62	£359.51	£783.25

## G

G is 42 and has a learning disability and autism. She lives with her mother. She goes to a day centre 5 days per week and has 40 nights of respite per year funded by the LA. She does not have any Continuing Health Care needs.

The ILF pays for an additional 19.5 hours of support per week.

Impact: It is felt that the 19.5 hours of support from ILF would need careful examination and not all may be eligible to be provided by LA; there may need to be some minor increase in funding from LA to support personal care to G and to support the carer. The impact to G would be fewer leisure activities outside day services. Without the ILF support the need for alternative care may become more urgent if the carer cannot fill gaps from any reduction to support.

It is estimated that the LA would need to take on 50% of the ILF funding.

Current LA contribution for G	ILF package	Estimated Future LA contribution if no ILF
£409.71	£264.98	£542.20

<b>ROTHERHAM BOROUGH COUNCIL – REPORT TO CABINET MEMBER</b>
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<b>1.</b>	<b>Meeting:</b>	<b>Cabinet Member for Adult Social Care and Health</b>
<b>2.</b>	<b>Date:</b>	<b>17 November 2014</b>
<b>3.</b>	<b>Title:</b>	<b>Restructure of Enabling and Out of Hours Service</b>
<b>4.</b>	<b>Directorate:</b>	<b>Neighbourhoods and Adult Services</b>

## **5. Summary**

The purpose of this report is to set out a proposal for a restructure which brings together three strands of work: social work out of hours service, Better Care Fund service developments and the current enablement service. The vision is to strengthen our existing structures to ensure that Rotherham is able to provide a modernised enabling service which maximises individual's independence, provides a more robust 7 day social work response and aligns services with changes proposed in the Better Care Fund plan. In addition the changes will provide additional capacity across a number of other parts of the service.

## **6. Recommendations**

It is recommended that Cabinet Member notes the proposal to combine three current priorities improving and streamlining our current enabling offer, developing a Better Care Fund fast response social care offer and improving the current out of hours response and notes the revised structure which:

- **Increases social work capacity across the department through additional resources deployed over a 7 days a week**
- **Addresses some of the difficulties experienced though current out of hours provision and contributes to the Better Care Fund priorities around 7 day working**
- **Refocuses our enablement offer to improve outcomes for customers, provide a more streamlined service and increase the number of customers offered enablement.**

It is recommended that Cabinet Member notes the progress to date on this proposal:

- **External recruitment has commenced for 4 additional social workers (three funded from better care fund, one funded from a re-direction of an existing HEO vacancy) to provide the social work enablement role.**
- **Permanent recruitment to the Enabling Manager Post (currently Home Enabling Manager) has commenced**
- **Consultation on the proposal is well underway and transitional arrangements for closer working of enabling and out of hours has started.**

## 7. Proposals and Details

The purpose of this report is to set out a proposal for a restructure which brings together three strands of work: social work out of hours service, Better Care Fund service developments and the current enablement service. The vision is to strengthen our existing structures to ensure that Rotherham is able to provide a modernised enabling service which maximises individual's independence, provides a more robust 7 day social work response and aligns services with changes proposed in the Better Care Fund plan. In addition the changes will provide additional capacity across a number of other parts of the service.

The current position for each of these areas is outlined below:

### **Social Work out of Hours Service**

The current social work out of hours service runs from 5pm to 10pm on weekdays and from 8am to 10pm at weekends. The remit of this service is to address any urgent social care issues which cannot wait for the following working day. Out of hours calls are answered by Rothercare and messages taken. These calls are passed through to a duty social worker or SSO. This is a rota of all adult social care assessment and care management staff who undertake this duty as part of their working week. Two workers are always on rota in case a high risk visit is required. A manager is on call to provide advice for complex issues.

A review of the current system was undertaken by performance and quality team earlier this year. The review noted a number of weaknesses in the system including lack of screening of out of hours calls, gaps in provision due to sickness and annual leave and fundamentally a lack of buy-in to the current system at all levels. Feedback was a preference for a stand-alone team of social workers. Managers expressed a preference for on-call to be recognised as part of their working week.

### **Better Care Fund Plan and Fast Response**

The Better Care Fund sets out joint Council and NHS priorities. A prominent feature of this is a move to 7 day working across all disciplines with a string emphasis on avoiding hospital admissions.

To meet these outcomes the plan provides funding for four additional social work posts. The intention of these posts was to provide an integrated fast response service with the NHS which would operate 7 days a week however looking at the social care elements suggested that whilst there is a social work role there would be insufficient work to justify dedicating resources solely to this team.

### **The Enabling Service**

The enabling service is a registered service that operates a "free" home care support provision for six weeks prior to assessment, with a view that during this period social care needs can be removed or reduced. Packages of support are set up and organised by a Home Enabling Officer (HEO) who tracks customer progress and reviews packages. Individuals who have eligible social care needs at the end of the enablement period are referred to a SSO for a full assessment and appropriate support

package. Care Coordinators plan and deploy the front line staff who provide the hands on support to customers.

There are some difficulties in the current system. Enabling outcomes, rather than provision of care, need to be re-emphasised throughout the team and a coaching package of support is planned to address this. Planning and deploying of resources needs to be more efficient and there is a capacity issue at HEO level for taking on new packages following a number of year on year budget reviews. There is also a duplication between the work undertaken by the HEO and the assessment and care management role.

The enabling service has reduced incrementally over the years and there is a need to provide further efficiencies to meet budget pressures.

### **The Proposal**

The proposal is to reshape the current enabling service to include social work capacity as part of the management of the service delivery. The new service will concentrate on reducing social care needs at the front end of the service through:

- Provision of enabling which is more focused on achieving independence outcomes for customers.
- faster throughput for customers where longer term support is needed
- A more responsive approach to picking up packages quickly.

The service will operate 7 days per week and provide a virtual link into the fast response team to avoid hospital and residential care admissions and provide out of hours social work cover.

This service will need to stop providing long term support to customers and a review of customer needs will drive the recommended options for this part of the service. An options report will be presented to DLT with recommendations following these reviews.

In order to achieve this a number of establishment changes are required:

- A change of title for the registered Manager to Enabling Manager (Band K no change). This post also needs to be formally recruited to as temporary arrangements are currently in place.
- The deletion of the implementation officer post and replacement with Care Coordination Manager (band I no change) with a revised job description to more accurately reflect the role. It is anticipated the current post holder will be ring-fenced into this role.
- A reshape of the current HEO role to become an Enabling Officer (Band H no change). This would incorporate a number of functions currently undertaken by the SSOs. It is anticipated that the 9 existing HEO will be ring-fenced into these posts with competency assessments and development plans as needed to address any skill deficits.
- Recruitment of 4 FTE social worker posts (Band G-I) to join the team and work alongside the HEO's.

- A change in the out of hours management response to provide more robust support. This splits the Service Manager / Service Director response from the Team Manager response and ensures more availability of management particularly at weekends.
- The development of a professional supervision arrangement for social workers based in the Enabling Team.

A top-down training programme starting at management level will support the new structure

## **8. Finance**

The Enabling service has been subject to a savings plan for 2014/15 and 15/16 (£275K per year) based on ending of health and well-being checks. A further £250K savings have been put forward for the 15/16 plans to be achieved in 15/16 and 16/17. This is a total savings target of £800K over a three year period. A large proportion of these savings will have already been achieved by allowing staff to leave under the voluntary severance schemes and plans to achieve the remaining elements will be based on achieving a more efficient service.

This restructure is the next step in ensuring the infrastructure is in place to make sure the full savings can be released.

This proposal increases the social work capacity of the department by four FTE. One of these posts will be funded from within the enabling budget utilising a current HEO vacancy that has been held in anticipation of a restructure.

The remaining three posts will be funded from new money which has been identified in the Better Care Fund. There is currently £160K recurrently identified for social workers as part of the Fast Response workstream. This money is available to draw down immediately. This resource covers four social workers posts, one of which will be utilised within the community teams to support with hospital discharges into nursing beds.

## **9. Risks and Uncertainties**

- There is a risk that we will be unable to recruit social workers to the hours proposed in the structure and this will mean that the service is not deliverable. A recent social work recruitment process produced a high number of applicants and it is hopeful that this can be used to support the recruitment to these posts.
- This constitutes a major change to the way the team operates and robust management and engagement is needed to reduce the risks associated with this.
- The current out of hours service is not consistent and presents an operational risk.

## **10. Policy and Performance Agenda Implications**

- Supports performance indicator ASCOF 2 (no of people offered reablement) which is an areas on which we currently benchmark low.



- Meets Care Act and BCF priorities around the development of a Rapid Response Service and 7 day working (BCF04 and BCF05)
- Helps deliverability across the system (assessment direct, all social work teams, Rothercare)
- Increase the robustness of current out of hours response
- Responds to feedback and addresses issues raised by social workers and team managers as part of the out of hours issues

## 11. Background Papers and Consultation

- Better Care Fund Plan – Supported Discharge Care Pathway
- An outline consultation and deliverables time table can be seen at appendix 1.

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<b>ROTHERHAM BOROUGH COUNCIL – CABINET MEMBER</b>
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<b>1.</b>	<b>Meeting:</b>	Cabinet Member for Adult Social Care and Health
<b>2.</b>	<b>Date:</b>	17 November 2014
<b>3.</b>	<b>Title:</b>	Safeguarding Adults Annual Report 2013-2014
<b>4.</b>	<b>Programme Area:</b>	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

**6. Recommendations**

- **That the attached Safeguarding Adults Annual Report 2013-2014 be submitted to Cabinet Member for information.**

**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 6th 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 when approved will be presented to:

**9. Finance**

The costing is £500 for the design and art work.

**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”

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# Rotherham Safeguarding Adults



## Annual Report 2013/14

“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
- Know what to do when abuse happens

## What does Zero Tolerance mean in Rotherham?

Since 2007 we have worked hard to raise awareness of adult abuse in Rotherham and all safeguarding alerts made were responded to and the people involved made safe within 24 hours of contact.

After people were made safe we thoroughly investigated 314 referrals. All 314 cases had a protection plan in place to protect them, to prevent further abuse and ensure that the outcomes desired by the individual were met.

Following investigation 85 people were found to have suffered some form of abuse. These can be broken down into the categories of abuse as:

- 46** as a result of neglect or acts of omission
- 14** as a result of physical abuse
- 13** as a result of institutional abuse
- 5** as a result of psychological abuse
- 4** as a result of financial abuse
- 3** as a result of sexual abuse.

We put in place ongoing support for these people to protect them from further abuse and to help them to achieve their outcomes. The action we take when we find out abuse has taken place is:

- When staff across any agency are involved staff are suspended by their employers.
- Police are called in to investigate to see if a crime has taken place and followed up by the Police where criminal activity is evidenced.
- Work with the victim to meet their outcomes, ie. services are put in place to provide additional support.
- 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.
- We have clear expectations that providers suspend, investigate and take appropriate disciplinary action against any staff members alleged or proven to have abused someone.

- All perpetrators were reported to the Police for consideration of criminal prosecution

When abuse or poor standards were evident in residential homes or through care being provided in people's own homes we took swift action.

- Of the 84 contracted care homes in Rotherham, 10 care homes were failing to provide good care – we set deadlines for improvements through Special Measures Improvement Plans, monitored and held providers to account for their care practice in order to improve standards. Our interventions helped keep around 1600 residents in those homes safer.
- All new placements to 7 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 2 homes to ensure that people were safe while the homes were under scrutiny and while improvements were being made. Our everyday on-site presence in both care homes supported 55 people to be safe and get the standard of service they needed. Unfortunately 1 of these care homes failed to improve and deliver safe care and the Local Authority took the necessary action to transfer the residents to alternative care homes, in order to maintain their safety and welfare.
- We carried out quality assurance visits on all 158 regulated homes and services. 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



I cannot believe that it is a year since our last report and as always so much has happened and so much remains to be done. As Independent Chair of the Adult Safeguarding Board it is my pleasure to introduce this report which provides us with an opportunity to celebrate the achievements of the past year and consider how we, as a Board, will move forward in the coming year to ensure that our focus and our priorities reflect the need to safeguard vulnerable adults in Rotherham. The information in this report reflects the changes that have taken place during the year. It sets out what partner agencies have and are hoping to achieve individually as well as the shared achievements and issues of the Board.

The first thing to acknowledge is that the achievements outlined in this year's annual report have taken place against a backdrop of considerable change in all partner organisations, resulting from changes in structures, people and resources. In health agencies particularly where the changes in the NHS have resulted in new challenges. The end of Primary Care Trusts has meant the introduction of Clinical Care Groups. We now have Health and Wellbeing Boards and HealthWatch. This has resulted in us having to establish new collaborative partnerships which is key if our Board is to achieve cross agency engagement and effectiveness with agencies represented by designated senior managers who come with a mandate to go back and implement change. It is to the credit of all partner agencies that they have managed to maintain the level of input they have during 2013- 2014 and I look forward to working with them over the coming year. We have appreciated the input of emergency services attending the Board on a regular basis and of those agencies that span South Yorkshire such as the Police and Fire Service. We also value the input on the Board from the Voluntary agencies who have also had a difficult year as a result of the challenges of increasing demand and reducing resources.

This year at a national level we have all been alerted to the challenges that result from tragedies and poor practice arising out of poor systems, leadership and management such as those resulting from the lessons to be learned inquiries including the Francis report of Mid Staffordshire NHS Foundation Trust and the serious case review into Winterbourne View private hospital and from Mencap's work on the way that people with learning disabilities have been treated in hospital. These inquiries remind us that we have to be positive and vigilant and make sure that we all play our part in recognising when adults are not being safeguarded and make sure that we alert people with responsibility so that the required changes can be made.

As always the year ahead will bring with it many challenges that the Board will have to address. We will have to build on this year's achievements and learn from what we did not do as well. At the time of writing the report we are still awaiting the introduction of the Care Act 2014. This will demand changes in the way that the Board functions particularly in relation to its accountability and responsibilities. It will put the requirements of the Board more in line with Children's Safeguarding Board. Safeguarding adults is much broader than just protecting adults at risk. It is also about individuals living their lives with dignity and, where possible, making their own decisions. The Board aims to always work to the principle that 'safeguarding is a balance between rights and risk'. It is a difficult balance to achieve and we will only be successful in this with the help of the people of Rotherham. We need your eyes and ears and determination to make Rotherham a safe place for the vulnerable people.

## Message from the Safeguarding Adults Champion:

Councillor John Doyle



Safeguarding Adults remains our number one priority and is a crucial aspect of Local Authority work. 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 2013-2014 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. Safeguarding adults is everybody's business, as Safeguarding Adults Champion I sit on the Safeguarding Adults Board and continue to be committed to preventing harm and promoting dignity and to ensure empowerment and choice are taken seriously. Contributing

to the work of the Board enables me to hold to account those responsible for adult safeguarding and to ensure safeguarding adults is given sufficient priority to improve outcomes for vulnerable adults in Rotherham.

A red and white advertisement for adult abuse reporting services. The background features a blurred image of a person's face. The text is as follows:

**Don't let adult abuse go unnoticed**  
**Call 01709 822330**  
**(Monday to Friday 8.30 until 5.30)**

Out of Hours call 01709 336080  
**Or contact us with your concerns on our new Confidential Text to Tell Service**  
**07748 142816**  
South Yorkshire Police 101

[www.rotherham.gov.uk](http://www.rotherham.gov.uk)



# Rotherham Safeguarding Adults Review 2013/14

The Rotherham Safeguarding Adults Board's (RSAB) 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. The RSAB sets out its priorities as:

## Mission Statement

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

- Have a culture that does not tolerate abuse
- Work together to prevent abuse
- Know what to do when abuse happens

## Objectives

- All organisations and the wider community work together to prevent abuse, exploitation or neglect wherever possible
- Where abuse does occur we will safeguard the rights of people, support the individual and reduce the risk of further abuse to them or to other vulnerable adults
- Where abuse does occur, enable access to appropriate services and have increased access to justice, while focussing on outcomes of people
- Staff in organisations across the partnership have the knowledge, skills and resources to raise standards 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'

## Charter

### We will:

- Take a zero tolerance approach to abuse and the factors that lead to abuse
- Take action to protect vulnerable adults
- Listen and respond to customers and citizens
- Investigate thoroughly and in timely manner any concern that is raised
- Pursue perpetrators of abuse
- Empower customers
- Embed an outcomes focused approach
- Learn lessons and improve services as a result
- Ensure that our approach to safeguarding is personalised

## The Board delivered on its promises in 2013/14

In 2013-14 The Board:

- Undertook a strategic review and self-assessment of the Board collaboratively between partners in order to create a framework of inter-agency arrangements, to ensure vulnerable people are protected from abuse.
- Reviewed the constitution and governance of the RASB in line with National and Local priorities.
- Adopted a Safeguarding Adults Charter and a partnership agreement of commitment.
- Aligned the interface between Children and Adult Safeguarding ensuring cross representation at a strategic and operational level to ensure a holistic view across the safeguarding agenda, to reinforce the view that everyone should be protected from abuse and that safeguarding is everybody's business.
- Further developed 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.

- Working with partners across South Yorkshire to review and update the South Yorkshire Safeguarding Adults Procedures.

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 culture of abuse 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. Once again this year, all people who reported that they "don't feel safe" in the Adult Social Care

Survey were contacted personally. Through the conversations with individuals we established that 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.

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. 2013-14 has yet again 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 coming 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 **using fictional names** and highlights of key achievements.



## Key Partnership Contributions 2013/14

### Safeguarding Adults Service:

Robust safeguarding arrangements are in place in Rotherham to promptly and effectively react to protect individuals where allegations are made. We have reviewed and further strengthened our approach. Rotherham has in place a Safeguarding structure covering all user groups. This focuses on investigation, raising standards and quality of residential/nursing homes, Mental Capacity Act, Deprivation of Liberty Safeguards and strong leadership.

The specialist teams of highly qualified Social Workers track and manage all safeguarding alerts through strategy, investigation, conference and reviews to ensure individuals are appropriately protected. The Safeguarding Adults Investigation Teams remain focused on ensuring perpetrators of abuse are held to account and through appropriate disciplinary actions and referrals to Disclosure Barring Service and appropriate registered bodies.. A clear result of this is that they held 314 strategy meetings and this ensured robust and effective protection plans were in place for the victim. 166 case conferences were held and abuse was substantiated in 51% of these cases. Details of the activity of these teams are evidenced in Appendix 1 of this report.



### Achievements:

- Developed the performance management framework, strengthening the process to respond in a timely manner to ensure where possible investigations are completed within 6 weeks from strategy and case conferences held within 2 weeks of completion of investigation.
- Introduced virtual strategy meetings and case conferences, where appropriate. This ensures a swift and effective response, making best use of resources.
- With partners across South Yorkshire reviewed and implemented new South Yorkshire Safeguarding Adults Procedures (Launched June 2014).

- Developed a Local Authority Designated Officer (LADO) database.
- Reviewed and revised the Home Closure Protocol

### Case Outcome:

After living in squalid conditions together for several years Mr R and his daughter Mrs G reached crisis point. Their health was severely affected, food provision was limited, they had mounting debts and were at risk of eviction. Mrs G's daughter and Mr R's great granddaughter had responsibility for financial management but despite numerous requests to surrender finance, their poor circumstances continued. The two service users were placed in emergency respite care and the case was reported to Safeguarding. It became evident that Mr R and Mrs G had had their benefits misappropriated by their family members but refused any Police intervention preferring support via the Safeguarding process..

Although the couple thrived in respite care, due to the long-standing neglect that they had endured, their health did not improve sufficiently to return to independent living. Following a series of discussions with the couple, and in agreement with them, the social worker proposed long stay residential care. Following the Safeguarding investigation, benefits were eventually secured for Mr R and Mrs G. The RMBC financial appointee now assists Mr R to manage his finances, and Mrs G manages her own affairs with support from her key worker in the residential home. This case was heard at a Safeguarding case conference where the abuse Mr R and Mrs G endured was substantiated as neglect, psychological and financial abuse by the alleged perpetrators, their family members.

*Thank you for listening to us and thank you for your help and understanding today*

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



### Achievements:

- In March 2014 The Supreme Court handed down its judgement in a case in respect of DoLS. This judgement has widened the definition of a deprivation of liberty and has introduced a new “acid test” in deciding whether an adult is being deprived of their liberty. As a result we envisage a significant impact on this work in 2014-15 and beyond.
- We have appointed a Support Officer due to increased need.
- The Court of Protection (COP) team’s workload continues to increase forging new links with a discovery agent who has expertise to enable the settling of complicated estates of a deceased person where historically the finances have been managed by COP team - this has freed up capacity to take on additional cases.
- The team have taken on several new appointeeship cases as a result of financial abuse, which ensures that people’s finances are safeguarded in the future.



### Case Outcome:

Susan had been given a diagnosis of a cerebral arteriovenous malformation which tragically ruptured and was admitted to hospital to receive surgery. Susan remained in hospital for approximately nine months due to the high level of care and supervision required; Susan was then transferred to a Neurological Rehabilitation Centre to commence a rehabilitation program.

Susan’s partner considered that Susan had shown some positive change with regard to personality/character since being at the rehab centre and considered that Susan would prefer to return home if provided the opportunity and would choose rehabilitation to achieve this. Susan’s partner was of the opinion that the care and intervention provided by the rehabilitation centre was in Susan’s best interest to provide the optimum opportunity for recovery.

Susan’s parents considered that whilst Susan’s improvements have been relatively minimal during the early period of rehabilitation, the improvement over the past weeks had been significant compared to any improvement made in hospital in the previous months

Susan’s parents were also in agreement with the lawful deprivation of Susan’s liberty and that this would enable Susan to access the rehabilitation program and provide Susan with the optimum opportunity of regaining some abilities in order to return home to live.

The medical staff involved in Susan’s treatment stated that this was a crucial time of rehabilitation; and therefore in Susan’s best interest to remain at the rehabilitation centre. Therefore Deprivation of Liberty Safeguards were applied appropriately to protect Susan and ensure she received the most appropriate care and treatment available to her.

## Domestic Abuse Service:



### Achievements:

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 2013-2014.

### IDVAS

- Received 570 referrals – (a 34% increase from 2012-13)
- Supported 455 Multi Agency Risk Assessment Conference cases (MARAC)- (a 32% increase from 2012-13)

### Domestic Abuse:

- With support from the Safer Rotherham Partnership Domestic Abuse Priority Group (DAPG), sustained the funding of the Rotherham IDVAS. This funding is now mainstreamed.
- The Safer Rotherham Partnership (SRP) has adopted the national Young Person's Advocacy Programme alongside the 3 other Community Safety Partnerships in South Yorkshire. This Programme ensures the support of 16 – 18 year olds of victims who are direct victims of Domestic Abuse.
- The Domestic Abuse Coordinator commenced 2 Domestic Homicide Reviews, on behalf of the Safer Rotherham Partnership.
- Delivered 12 Multi Agency Domestic Abuse training events, 3 x Awareness Raising, module 1 and 6 x Multi Agency Risk Assessment Conference workshops module 3, and, with the Rotherham Local Safeguarding Children Board, delivered 3 x Domestic Abuse from a Child's Perspective, module 2.

## Case Outcome:

Claire's case had been heard at the Multi Agency Risk Assessment Conference on several occasions in Rotherham. Claire had been subject to sexual abuse from her partner over a number of years. Her partner was never prosecuted as Claire felt unable to report the incidents to the police. During this time Claire was supported by the ISVA (Independent Sexual Violence Advocate) based at the Hospital. Throughout this time Claire had become dependent on alcohol and struggled to find clarity in any of her life. Claire rang the IDVA (Independent Domestic Violence Advocate) and said she wanted to leave the relationship. Claire had arrived at this decision as she had been receiving support in regards to her drinking and she had been abstinent for a number of months. The IDVA discussed her options in regards to leaving in a planned way. Claire worked full time and seeking a refuge place would come at a huge cost to her. Her employer had agreed to re-locate her to another town to enable her to keep her job. The IDVA sourced a refuge place for her but the cost was out of Claire's reach on her salary. The IDVA looked at all options and funding was secured for accommodation for Claire in the short term. The IDVA also supported a housing application for Claire, everything was put in place and Claire found herself a property of her own.

After seven months of being away from the area Claire contacted the Rotherham IDVA because her support workers where she lived were on leave. Claire was facing a crisis. The IDVA supported her in dealing with this matter as Claire said she knew if she rang Rotherham IDVA the situation would be sorted. Claire rang the IDVA and disclosed historical abuse which had affected her throughout her life. Rotherham IDVA continued to keep in contact with Claire until local IDVAs were able to offer support.

Claire stated she had come a long way in the time that we have known her and there is a possibility that she may take her complaints regarding the abuse further. Claire has all the support in place to enable her to make a decision in regards to this.

Claire felt able to come back to the Rotherham IDVA as she trusted their work and knew she would be fully supported.



## Customer Compliment

Regarding the Rotherham Independent Domestic Violence Advocacy Service;

***I always know you will do what you say'***

***Your support empowered me to go to court to give evidence and I felt amazing when I had done it***

***Thank you for all the support you have given me***



## Joint Learning Disability Service:

### Achievements:

- Further strengthened joint work with Contracts and Commissioning Teams to successfully respond to significant institutional safeguarding concerns in 24 hour residential care and bring about change in the Services. This approach has led to a significant increase in safeguarding alerts into the service, with the joint learning disability service seeing a 100% increase in safeguarding alerts.
- 2 Social Workers have completed specialist masters levels in Safeguarding Adults
- Safeguarding Investigations undertaken jointly by Health and Social Care colleagues to increase expertise and efficiency in the investigation process.

### Case Outcome:

Debbie is a 28 year old woman who lives in 24 hour care. She raised her concerns with her independent advocate, who assisted her to discuss the fact that she thought she was being bullied and was very unhappy in her home. The worker who was accused of this was suspended and the allegations were investigated. The outcome was that abuse was substantiated in the category of psychological abuse. The outcome for the Service User was that the fear she was feeling was removed and she personally felt that she had been able to make a difference to her own life and stop it happening to anyone else. As a consequence of this the worker lost their job and was referred to the Disclosure and Barring Service.

## Rotherham NHS Foundation Trust:



### Achievements:

- Adopted and implemented the Prevent strategy within the existing resources and implemented a robust process for providing and demonstrating evidence for CQUIN – Recognised by CCG as an excellent process
- Delivered CQUIN standards and achieved significant progress against safeguarding standards
- Implementation of new Key Performance Indicators
- Recognised and brought together the processes related to safeguarding issues in respect of pressure ulcers and work is continuing to improve this process
- Developed a training needs analysis which identifies level of safeguarding training required and improved processes for registering training on Electronic Staff Records
- Brought together both Adult and Children's Safeguarding Teams under the Corporate Management structure
- Co-located Adult and Children Safeguarding Team to provide support and sharing of processes
- Combined the Safeguarding Operational Meeting to include both Adults and Children Safeguarding agendas
- Developed robust processes regarding monthly data reporting
- Developed Governance processes and charts to provide clarity and clear reporting arrangements with TRFT and partner organisations



## Good news Story

Following the setting up of a Task and Finish Group for Pressure ulcers, a new robust process was developed and embedded within the organisation regarding pressure ulcers and safeguarding. All Grade 3, Grade 4 and deep upgradeable pressure ulcers are fully investigated using a detailed Root Cause Analysis (RCA) investigation Proforma.

The investigation Team is the Area Manager and Matron supported by a named member of the Tissue Viability Team. Once investigation is completed the investigation Team is invited to an RCA Pressure Ulcer Panel Meeting. The Panel Meeting is chaired by the Assistant Chief Nurse. At the Panel the investigation is reviewed and assessed in order to provide an overall outcome as to whether the pressure ulcer is avoidable or unavoidable using the Department of Health Definition.

The outcome of the panel is then verbally provided to the investigatory Team – if found to be avoidable, the case is then managed as a Serious Incident and immediate consideration of any safeguarding concerns. An action plan is developed by the Area Team and managed within the Directorate. The findings are followed up via an email and the Adult Safeguarding Team is included in the correspondence that includes minutes of the Panel Meeting and also the full RCA investigation findings, in order to address and follow up any actions via safeguarding. Learning and feedback from these cases are shared via Quarterly managers Meetings and via the joint Safeguarding Operational Meeting.

## Case Outcome:

An elderly gentleman Ted was being treated in A&E when his son became violent toward his father and staff, the son was removed from the scene of the incident by police and detained under police arrest Ted was provided with a place of safety at the community hospital. A risk assessment was completed by staff at the community hospital to ensure the immediate safety of Ted whilst in their care. A referral was made to the hospital social work team for risk assessment for support on discharge from community hospital as there was evidence to suggest there was potential for further physical harm/psychological harm and financial abuse of Ted by son.

Social Worker and staff nurse met with Ted. He was disoriented to time, place and person Ted was unable to recall his children or identify that he received any care from them. Ted was unaware that he was in hospital at the time and could not recall his reason for admission

A lasting power of attorney was in place for both property and financial affairs and welfare decisions with son named as attorney. Due to the risk of significant harm if returned to the care of his son an urgent application was made to the Court of Protection to place Ted in a care home and remove the control family had over his finances and welfare. This was granted by the court and Ted now resides safely and happily in a care home.



## NHS Rotherham Clinical Commissioning Group – RCCG

Rotherham CCG firmly believes that every person has the right to live a life free from abuse and neglect. With this in mind Rotherham CCG will continually develop their safeguarding agenda; in particular their safeguarding adults agenda which will continue to evolve and develop in line with contemporary understanding and legislation, including the expectations of the pending Care Act 2014. Additionally Rotherham CCG will continue to develop their sexual exploitation prevent plan in light of the Department of Health review into the alleged sexual abuse committed on health premises by the late Jimmy Saville.

The White Paper 'Caring for our future: reforming care and support' and the pending Care Act 2014, confirm the intention that Adult Safeguarding should be placed on a statutory footing, through legislating for Safeguarding Adults Board and empowering local authorities to make safeguarding enquiries. In anticipation of this equal footing with safeguarding children and young people Rotherham CCG utilise the term vulnerable clients to denote all children, young people or adults who are, or potentially are, vulnerable to abuse, maltreatment or neglect. Annually Rotherham CCG publish their safeguarding vulnerable clients report; this reports provides information on safeguarding for the period 2013 to 2014 and Rotherham CCGs vision and objectives for the period for 2014 to 2015.

Rotherham CCG's vision and objectives for 2014 to 2015 include the need to ensure that all staff working in CCG commissioned services are trained to an acceptable safeguarding standard; that Prevent training in undertaken and in relation to the recent court ruling regarding Deprivation of Liberty Safeguards (DoLS) that all health staff are aware of their duty of care. Health care providers will need to ensure that all staff members (including staff on fixed-term contracts, temporary staff, locums, agency staff, volunteers, students and trainees), have an understanding of the principles of the Mental Capacity Act 2005 and consent processes, appropriate to their role and level of responsibility, at the point of induction.



### Achievements:

- In November 2014 Rotherham CCG is undertaking Safeguarding Adults and Children training at a Protected Learning Time (PLT) event. PLT is available to all Rotherham GPs and their Practice Staff. The event will cover self-neglect, exploitation, domestic violence and substance misuse and it is being supported by speakers and facilitators from RLSCB, RLSAB and the South Yorkshire Police.
- Rotherham CCGs have published "Top Tips for Safeguarding Adults" and "Top Tips for Safeguarding Children" and have disseminated them to all Rotherham GP Practices and they are also available on the RCCG Intranet. To embed the Top Tips into practice audits were undertaken using a survey monkey technique; some 1,025 responses were received for the 3 safeguarding surveys. 91.9% of GP Practice staff across Rotherham responded that they have access to the Safeguarding Adults & Children top tips within their practice. Whilst these safeguarding 'Top Tips' are not their Safeguarding Policy they do form a picture of what staff know and understand about safeguarding within the GP Practice, the wider multi-agency partnership and where they can get immediate support from when safeguarding is an issue. 95% of Practices across Rotherham are aware of where their practice's Safeguarding policies are stored.
- Rotherham CCG successfully appointed a Safeguarding Adults and Clinical Quality Lead from August 2013 to support and take forward the work of the CCG. The Safeguarding Adult and Clinical Quality Lead represents the CCG at Rotherham Safeguarding Adults Board sub-group and provides expertise and a point of contact for advice and intelligence regarding adult safeguarding across the health economy. Working in partnership with other key stakeholders such as CQC and the Local Authority, particularly around care homes and adult protection processes has been a priority for the post holder.
- Other key priorities are, to ensure that prevention of avoidable harm is seen as

essential, ensuring that when individuals require health care in Rotherham they receive safe, quality care. This is achieved by supporting commissioned services and the wider health community to understand safeguarding.

- Rotherham CCG have organised a safeguarding self-assessment and peer challenge which commenced January 2014 and will be completed in April 2015. As before the self-assessment complies with the aims of CQC Essential Standards of Quality and Care, Outcome 7 and also Section 11 Children Act 2004 to ensure that patients and carers can expect health care services, in Rotherham, to meet the standards to protect the safety and respect the dignity and rights wherever healthcare is provided. A final report will be published to provide assurance and transparency that RCGG has benchmarked individual GP Practices against expectations highlighted in No Secrets and the CQC Essential Standards of Quality and Safety Outcome 7.

Whilst the responsibility for coordinating safeguarding arrangements lies with the Borough Council, effective safeguarding is based on a multi-agency approach. Rotherham CCG is a willing safeguarding partner and has robust governance arrangements in place to ensure that its own safeguarding structures and processes are effective and that the agencies from which Rotherham CCG commissioned services meet the required safeguarding standards. In addition Rotherham CCG ensure that they are in line with the roles and responsibilities and capacity requirement for senior lead clinicians in safeguarding children in CCGs is outlined in full in the Safeguarding Competencies intercollegiate document (Royal Colleges 2014)

The safeguarding of all those who are vulnerable is an enormous obligation for all of us who work in the NHS and partner agencies. There is still much to do to ensure this happens. In March 2013, NHS England published the Safeguarding Vulnerable People in the Reformed NHS; Accountability and Assurance Framework (2013). The Framework provides a clear set of principles and guidance to ensure the new system delivers improved outcomes for children and vulnerable

adults. A strategic national steering group has been established to ensure the framework is embedded, and it provides a national forum to enable safeguarding leaders in NHS England to implement cross governmental policy.

A number of key safeguarding priorities are emerging nationally which include policies to prevent sexual violence, female genital mutilation, forced marriage and radicalisation of vulnerable people. Rotherham CCG in conjunction with South Yorkshire and Bassetlaw NHS England Area Team have written a Safeguarding Vulnerable Clients policy template for all independent health providers to utilise. The effective implementation and embedding of this policy will go some way to ensuring that vulnerable children and adults are afforded their 'right to live a life free from abuse, neglect and be safe'.

### **Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH):**

#### **Achievements:**

Each year the Safeguarding Adults Team develops a Core Work Plan which structures the key outcomes to be achieved in relation to safeguarding vulnerable adults for the following year.

The Safeguarding Adults Team have worked throughout the year to implement the improvements proposed for 2013/14. Some of this work was assigned to individual Lead Professionals through their Personal Development Review process, and has supported both individual professional development and service developments in relation to safeguarding vulnerable adults.

Listed below is the progress we have made against the targets set for 2013/14:

- **Leadership**

The Lead Professionals have provided an independent opinion on a range of strategies, policies and developments across the Trust throughout 2013/14.





Further, each of the Trust's Lead Professionals has an identified locality of the Trust which they are aligned to, providing safeguarding leadership and guidance for referrals in these localities. The Lead Professionals also provide guidance to support the development of multi-agency safeguarding processes within their designated area and identify specific needs or areas of development as part of their role. In addition, the Team has a central role in supporting, advising and developing staff skills in relation to safeguarding across the Trust.

- **Partnership Working and Multi-agency Referral Pathways**

Over 2013/14 the Safeguarding Adults Team has built positive working relationships with the Clinical Commissioning Groups (CCG) that formed at the start of the financial year. This facilitates a collaborative approach to the development of safeguarding processes and strategies. Each Lead Professional meets regularly with the CCG's safeguarding lead for their identified area to facilitate good communication, awareness of regional safeguarding issues and development of safeguarding processes. Key achievements in this domain include:

- The Vulnerable Adults Risk Management Model (VARMM) process has been jointly developed with Rotherham Metropolitan Borough Council.
- There is now representation from the Safeguarding Adults Team at the quarterly Regional Police Forum.
- Introduction of more user friendly forms developed as part of the multi-agency process which improves referral pathways.

**Policy Implementation**

The Safeguarding Adults Policy was reviewed and updated by the Lead Professionals in August 2013 to reflect the new developments and inclusions.

- **Links with Mental Capacity Act, Deprivation of Liberty Safeguards Lead**

Over 2013/14 the Team has worked collaboratively to further strengthen the

interface between the Safeguarding Adults Team within RDASH and the Mental Capacity Act, Deprivation of Liberty Safeguards Lead within RMBC

- **Strengthening User and Carer Engagement**

This has been a high priority for the Safeguarding Adults Team who together with the business divisions, developed a plan to ensure that service users have a strong voice in decision making and remain at the centre of the safeguarding adults process.

**Quality Referrals**

The Lead Professionals review all referrals into the RDaSH to ensure consistency and quality of the processes. Furthermore, the Lead Professionals have contributed to a number of internal and multi-agency quality audits and the development of action plans in line with the audit results throughout 2013/14.

**Consistent Safeguarding Documentation**

Over 2013/14 the Team has worked with the Records Manager, Operational Leads in the business divisions and Local Safeguarding Adults Partnership Boards to develop and implement a consistent approach to safeguarding documentation both within the Trust and across the healthcare community.

**Appropriate Safeguarding Supervision**

Throughout 2013/14, the Lead Professionals have worked with Operational Leads in the business divisions to review the current provision of safeguarding adults supervision across the Trust and have developed a model to reflect the diversity of services provided by RDaSH. This model is now at the implementation stage and reflects the different types of supervision available to staff. The model encompasses '1 to 1' supervision when requested, peer supervision, development days for staff, additional support for complex cases, email and phone support as required and bespoke training for specific needs.

- **Central System for Recording Safeguarding Activity**

During 2013/14 the system for recording safeguarding activity has been further developed to provide a comprehensive database that allows for the collation and reporting of safeguarding data, enabling the safeguarding team to identify any areas that require development and further support.

In addition, the following achievements have also arisen within the year:

- **Training**

Throughout 2013/14 we have reviewed and developed the training matrix for safeguarding adults, culminating in the production of a leaflet to provide Level 1 training. This has resulted in the Trust achieving 100% compliance at Level 1. In addition, we have improved the delivery of Level 4 training for investigators and managers by providing bespoke refresher training according to need.

- **National Guidance**

The Lead Professionals have provided specific support to staff across the Trust on the implementation of the recommendations in the following:

- 'Transforming care: A national response to Winterbourne View Hospital' report with regard to safeguarding adult practices.

- **Prevent Training**

In order to support Trusts nationally in implementing Prevent, the Department of Health in conjunction with the Home Office has arranged for training to be delivered to key people within organisations who in turn will then cascade it to staff throughout the Trust.

The Named Nurses and Adult Professional Leads have completed this training and from May 2013, have been delivering it to all staff as part of the induction and refresher training programme. To support the training an awareness raising leaflet regarding Prevent was attached to the pay slip of every staff member.

Currently **1741** members of staff have completed the training.

Positive and Proactive Care: reducing the need for restrictive interventions

In November 2013, Wendy Proctor, Lead Professional in the Safeguarding Adults Team was invited to present at a national conference on safeguarding vulnerable adults in mental health services, presenting her work on 'Safeguarding, Restrictive Practices and Restraint'

The presentation looked at concerns raised by MIND and other bodies about the use of restrictive practice and the variation of use of restraint in different organisations throughout the country, with an emphasis on the need for greater transparency on restraint processes and the need to encourage alternatives where possible.

Following this conference, guidance has been published by the Department of Health 'Reducing the need for restrictive interventions', which takes forward a number of recommendations made by experts in the field, including those presented by Wendy.

### **South Yorkshire Fire and Rescue Service (SYFR):**

The SYFR 2013 – 2014 Prevention & Protection Strategy includes cross cutting themes related to inclusion, partnerships, safeguarding and education. The focus is on developing best practice in targeting the most vulnerable to reduce the numbers of fire related deaths and injuries.

### **Achievements:**

The Safeguarding Guidance & Procedures have been reviewed and rewritten in a format that will make it easier for the reader to follow.

### **Fire Safety**

In response to the increasing number of cases where a high risk of fire is identified a new guidance document has been drafted to provide an agreed process for the "Management



and Coordination of High Fire Risk Home Safety Checks”This will require a multi-agency approach and joint ownership with relevant partners to manage the risk to the individual and particularly where there is a risk to others.

- A total of 21,544 Home Safety Checks were carried out across South Yorkshire, 17,384 were for those considered to be most vulnerable e.g. households where the occupants are very young or elderly, are disabled have mobility problems and/or lifestyle increases the risk of fire.
- 4,182 referrals for the latter came from our partners and our Vulnerable Persons Advocate continues to deliver Fire Safety talks and presentations to professionals and service user groups e.g. Falls Prevention Group
- SYFR has now established an internal process for responding to and learning lessons following a Fire Death or Serious Injury. A number of cases over the last 2 years have been subject to a Serious Case review and recommendations from Internal Management Review have led to significant improvement in the way our fire risk assessments are carried out.

**Adult Safeguarding Alerts & Referrals**

Our annual total for April 2013 – March 2014 for all Adult Safeguarding Alerts across South Yorkshire was 54 (18 were for Sheffield) and this is consistent with previous years. The majority of these were as a result of a Home Fire Safety check, but 12 were from fire incidents. 9 cases were linked to self-neglect and/or hoarding and for some of those in Sheffield the Vulnerable Adult Risk Management (VARM) process was initiated. In 6 cases a perpetrator was identified and a Safeguarding Alert/Referral processed (e.g. theft). Some of the remaining cases were related to:

- Alcohol intoxication = **7**
- Physical disability/mobility problems = **11**
- Mental Capacity/ Dementia = **12**
- Learning Disability = **4**

For these, support from other services was requested

**Safeguarding Training**

In 2013 – 14 SYFR staff received Safeguarding Training as follows: -

- Induction = 42 (plus 30 Volunteers)
- Introductory = 22
- Refresher = 71

A programme of Safeguarding Update & Refresher training has been piloted with Community Safety staff is being rolled out to Operational Fire Fighters throughout 2014 – 2015.

**South Yorkshire Police:**

**Achievements:**

- 821 referrals made to Public Protection Unit PPU from attending officers and partner agencies. This is an increase of 58% on the previous year.
- The introduction of a dedicated Central Referrals Unit for all Adult safeguarding concerns in Rotherham/SYP ensuring timely review and progress of all Adult safeguarding referral
- 25% increase in investigative capacity in Rotherham for combined Adult and Child safeguarding concerns and investigation.
- Project on co-location of the Rotherham Public protection unit which will see operational Adult safeguarding staff and investigators located at Riverside House Rotherham by September 2014
- Police now leading on all Vulnerable Adults Risk Management (VARM) meetings with the Vulnerable persons unit already co-located in Riverside House.
- New Force policy and referring protocols for all SYP staff ensuring force wide corporate approach in how referrals are made and progressed across South Yorkshire.



## Case Outcome:

Examples of convictions following safeguarding investigations-

Male Personal Assistant financially targeted 4 profoundly deaf adults he provided support for. Following investigation he was convicted and sentenced to 18 months imprisonment, suspended for 24 months and made to pay 2k in compensation to his victims.

Female carer financially targeted a 92 year old male she provided care for. Due to the large amount stolen she was sentenced to 18 months imprisonment.

## Rotherham Voluntary and Community Sector:



### Achievements:

- 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.
- Hate Crime Initiative: 14 VCS organisations in Rotherham are registered as community reporting centres.
- Alzheimer's Society: working with Police and other VCS partners to develop a missing person's protocol for people with dementia.
- Rotherham Older People's Forum: hosted an event for Older People's Day designed to help older people feel and stay safe.
- The Adult Services Consortium is helping to raise awareness of the safety scheme Safe in Rotherham which is for people with learning disabilities and other vulnerable adults. VCS organisations for example VAR and MyPlace who have community buildings display the purple hand logo identifying them as a place of safety.



## Case Outcome:

Helen lives with her son who has Mental Health needs, she had referred herself to Adult Services a number of times alleging verbal/emotional abuse to her by her son. Her son was not receptive to support from outside agencies, would not engage and at times would be hostile to staff. Previous attempts had been made by the Assessment Team to support Helen and to offer protection planning under safeguarding but, this would always be refused. Helen felt a duty of care to her son and was worried this would be detrimental to their relationship.

The concern escalated to the point where Helen couldn't cope any longer, emergency accommodation was arranged, while this provided a place of safety for Helen it also allowed her time to weigh up all options available to her. It became evident Helen and her son could no longer live together. Work involved contacting other agencies such as health and housing to support Helen during this difficult time. Agencies also worked with her son in providing alternative accommodation and attempts to meet his health needs so they could both lead their own lives.

The ultimate aim was to enable Helen to return back to her own home with appropriate measures in place to safeguard her welfare. This included a tag on the property, installing Rothercare and arranging a safe code to use, home security, emergency numbers and general advice on personal safety. This did happen and Helen is now back at home.

Helen's son left the property prior to her moving back home. He was alternatively accommodated, given advice and attempts made for him to engage with health services. This also involved working with colleagues in housing and staff supporting him to move his personal items out of the property while still safeguarding Helen.

The workers involved continued to monitor the situation by visiting at home and telephoning Helen regularly to check there had been no changes.

## Commissioning. Policy and Performance Services:

All contracted providers of care and support are:

- Monitored throughout their contract term for compliance against 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.
- Obligated 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 8 homes receiving a rating of Excellent, 19 were rated Good, 5 were rated Adequate. A premium payment is paid to homes in the older people's sector that receive a rating of Good or Excellent.

2014-2015 will see the introduction of a new customer rating that will rate the home on customer satisfaction as either Bronze, Silver or Gold.

Community and Home Care Service Providers are rated as outcomes met or outcomes exceeded. The "Home Matters" review resulted in 4 providers being rated as outcomes exceeded and 10 rated as outcomes met. This ensures that all commissioned services maintain a focus on customer outcomes.

Completed reports are published on the Council's website.

### Action taken with providers

A default notice is served if the provider fails to fulfil 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 in accordance with the terms and conditions. 10 contracting default notices were applied in 2013/14, 7 of which involved an imposed temporary suspension of placements ensuring that nobody was placed in a service that failed to meet acceptable standards. Areas of concern included, for example, recruitment, record keeping, staffing levels, lack of clinical policies and procedures, infection control, equipment and environmental issues, and medicine management

Suspensions of placements are either voluntary or mandatory and can be invoked by the Safeguarding Team 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 2013/14 3 of the 7 suspensions of placements were due to alleged abuse/neglect.

### Case Outcomes

(1) Care home X 'The Home' in Rotherham was a privately owned care home providing both residential and nursing care for 36 residents. Through robust monitoring of the care standards within the home it became evident that the home was failing to deliver safe and appropriate care to its residents. Working in partnership with Care Quality Commission (CQC) there was an investigation into the standards of care. As a direct result the Local authority suspended all new placements and served a default notice against their contract.

The individual reviews of all residents care needs and the safeguarding investigation into allegations of neglect quickly highlighted serious failings within the home. CQC took the necessary enforcement action and RMBC instigated the Home Closure Protocol and begin the process of transferring residents from 'The Home' 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 and their families. The Local Authority had a presence in the care home throughout the process, offering support to residents, their families and staff within the home. The transfer of all residents from 'The Home' was achieved both sensitively and in a timely manner and all were found alternative, safe and appropriate care.

(2) Following an Investigation it was established that a call handler had failed in their duty to respond appropriately to an older person who had fallen in their home. As part of the Investigation safeguarding was able to recommend new processes to the service provider to improve auditing and call handling.. As a result of suffering the fall a social worker review took place and it was decided that Mrs Brown's needs would be best met in a care home. Mrs Brown is now safe and settled in her new home and has all the support that she needs. Mrs Brown's family had informed us following the Investigation that they had felt informed and involved in the Investigation process and were happy that Mrs Brown was being well cared for and changes had been

made to reduce the risk of the same thing happening to a different vulnerable adult. The safeguarding report, following investigation, also provided evidence to inform the decision making regarding the disciplinary action taken against the call handler.

## Learning and development

To support a more confident, capable and skilled workforce we continued to operate a strategic and structured framework of workforce development activities utilising our Safeguarding Adults Workforce Development Policy and its Strategic Training Programme of courses.



### Achievements:

- Over 1,500 learners attended ninety courses in 2013/14.
- Our approach to training course delivery continued to be planned and responsive with both open off-site courses and a growing number of closed on-site courses provided to support some providers, for example, to meet emergent needs derived from contract compliance issues or high learner numbers.
- We continued to give access, without attendance charge, to all of our training courses and this will continue into 2014/15 as will the cancellation charge and no-show policy.
- Significantly, to ensure best value and quality of provision, we finalised a framework agreement for the procurement of our training courses - appointing one provider to deliver our silver level course and one provider to deliver gold and platinum levels courses. In 2014/15 we will be working with both training providers to devise new, high quality, training materials and roll-out refreshed training courses. Once finalised, we will refresh our Workforce Development Policy.

## Safer Rotherham Partnership

The Safer Rotherham Partnership is a statutory partnership formed as a result of the Crime and Disorder Act 1998 and is managed by two multi-agency groups. The Safer Rotherham Partnership Executive Group meets monthly to set strategic direction and is accountable for delivering the partnership plan by making decisions about activity, resource allocation and problem solving. The partnership also performs the function of the Drug & Alcohol Action Team and the Youth Offending Service Management Board. It is made up of senior officers from the 'responsible authorities' and 'co-operating bodies' these are:

- Rotherham Metropolitan Borough Council
- South Yorkshire Police
- Rotherham Clinical Commissioning Group
- South Yorkshire Fire & Rescue Service
- Probation Service
- South Yorkshire Local Criminal Justice Board
- Voluntary Action Rotherham
- Rotherham Victim Support

The responsible authorities are under a statutory duty to work together to:

- reduce reoffending
- tackle crime and disorder
- tackle anti-social behaviour
- tackle alcohol and substance misuse
- tackle any other behaviour which has a negative effect on the local environment

### Achievements:

Throughout 2013/14, the Partnership made considerable progress in tackling Crime and Anti-social Behaviour across the borough. During that period 16,957 crimes were recorded across Rotherham, which was a 1.2% reduction on the previous year, despite the difficult economic conditions. Additionally 1,534 fewer Anti-Social Behaviour incidents were recorded compared to the previous year, a reduction of 9%. Recorded crime and anti-social behaviour (ASB) has been falling in Rotherham over recent years with ASB showing significant reductions.

Although it is acknowledged that maintaining these reductions in the current economic climate will be a challenge, the partnership believes it has the structures and performance management frameworks in place to meet this challenge and continue to contribute to Rotherham being a safe place to live, work and visit.

**Key Indicators:**

- Recorded Crime **fell by 1.2%**
- ASB **fell by 9%**
- Domestic Burglary **fell by 4.7%**
- Theft of motor vehicles **fell by 0.1%**
- Theft from motor vehicles **fell by 9.3%**
- Criminal Damage **fell by 0.2%**
- Violence against the Person **fell by 6.3%**
- Public Order offences **fell by 18.2%**
- Drug Offences **fell by 0.8%**





## Looking forward 2014-2015

### **Rotherham Safeguarding Adults Board's priorities for the coming year. We will:**

- Hold a Board away-day to refresh the governance objectives and quality assurance framework.
- Develop a Safeguarding Communication strategy and action plan.
- Take part in a 360 degree web based assessment to identify individual development needs of those undertaking their role as a member of the RSAB.
- Undertake The Yorkshire & Humber Safeguarding Adults Board Self-Assessment. This is a self-assessment of each agency's internal roles and responsibilities in relation to safeguarding adults at risk.
- Deliver on the actions required from the Care Act 2014 in respect of "Safeguarding Adults at risk of abuse and neglect" and to make sure the Council delivers against any new duties or responsibilities.
- Review Serious Case Reviews (SCR) nationally to provide information on how we can consider how to use these SCRs as a learning opportunity. Development Day.
- Consider wider implications for the Rotherham Safeguarding Adults Board from the Jay Report.



## Key Facts and Figures

A total of 1,556 alerts were reported through the new Safeguarding Adults Returns (SAR).

The way we now report to the Health and Social Care Information Centre has changed from the Abuse of Vulnerable Adults Return (AVA) to the Safeguarding Adults Return (SAR). The difference is that we now have to record in more detail and some of the reporting terminology/headings have changed. This has had an effect on some of the % changes and therefore in some areas it is difficult to make direct comparisons with previous years.

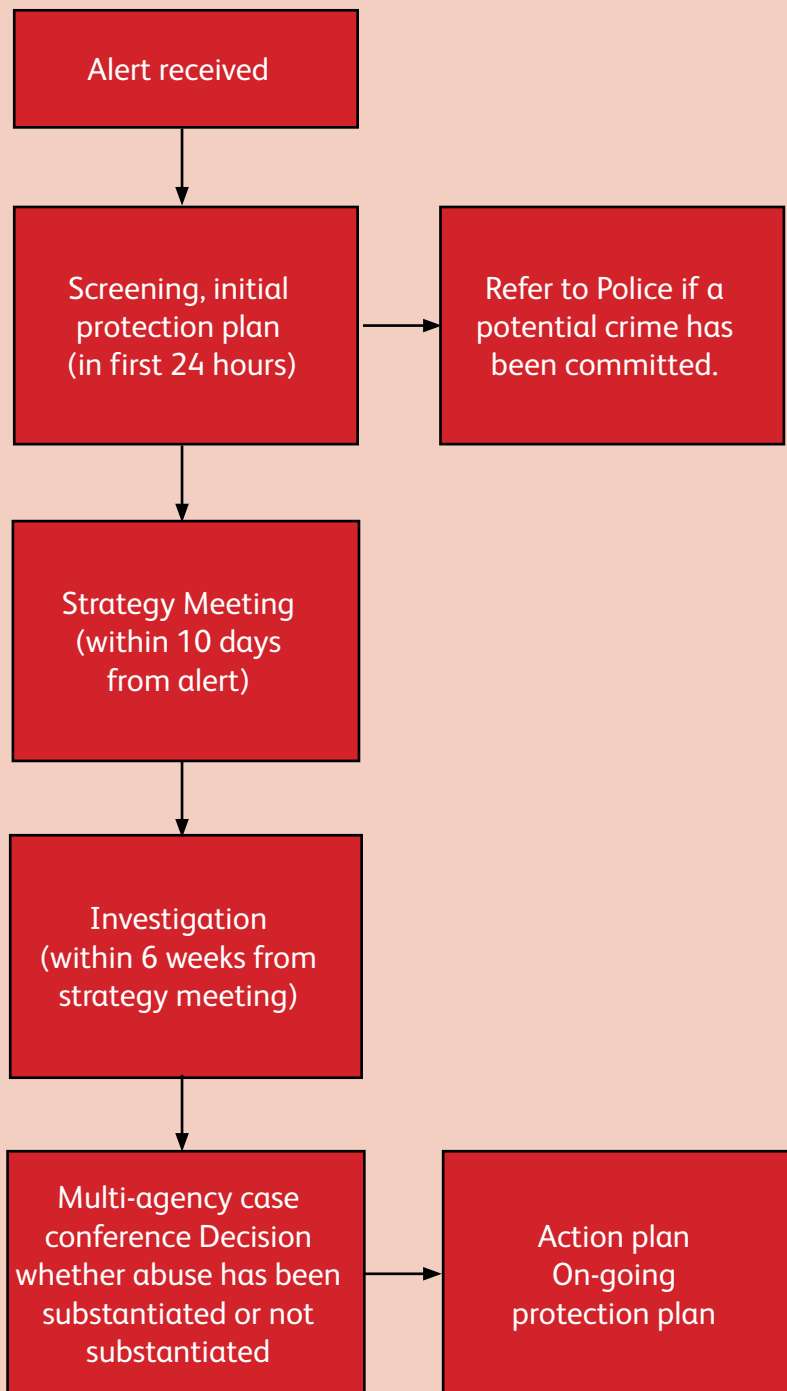
The table below illustrates how Safeguarding Adult's activity regarding alerts has remained consistent with 2012/13. 2013/14 there has been a continued public and professional awareness in relation to safeguarding particularly, following Winterbourne, within the Learning Disability Service. There is 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 an increase in the number of safeguarding alerts in The Learning Disability Service by over 100%.

Older Peoples Services have consistently recorded the greatest number of safeguarding alerts accounting for 74% of all alerts, the table below shows the breakdown of the remaining 26% of alerts. Numbers in some areas remain the same from 2012-2013.

<b>Number of Alerts 2013 – 2014</b>									
<b>In total there were 1,556 Alerts made to Safeguarding Adults</b>									
Physical & Sensory Disability, Frailty, other vulnerability		Learning Disability		Mental Health		Substance Misuse		<b>Total</b>	
18-64	65+	18-64	65+	18-64	65+	18-64	65+	18-64	65+
262	1014	113	16	16	134	1		392	1164

<b>Number of Alerts 2012 – 2013</b>									
<b>In total there were 1,565 Alerts made to Safeguarding Adults</b>									
Physical & Sensory Disability, Frailty, other vulnerability		Learning Disability		Mental Health		Substance Misuse		<b>Total</b>	
18-64	65+	18-64	65+	18-64	65+	18-64	65+	18-64	65+
293	1014	47	12	62	134	3		405	1160

## Safeguarding Adult's Process



The strategy meeting/discussion is a crucial stage in the safeguarding process. The purpose of the Safeguarding Strategy is to determine whether to proceed to Safeguarding investigation and if so plan the multi-agency investigation. A Strategy Meeting, actual or virtual should be held within 10 working days of the initial alert. In 2013-2014, 97% of strategy meetings met this target

All relevant professionals and organisations should be included in strategy meetings.

The table below indicates a significant increase in strategy meetings convened in year to those in 2012/2013.

## Number of Strategy Meetings Convened 2013 – 2014

**314** Strategy Meetings/discussions held across all services compared to **264** in 2012/2013

Previously all alerts that progressed to a Strategy Meeting were called 'referrals'. The introduction of the SAR now states that only cases that progress to investigation are called 'referrals'. Also another change to practice is that the purpose of the Safeguarding Strategy is now to determine whether to proceed to Safeguarding investigation whereas previously this decision was often made following screening of an alert. This is reflected in the 18% increase in the number of strategy meetings held.

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, below, reflect a decrease in the number of investigations (referrals) that culminate in a case conference this is due to the changes in purpose of strategy as outlined above which means that alternative ways of supporting the individual is agreed thus preventing escalation to investigation and case conference.

## Number of Case Conference Convened 2013 – 2014

**166** Case Conferences convened across all services compared to **227** in 2012/2013



## Review of Alerts

April 2013 – March 2014

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.

<b>Source of Alert</b>		
<b>Alerter:</b>	<b>2012/2013</b>	<b>2013/2014</b>
Residential/Nursing Care	301	385
Social Care Staff	264	243
Police	131	152
Health – Hospitals	91	139
Domiciliary Care	162	114
Health – Community	60	103
Relative	112	97
Other Source*	269	89
Other Council Dept.	9	56
Ambulance	20	39
Neighbours/Public/Friend	14	31
Anonymous	67	27
Care Quality Commission	Not recorded	23
Alleged Victim	15	20
Health – Mental Health Staff	15	20
GP's	16	15
Other Local Authority	19	3
<b>Total Number of Alerts from Health</b>	<b>1565</b>	<b>1556</b>

- Other source refers to a variety of sources e.g. Probation, Prison, Employment, schools and other agencies and the Voluntary and Community Sector. There has been a significant decrease in this group as recording systems are now able to provide more details on the source of alert.

If we make a direct comparison between the numbers of 'alerts' reported in 2013/2014 from the previous year there is consistency in many areas. Key factors to highlight are the reduction in alerts from Domiciliary Care, this was expected as there was a dramatic increase the previous year and it was expected that these would begin to fall and settle. The significant increase in alerts from the public is welcomed; this is a year on year increase and indicative of heightened awareness. There has also been a concerted effort to encourage alerters to provide their details at contact; this is reflected in a decrease of 60% in anonymous alerts.

## Who was the subject of the alert?

### Alleged Victim

Approximately 63% of all alleged subjects of safeguarding concerns, who were referred into the Safeguarding Adults procedure in Rotherham in 2013/2014 were female. Whilst the highest gender category is consistently females, this year there has been a slight % increase in male victims.

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.

Gender of Alleged Victim		
	2012/2013	2013/2014
Female	66%	63%
Male	34%	37%

Age of Alleged Victim		
	2012/2013	2013/2014
Over 65 years	74%	75%
Under 65 years	26%	25%

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. 2.2% of the total number of alerts during 2013/2014 concerned alleged victims from BME communities.

The number of cases with "unknown or refused" ethnicity at the alert stage has slightly increased again this year. However, this is reduced considerably at the point of referral; at the referral stage in the process only 8 cases remained where the information of ethnicity was still not available. This demonstrates the effectiveness of information gathering at referral stage.

Ethnicity of Alleged Victim		
	2012/2013	2013/2014
White/British	1406	1412
White/Irish	5	6
Asian/Pakistani	22	12
White/European	13	2
Asian/Other	4	2
Asian/Indian	0	2
Black/Caribbean	0	2
Black/African	5	0
Other Black Background	2	0
Dual Heritage	8	9
Unknown Ethnicity	6	0
Other Ethnic Groups	94	109

## Review of Referrals and Investigations

April 2013 – March 2014

### What Were the Categories of Alleged Abuse Investigated?

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%

Categories of Alleged Abuse 2013 - 2014						
Neglect	Physical	Financial/ Material	Psychological	Institutional	Sexual	Discriminatory
58%	14.5%	10%	6.5%	8%	3%	0%

The category of neglect and acts of omission continues to be the highest category of abuse investigated with another 4% increase this year. The only other category to have increased in 2013/14 is Institutional abuse with a 4.5% increase. This is as a result in the suspension of placements at care homes this year as a consequence of abuse and neglect. Also when there are several individual cases investigated in one care home that result in neglect being substantiated as a result of poor practice and culture within the care home then Institutional abuse will also be confirmed at case conference.

### What was referred?

Who was the alleged perpetrator?

Relationship of Alleged Perpetrator to Alleged Victim		
	2012/2013	2013/2014
Residential/Nursing Care Provider	46%	70%
Domiciliary Care Provider	11%	10%
Health Care Worker	7%	8%
Family	13%	7.5%
Other	17%	3%
Neighbours/Public/Friend	3%	1.5%
Day Care	1%	0%
Other Vulnerable Adult	2%	0%
Stranger	0%	0%

<b>Setting of Alleged Abuse</b>		
	<b>2012/2013</b>	<b>2013/2014</b>
Residential/Nursing Care Home	53%	67.5%
Own Home	35%	12%
Hospital	7%	8%
Public Place	0%	1.5%
Day Care	1%	1.5%
Alleged Perpetrators Home	0%	1%
Other	4%	8.5%

Consistent with the figures for 2012/2013 the highest numbers of alleged victims in 2013/2014 were living in Residential/Nursing Care and that 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. This is an expected outcome of the increase this year in Institutional abuse.

The effects of the change from AVA to SAR are reflected in the decrease in the "other" category as we can now more accurately associate to a category.





## Review of Referrals and Investigations

April 2013 – March 2014

### What were the outcomes?

The Conclusion of the Safeguarding Adults Case Conferences

Of the 1556 Safeguarding Adults alerts received in 2013/2014 166 culminated in an investigation, 161 of the investigations concluded with a case conference.

This is due to the changes introduced to how we effectively monitor the information at the strategy meeting and the increased quality control of all safeguarding investigations in the initial stages. This year the number of safeguarding alerts that were closed (no further action) prior to a strategy meeting being convened or following a strategy meeting was 89% of the total alerts. 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) or the vulnerable adult or their advocate wanted a different outcome or resolution to their concerns.

*'The definition of a vulnerable adult is – A person aged 18 or over who is or maybe 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			
166 Case Conferences held regarding individuals			
Abuse Substantiated	<b>85</b>	Abuse Not Substantiated	<b>76</b>

*\*The remaining 5 cases were terminated prior to case conference at the request of the victim.*

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.

This year the SAR introduced new outcomes of a safeguarding investigation where abuse had been substantiated, these are:

- Risk remains
- Risk reduced
- Risk removed

In 2013/2014 there were only 2 cases where it was recorded that risk remained, these 2 cases were as a result of personal choice by the victim and involved complex family dynamics. Risk was reduced in **40% of cases** and risk removed in **58% of cases**.

## 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 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 a full time Support Officer. The posts sit within the Safeguarding Adults Service. The disestablishment of the PCT in March 2013 has resulted in the Local Authority taking over the responsibility for the processing and authorisation of DoLS referred from the hospital. Rotherham has 10 qualified Best Interest Assessors available to undertake assessments.

### Ongoing Work

Work remains ongoing in terms of education and training around DoL's for both staff and providers. In light of a Supreme Court judgement (March 2014), despite not being able to fully recognise the full extent of the impact of the judgement at the time of writing this report, it is apparent the number of qualified assessors will need to increase significantly to meet expected demand.

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

<b>Mental Capacity Act and Deprivation of Liberty Safeguards 2013/2014</b>			
Referrals Received by RMBC	54	Referrals Received by NHS Rotherham	2
Authorised Referrals by RMBC	44	Authorised by NHS Rotherham	0

Compared to the requests made in 2012/2013:

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

## 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:

<b>Safeguarding Adults Training Attendance (excludes e-learning)</b>			
	<b>2011/2012</b>	<b>2012/2013</b>	<b>2013/2014</b>
Local Authority	249	552	150
Independent/Voluntary Sector	1072	894	933
Health	508	363	388
Police/Probation	0	3	2
Service users/carers	13	2	2
Students	32	7	7
Other	16	8	2
<b>Totals</b>	<b>1890</b>	<b>1829</b>	<b>1484</b>



<b>ROTHERHAM BOROUGH COUNCIL – CABINET MEMBER</b>
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<b>1</b>	<b>Meeting:</b>	<b>Cabinet Member for Adult Social Care and Health</b>
<b>2</b>	<b>Date:</b>	<b>17 November 2014</b>
<b>3</b>	<b>Title:</b>	<b>Making Safeguarding Personal</b>
<b>4</b>	<b>Directorate:</b>	<b>Neighbourhoods and Adult Services</b>

## 5 Summary

Making Safeguarding Personal (MSP) is a Local Government initiative that supports Councils and their partners to develop outcomes focused, person centred safeguarding practice. The Making Safeguarding Personal Approach is embedded in the Care Act 2014 and therefore utilisation of this approach is now essential for every local authority in England. This report outlines what MSP is, the key drivers to initiate MSP in Rotherham and the recommended approach and scope of the initiative.

Councils are invited to engage in work on one or more of three levels:

- **Bronze:** working with people (and their advocates or representatives if they lack capacity) at the beginning of the safeguarding process to identify the outcomes they want and then looking at the conclusion of the process at the extent to which these outcomes are realised.
- **Silver:** the above, plus developing one or more types of responses to safeguarding and/ or recording and aggregating information about responses.
- **Gold:** the above, plus independent evaluation by a research organisation/university.

Rotherham, in taking part in an introductory event, has initially signed up to commence at Bronze level.

## 6 Recommendations

- **That Cabinet agree to consolidate Making Safeguarding Personal at Bronze Level.**
- **That Cabinet agree to engage at Silver level by developing one of the proposed tools/responses to safeguarding.**

## 7 Proposals and Details

MSP is a shift in culture and practice in response to what we now know about what makes safeguarding more or less effective from the perspective of the person being safeguarded. It moves away from being process led to being person led. It is about having conversations with people about how we might respond in safeguarding situations in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety. It is about seeing people as experts in their own lives and working alongside them. It is about collecting information about the extent to which this shift has a positive impact on people's lives. It is a shift from a process supported by conversations to a series of conversations supported by a process.

The core principles for safeguarding adults are set out in recent government policy on safeguarding adults: empowerment, prevention, proportionality, protection, partnership, and accountability. These are now embedded in the Care Act 2014 and MSP supports translating those principles into effective practice.

Whilst people tell us that they appreciate the work of individual staff involved in the Safeguarding process, they also tell us that they tend to feel 'driven through' a process. At best they are involved rather than in control, at worst they are lucky if they are kept informed about what professionals are doing. What councils have monitored as outputs have tended to centre on decisions about whether abuse was substantiated or not and what was done as a result: often additional services or monitoring.

MSP aims to facilitate a shift in emphasis in safeguarding from undertaking a process to a commitment to improving outcomes alongside people experiencing abuse or neglect. The key focus is on developing a real understanding of what people wish to achieve, agreeing, negotiating and recording their desired outcomes, working out with them (and their representatives or advocates if they lack capacity) how best those outcomes might be realised and then seeing, at the end, the extent to which desired outcomes have been realised.

Adopting MSP does facilitate the development of quantitative and qualitative measures that enable practitioners, teams and Safeguarding Adults Boards to start to see how effective they are. However it is fundamentally about a change of focus and practice away from putting people through a process and towards engaging with them to identify and realise the outcomes they want. It is about using the process to support a conversation or series of conversations, and about adapting the process to most effectively improve those conversations and outcomes.

It is not expected, even in perfect circumstances, that the outcomes people want will be realised 100 per cent of the time. In many instances people want more than one outcome; outcomes can be difficult to reconcile with each other; people develop in their understanding of the situation and the level of risk; negotiation of the different perspectives on outcomes means that initial expressed outcomes change. There are often good reasons why outcomes may be only partially met.

Where will we start and how will we ascertain the impact we are having?

Councils are invited to engage in work on one or more of three levels:

- **Bronze:** working with people (and their advocates or representatives if they lack capacity) at the beginning to identify the outcomes they want and then looking at the end at the extent to which they are realised.
- **Silver:** the above, plus developing one or more types of responses to safeguarding and/ or recording and aggregating information about responses.
- **Gold:** the above, plus independent evaluation by a research organisation.

Rotherham has initially signed up to commence at Bronze level. Our three neighbouring Authorities (Sheffield, Doncaster and Barnsley) have all signed up to Bronze. The proposal is for Rotherham to engage at Silver level by developing one of the proposed tools/responses to safeguarding.

In order to achieve this it is proposed that a project group be established in order to:

- Re-design policies and procedures to make them person centred
- Developing materials to support practitioners and the people they are working with
- Develop recording mechanisms
- Review how advocacy is made available
- Develop, brief on and implement one or more of the approaches approaches to support people to resolve their circumstances 'Making Safeguarding Personal: A Toolkit for Responses' gives examples of these as:

- 1 Empowering people – personalised information and advices
- 2 Building confidence, assertiveness, self-esteem and respect
- 3 Supported decision making
- 4 Peer support
- 5 Dealing with risk and problems when employing personal assistants.
- 6 Family group conferences
- 7 Therapeutic and counselling support
- 8 Brief interventions
- 9 Advocacy
- 10 Mediation and conflict resolution
- 11 Support for people who have caused harm
- 12 Restorative justice

## **8 Finance**

There is an acknowledgement that MSP will be time and resource intensive, however, it is envisaged that silver level can be achieved within current establishment and available resources.

## **9 Risks and Uncertainties**

- How we will record and evaluate peoples experience of safeguarding.
- Setting up a system/s and approaches to collecting and collating a range of information (capable of being used by the Safeguarding Adults Board).
- How we use MSP for monitoring and evidencing improvement in safeguarding adults.
- Balancing MSP with Performance Management Framework

Each of the above requires different skills, tools, quality assurance and other mechanisms to make them work. We will need to consider our approach to this. We will also need to consider the extent of change that will be needed to make in order to affect MSP based on current practice.

Failure to adopt this approach and embed systematic appreciation of the outcomes that people desire will mean that the council will be unable fully to implement the Care Act 2014 from 01.04.2015.

## **10 Policy and 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.

People in need of support and care get help earlier and have more choice and control to help them live at home (CP2, CP3).



## 11 Background Papers and Consultation

There are four key documents associated with this summary:

- Executive summary
- Guide to Making Safeguarding Personal
- Case studies
- Selection of tools used by participating councils

These are available on the safeguarding adult's pages on the LGA website:

[http://www.local.gov.uk/adult-social-care/-/journal\\_content/56/10180/3877757/ARTICLE](http://www.local.gov.uk/adult-social-care/-/journal_content/56/10180/3877757/ARTICLE)

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<b>ROTHERHAM BOROUGH COUNCIL – REPORT TO CABINET MEMBER</b>
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<b>1.</b>	<b>Meeting:</b>	Cabinet Member for Adult Social Care and Health
<b>2.</b>	<b>Date:</b>	17 <sup>th</sup> November 2014
<b>3.</b>	<b>Title:</b>	Vulnerable Adults Risk Management
<b>4.</b>	<b>Directorate:</b>	Neighbourhoods and Adult Services

## 5. Summary

This report introduces proposals to case manage vulnerable adults, improve outcomes and develop cross agency working in the support and protection of vulnerable adults in our communities. It introduces to Rotherham a Vulnerable Adults Risk Management (VARM) framework to enable, on a case by case basis, the assessment, case management and better co-ordination of an effective response to vulnerable adults. It provides a structured escalation process set within the context of the Safer Rotherham Partnership and Rotherham Safeguarding Adults Board. It has been developed in partnership with South Yorkshire Police, the Vulnerable Person's Unit and the Safeguarding Adults Team.

Vulnerable Adults may present to services in numerous ways including through substance misuse, chaotic lifestyles, domestic abuse, sexualised behaviour, Mental Health Services, the Criminal Justice System and through frequent use of emergency services.

These presentations may be a manifestation of childhood trauma, including Child Sexual Exploitation and Abuse. The Vulnerable Adults Risk Management process links all relevant services and involves all agencies to reduce risk, improve outcomes and prevent further abuse to the victim and others, for the adult victims of Child Sexual Exploitation and others at risk.

## 6. Recommendations

- **It is recommended that the Vulnerable Adult Risk Management Framework is supported and progressed for formal adoption across the Safer Rotherham Partnership and Safeguarding Adults Board.**
- **To ensure Vulnerable Adult Risk Management, urgent consideration must be given to resourcing of this service. As a result of the recent Child Sexual Exploitation, it is clear that VARM is invaluable in identifying adult victims of CSE, providing effective case management and risk reduction. In addition it provides a means to meet key national government priorities as outlined in the Care Act (2014) including recognition, assessment and sign posting to relevant services.**

## 7. Proposals and Details

There are local and national examples of incidents of exploitation involving vulnerable adults who are at risk due to self-neglect, refusal of services or abuse and exploitation by a third party. These individuals have capacity to make decisions which put them at risk and could result in the risk of serious injury or death, creating concern regarding their safety. There is a need to examine how all agencies respond to and support these individuals.

There is good evidence to show that on a day to day basis different agencies do provide such response and services and, often ensure a joined up approach to support the individual. Unfortunately, however, there are examples where, for a number of reasons, the vulnerable person is left at risk. These include circumstances where:

- The vulnerable adult sits outside defined eligibility criteria
- The vulnerable adult is 'bounced' from one service to another
- The vulnerable adult may be receiving a service but require more support and co-operation in response to their specific needs
- Unmet need is identified
- Lack of engagement by the vulnerable adult
- There has been evidence of a history or suspected history of Child Sexual Exploitation

This, in itself, often results in the vulnerable person being either "dismissed" by individual services and sometimes deemed a burden because of the high demand they place on services. The demand for support is often across a range of services including Adult Social Care, Housing and Neighbourhood Services, the NHS, Police, and Voluntary sector.

Not dealing with the matter in a co-ordinated, person centered approach leads to:

- an inefficient use of resources
- lack of multi-agency approach
- lack of information sharing
- a poor service to individuals with ineffective outcomes both from the person and the organisation's perspective.

In effect the vulnerable person falls between the gaps in services. This factor often features in Serious Case Reviews, and can be the result of the failure of service to be able to work together in a coordinated and person centred way, sometimes outside of the boundaries of the normally accepted service standard.

At this time, whilst services are reacting to the demand placed by the individual in an uncoordinated way on a range of services, the services involved are missing the best opportunity to reduce risk and improve outcomes for the individual and for services. The VARM policy provides an

opportunity for services to provide safer more effective service to this group of customers.

This work has been commenced by the Vulnerable Persons Unit (VPU) which has been drawing together information, managing the multi-agency risk and arranging for case specific multi-agency reviews.

The activity of each service, current local multi-agency working, and the assessment and case management by the VPU needs to be supplemented and embedded into a risk assessment framework, this will:

- Reduce risk and increase a co-ordinated and effective service to the individual
- Identify key agencies to work with vulnerable adult
- Identify needs to improve outcomes
- Reduce inappropriate use of services e.g. high frequency callers to Emergency Services
- Achieve this through the use of effective case management, multi-agency working including appropriate information sharing, action plans and continued monitoring to reduce risk and improve outcomes

The proposed Vulnerable Adults Risk Management Framework is attached.

## **8. Finance**

Support for vulnerable adults is already resourced via a range of support services. Additional resource to enable the process to operate smoothly requires consideration and, whilst the VPU is providing basic process support, enhancement is required to ensure a robust engagement, risk assessment, support and advocacy service. This will enable access and engagement of all relevant services.

## **9. Risks and Uncertainties**

The proposed Vulnerable Adult Risk Management Framework is designed to manage the following risks:

- Individual Risk
- Organisational Risk
- Inefficient use of resources
- Poor Outcomes

The Framework will require **all** agencies to take accountability to engage with other agencies to meet the objectives of the risk management process. This will involve training and appropriate briefings.

## **10. Policy and 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.

People in need of support and care get help earlier and have more choice and control to help them live at home (CP2, CP3).

## **11. Background Papers and Consultation**

No Secrets DoH 2000

SCIE Report 46: Self-neglect and adult safeguarding 2011

Serious Case Review "Anna" Sheffield City Council 2011

Care Bill 2013

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## **Vulnerable Adult Risk Management (VARM) Framework**

### **Introduction**

This guidance seeks to provide professionals with a framework to facilitate effective working with adults who are at risk due to self-neglect, refusal of services or abuse and or exploitation by a third party, where that risk may lead to significant harm or death. This model provides a framework to support vulnerable adults (as defined by 'No Secrets' DoH 2000) and those working with them. It should be applied when a vulnerable adult with mental capacity makes choices that could result in serious harm injury or death.

This VARM framework is intended for use in the following circumstances:

- Where an adult has capacity to make the decision(s) that is creating significant concern for agencies about the adults safety and/or wellbeing (risk of serious injury/death)

And

- The risk arises from the individual's refusal to engage with services and/or self neglect in one or more areas of their lives

And

- Where existing agency involvement have tried and been unable to resolve the issues.

### **Process**

It is always best practice to inform the vulnerable adult that the VARM is being initiated; however the vulnerable adult's refusal to engage with service may be a cause of concern. Request for a VARM should not therefore be delayed because it is impossible to engage with the individual. The vulnerable adults consent should be sought, but a decision to initiate the process without consent may be justified if there are concerns that the vulnerable adult is at risk of significant harm.

VARM is a multi-agency meeting and cannot be undertaken by one service in isolation. These complex cases can sometimes divide agencies and a multi-agency approach will promote better understanding of each other's roles and help to prevent any misunderstandings or conflicts.

The VARM process can be initiated by any partner agency and will be facilitated and led by the Vulnerable Persons Unit (VPU). However the initial VARM meeting should routinely include individuals from the following key agencies:

- NHS Rotherham / Clinical Commissioning Group
- RMBC, Adult Safeguarding,
- RMBC Adult Social Care
- RMBC Housing and Neighbourhood Services
- Rotherham Foundation Trust
- RDASH
- South Yorkshire Fire & Rescue
- South Yorkshire Police (VPU/PPU)
- Voluntary and Community sector

Other potential partners should be considered on an individual case by case basis.

### **Information Sharing**

There is a duty placed on public agencies under the Human Rights Act (1998) to intervene to protect the rights of citizens. The organisation that you work for will also have a Code of Conduct that places a duty of care to service users upon you. The information exchanged under this Framework will be used for the purpose of protecting the individual from significant harm. Wherever possible the individual should be informed of the need to share their information unless this would increase their risk of harm.

### **Guidance**

Capacity or lack of capacity is a vital element in support planning with, or on behalf of, adults who are at risk of self-neglect.

Once a person's capacity has been established, planning can follow one of two routes, either:

- i) In the case of lack of capacity, a decision to follow Mental Capacity Act (MCA) Guidance to work in the individual's 'best interests', or
- ii) In the case of capacity, to follow the Vulnerable Adults Risk Management Process.

If the Client is assessed as having the capacity to understand the consequences of refusing services, then a VARM meeting should be convened. This is a bespoke cross agency meeting to develop and co-ordinate activity to address the needs of identified vulnerable adults and provide a multi-agency response where interventions have tried and failed.

It is essential that all agencies involved once a case enters the VARM framework, should notify their Senior Managers within 24 hours of this decision being made. This will ensure that senior managers are aware and can support workers with high risk cases that may result in attendance in coroner's court, challenges in the press etc. and assess any organisational risks.

Once the need for a VARM has been identified in agreement with Senior Managers, a referral will be made to the VPU. The Safeguarding Adults Office should also be notified on a VARM notification form

The meetings will be chaired by Chief Inspector South Yorkshire Police and will be scrutinised by the Vulnerable Adults Panel (VAP).

The aims of the VARM meeting will:

- Reduce risk and improve outcomes for individuals and for services.
- Provide a balance of support for the individual and the needs of the organisations involved
- Establish capacity and record when, where and by whom the assessment was carried out.
- Critique the Support Plan and discuss with a network of professionals alternative options for encouraging engagement with the Vulnerable Adult.
- To provide a multi-agency framework to monitor and manage risks and record agreed outcomes
- To identify service development to achieve the required outcome for the individual

**Need to consider which professional is best placed to engage** –supported and co-ordinated by case workers within VPU/VPT

Having established an alternative/holistic Support Plan, the adult at risks' resistance to engagement should be tested by the re-introduction of the new plan by the person or the agency most likely to succeed (this would have been decided at the Risk Management Meeting – see above).

Where the adult at risk continues to refuse services, good practice would involve the person or agency documenting the risks / risky behaviour and the adult at risk signing this as understanding and agreeing that they understand the risks involved.

If the plan is still rejected, the meeting should reconvene to discuss a review plan. The case should **not be** closed just because the adult at risk and is refusing to accept the plan. Appropriate advice must be taken as to a reasonable review plan, including consideration of the timescales to be applied.



In summary, the following sequence of events should be applied:

- Test capacity
- Risk Assess
- Alternative Support Plan
- Engage and advocate
- Test Resistance
- Review

It is important to agree timescales for each part of the process (to prevent the case “drifting”). This will be different for each case dependent on individual circumstances.

It is also important to ensure that any decisions made are accurately recorded. This should be within the minutes of the Risk Management/Review Meetings. Where possible, the Service User’s views and wishes should be included and if they are not present, the reason for this should be clearly documented.

It should be clear on the agreed actions, who is responsible for carrying out the actions and the timescales involved. Disagreements should also be clearly documented. Co-ordination of actions will be undertaken by case workers within the VPU.

All disagreements will be referred to the Vulnerable Adult Panel (VAP). The VAP is a meeting of senior managers positioned at an appropriate level in their organisation to deliver an organisational perspective, able to provide information valuable to the process and able to make decisions regarding the movement of resources to meet demand. The VAP will be chaired by Service Manager Safeguarding Adults, RMBC, who will convene the meeting as and when required inviting the appropriate senior managers, identified by the VARM, to attend.

This process does not and should not affect an individual’s human rights, but seeks to ensure that the Council (in partnership with other relevant agencies) extends its duty of care in a robust manner and as far as is reasonable.

The dilemma of managing the balance between protecting adults at risk from self-neglect, abuse and exploitation against their right to self-determination is a serious challenge for all services.

Applying this robust process should ensure all reasonable steps are taken to ensure safety, by a multi-agency group of professionals.

This model will be critical for the reasons outlined above, but in addition will anticipate the possible extension of the definition of adults who may be in need of safeguarding (to include those at risk of harm as a result of self-harm/self-neglect and sexual exploitation).

## Exiting the VARM Framework

Only when:

- All outcomes are achieved
- Risk is reduced as far as possible and all agency involvement and support has been explored.

All cases exiting the VARM must be referred to VAP for final sign off.

## Capacity

The Mental Capacity Act 2005 was implemented in April 2007 and is accompanied by the Code of Practice.

The following principles are set out in Section 1 of the Act and will need to form the basis of all work in relation to adults at risk, to ensure best practice:

- A person must be assumed to have capacity unless it is established that they lack capacity.
- A person is not to be treated as unable to make decisions unless all practicable steps to help them to do so have been taken without success.
- A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
- An act done, or decision made for or on behalf of a person who lacks capacity must be in their best interests.
- Before the act is done, or the decision made, regard must be had as to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

Section 2 of the Act provides that a person lacks capacity if at the material time he/she is unable to make a decision for him/herself in relation to the matter because of an impairment or disturbance that is permanent or temporary.

This is a diagnostic test which could cover, but is not limited to, a range of difficulties, such as psychiatric illness, learning disability, dementia, brain damage or even a toxic confusional state, as long as it has the necessary effect on the functioning of the mind or brain, which causes the person to be unable to make a decision.

Each decision must be considered separately. General assessments of capacity are not accepted. It is not acceptable, for example, to conclude that someone 'lacks capacity' in a general or "global" sense.

Capacity, or lack of, **must** refer to a particular decision. The question of whether a person lacks capacity to make a particular decision, at the time when the decision needs to be made, must be decided on the balance of probabilities, i.e. more likely than not.

Section 3 of the Act defines what being 'unable to make a decision' means:

- The person is unable to understand the information relevant to the decision.
- Unable to retain the information.
- Unable to use the information as part of the process of making the decision
- Unable to communicate the decision

### **Best Interests**

If a person is deemed to be lacking capacity, all circumstances must be considered in deciding whether something is in a person's 'best interests'. The Act gives further guidance on particular factors to be taken into account in Section 4.

None of the factors carry any more weight or priority than another; the list is not exhaustive but should enable an objective assessment of what is in the person's best interest to be made.

Consideration as to whether the person is likely to have capacity at some time and if so, when, must be given. This suggests the non-urgent decisions can be left if there is a likelihood of the person regaining capacity. The person in question should also be as fully involved as possible.

Factors to be considered:

- Encourage participation
  - do whatever is possible to permit and encourage the person to take part, or to improve their ability to take part, in making the decision
- Identify all relevant circumstances
  - try to identify all the things that the person who lacks capacity would take into account if they were making the decision or acting for themselves
- Find out the person's views
  - try to find out the views of the person who lacks capacity, including:
    - the person's past and present wishes and feelings – these may have been expressed verbally, in writing or through behaviour or habits.
    - any beliefs and values (e.g. religious, cultural, moral or political) that would be likely to influence the decision in question.
    - any other factors the person themselves would be likely to consider if they were making the decision or acting for themselves.
- Avoid discrimination
  - Do not make assumptions about someone's best interests simply on the basis of the person's age, appearance, condition or behaviour.
- Assess whether the person might regain capacity

- consider whether the person is likely to regain capacity (e.g. after receiving medical treatment). If so, can the decision wait until then?
- If the decision concerns life-sustaining treatment
  - Do not be motivated in any way by a desire to bring about the person's death. They should not make assumptions about the person's quality of life
- Consult others
  - if it is practical and appropriate to do so, consult other people for their views about the person's best interests and to see if they have any information about the person's wishes and feelings, beliefs and values. In particular, try to consult:
    - anyone previously named by the person as someone to be consulted on either the decision in question or on similar issues
    - anyone engaged in caring for the person
    - close relatives, friends or others who take an interest in the person's welfare
    - any attorney appointed under a Lasting Power of Attorney or Enduring Power of Attorney made by the person
    - any deputy appointed by the Court of Protection to make decisions for the person

## **Vulnerable Adults Risk Management Meeting**

### **TERMS OF REFERENCE**

#### **Purpose**

A bespoke cross agency meeting to develop and co-ordinate activity to address the needs of identified vulnerable adults and provide a multi-agency response where interventions have tried and failed or have not been available.

The meetings will be answerable to their own organisations and will be scrutinised by the Vulnerable Adults Panel (VAP). The VARM meeting will be convened, by the Vulnerable Persons Unit (VPU).

The aims of the meeting will be to:

- Reduce risk and improve outcomes for individuals and for services.
- Provide a balance of support for the individual and the needs of the organisations involved
- Establish capacity and record when, where and by whom the assessment was carried out.
- Critique the Support Plan and discuss with a network of professionals alternative options for encouraging engagement with the Vulnerable Adult.
- To provide a multi-agency framework to monitor and manage risks and record agreed outcomes
- To identify service development to achieve the required outcome for the individual

#### **Frequency of Meetings**

The meetings will be held within 3 weeks of a new case being identified. The urgency of the meeting will depend on the vulnerability of the individual and the availability of the professionals required. This will be decided by the case workers/co-ordinators within VPU following appropriate screening and risk assessments.

The necessity of a review meeting should be discussed and decided whether required, with a recommendation of being no later than 8 weeks following VARM meeting.

#### **Governance**

The meeting will be chaired by Chief Inspector South Yorkshire Police and minutes taken by the VPU using the set agenda.

### **Scrutiny**

The scrutiny will be provided by the VAP, which will be chaired by Safeguarding Adults Service Manager (NAS).

**Attendees of VARM:** Membership of the meetings requires a commitment from all agencies requested to attend as they will have been deemed necessary to provide a valuable input to the meeting and / or likely to be able to offer support to the process. Where attendance is not possible, a suitable briefed deputy must be nominated.

Attendees at the VARM meetings will not be limited to the organisations listed below; however, they need to be considered as having the potential to add to the VARM process. Other partner / agency representatives or voluntary organisations can be called upon to attend in relation to specific issues where they will be able to contribute to the meetings.

The initial VARM meeting should routinely include individuals from the following key agencies:

- NHS Rotherham / Clinical Commissioning Group
- RMBC, Adult Safeguarding,
- RMBC Adult Social Care
- RMBC Housing and Neighbourhood Services
- Rotherham Foundation Trust
- RDASH
- South Yorkshire Police (VPU/PPU)
- Voluntary and Community sector

Other potential partners should be considered on an individual case by case basis.

Those attending VARM need to understand the individual cases and be at an appropriate level within their organisation to make appropriate decisions in respect of their individual services. Where movement or development of resources is required or there are disagreements this will be referred to the VAP. The VAP is a meeting of senior managers positioned at an appropriate level in their organisation to deliver an organisational perspective, able to provide information valuable to the process and able to make decisions regarding the movement of resources to meet demand.

<b>ROTHERHAM BOROUGH COUNCIL – REPORT TO MEMBERS</b>
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<b>1</b>	<b>Meeting:</b>	<b>Cabinet Member for Adult Social Care</b>
<b>2</b>	<b>Date:</b>	<b>Monday 17<sup>th</sup> November 2014</b>
<b>3</b>	<b>Title:</b>	<b>Adult Services Revenue Budget Monitoring Report 2014/15</b>
<b>4</b>	<b>Directorate :</b>	<b>Neighbourhoods and Adult Social Services</b>

## **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 2015 based on actual income and expenditure for the period ending September 2014.

The latest forecast for the financial year 2014/15 shows an overall overspend of £900k against an approved net revenue budget of £69.267m, this represents a reduction of £370k since the last report. The main budget pressures relate to budget savings from previous years not fully achieved in respect of additional continuing health care (CHC) funding, recurrent pressures and increasing demand for Direct Payments plus delays on achieving budget savings proposals within Learning Disability Services.

Management actions are being developed with the aim of containing expenditure within the approved cash limited budget by the end of the financial year.

## **6 Recommendations**

**That the Cabinet Member receives and notes the latest financial projection against budget for 2014/15.**

## 7 Proposals and Details

### 7.1 The Current Position

The approved net revenue budget for Adult Services for 2014/15 is £69.267m. The approved budget includes budget savings of (£4.472m) identified through the 2014/15 budget setting process with no investments for demographic pressures including transitional placements from Children's services.

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

<b>Division of Service</b>	<b>Net Budget</b>	<b>Forecast Outturn</b>	<b>Variation</b>	<b>Variation</b>
	£000	£000	£000	%
Adults General	1,810	1,656	-154	-8.50
Older People	27,846	28,085	+239	+0.80
Learning Disabilities	22,125	22,843	+718	+3.24
Mental Health	4,759	4,538	-221	-4.64
Physical & Sensory Disabilities	5,375	5,717	+342	+6.36
Safeguarding	686	713	+27	+3.93
Supporting People	6,666	6,615	-51	-0.77
<b>Total Adult Services</b>	<b>69,267</b>	<b>70,167</b>	<b>900</b>	<b>+1.30</b>

7.1.2 The latest financial forecast shows there remains a number of underlying budget pressures. The main pressures being in respect of continued increase in demand for Direct Payments and unachieved budget savings within Older People's independent sector residential and nursing care. In addition budget pressures remain within Learning Disability Services on external transport provision together with delayed implementation on the de-commissioning of employment and leisure services plus pressures on supported living schemes. These pressures are being reduced by a number of forecast non recurrent under spends including additional one off grant funding.

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

#### **Adults General (-£154k)**

This area includes the cross cutting budgets (Workforce planning and training, and corporate charges) are forecasting an underspend due to higher than anticipated staff turnover within the Contract and Reviewing Officers team and the impact of the moratorium on training budgets.



### **Older People (+£239k)**

- Recurrent budget pressure on Direct Payments over budget (+£384k). Client numbers have increased (+63) since April together with an increase in the average cost of care packages.
- Forecast under spend on Enabling Care and sitting service (-£42k) based on current level of service together with an under spend within Independent sector home care (-£11k), which has experienced a slight reduction in demand (-40 clients) since April.
- An over spend on independent residential and nursing care (+£675k) due to delays in achieving the savings target for additional Continuing healthcare income. Additional income from property charges is reducing the overall overspend.
- Planned delay's on recruitment to vacant posts within Assessment & Care Management plus additional income from Health is resulting in an overall underspend (-£376k).
- Overall under spend on Rothercare (-£111k) due to savings on maintenance contracts on the new community alarm units and supplies and services.
- Other under spends in respect of vacancies with Community Support and Carers (-£52k).
- The forecasts include one off Winter Pressures funding from the CCG of £228k to increase social work capacity and prevent delayed discharges from hospital.

### **Learning Disabilities (+£718k)**

- Independent sector residential care budget is forecasting a slight overspend (+£5k). Work continues on reviewing all CHC applications and high cost placements as part of budget savings target.
- Forecast overspend within Day Care Services (+£160k) due to a recurrent budget pressure on external transport plus provision for 7 specialist transitional placements from Children's Services. This is being reduced slightly due to staff turnover higher than forecast.
- Overspend in independent sector home care (+£37k) due to increase in demand over and above approved budget.
- New transitional placements from Children's Services into Supported Living, plus additional demand for Shared Lives is being offset by additional CHC and one off funding resulting in an overall forecast underspend (-£115k).
- Delays in meeting approved budget saving on contracted services for employment and leisure services has increased the overspend (+£213k) due to extended consultation to the end of the financial year.
- Forecast pressure on changing the provision of residential care to delivering of Supported Living by RDASH (+£365k).
- Staff turnover lower than forecast within In House Residential Care (+£68k) reduced by saving on RDASH administration support (-£15k).

### **Mental Health (-£221k)**

- A projected under spend on residential care budget (-£160k) due to a reduction of 3 placements since April plus additional Public Health funding for substance misuse.
- Pressures on employee budgets due to lower than expected staff turnover plus review of night cover arrangements (+£19k) offset by underspend on Direct Payments (-£80k) due to a review of a number of care packages plus additional Public Health funding.

### **Physical & Sensory Disabilities (+£342k)**

- Further increase in demand for Direct Payments (+ 29 clients since April) in addition to a recurrent budget pressure is forecasting an overspend (+£436k).
- Efficiency savings on contracts for advice and information (-£18k).
- Underspend on Independent sector homecare (-£76K) as clients migrate to direct payments scheme.

### **Safeguarding (+£27k)**

- The increase in demand for assessments under Deprivation of Liberty Safeguards (144 to date compared to a total of 56 in 2013/14) is putting additional pressure on existing budgets (+£104k). This is being reduced by higher than anticipated staff turnover plus additional one off income from health (-£77k).

### **Supporting People (-£51k)**

- Efficiency savings on supplies and services budgets.

#### **7.1.3 Agency and Consultancy**

Actual spend on agency costs to end September 2014 was £88,350(no off contract), this is a significant reduction compared with actual expenditure of £238,867 (no off contract) for the same period last financial year. The main areas of spend is within Residential Care and Assessment & Care Management Social work Teams.

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 September 2014 was £92,945 compared with £198,280 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 which has not been funded for transitions in 2014/15. To-date there has been 28 transitional placements from Children's to Adult Social care services.

Another significant risk is the additional demand and cost of assessments under Deprivation of Liberty Safeguards reported earlier in the report.

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 third quarter of 2013/14 shows that Rotherham remains below average in terms of activity in respect of continuing health care (16<sup>th</sup> out of the total 23 CCG's).

## **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 26th February 2014 –Proposed Revenue Budget and Council Tax for 2014/15.
- The Council's Medium Term Financial Strategy (MTFS).

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](mailto:Mark.Scarrott@rotherham.gov.uk)*.

<b>ROTHERHAM BOROUGH COUNCIL – REPORT TO MEMBERS</b>
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<b>1.</b>	<b>Meeting:</b>	<b>Cabinet Member Adult Social Care and Health</b>
<b>2.</b>	<b>Date:</b>	<b>17<sup>th</sup> November 2014</b>
<b>3.</b>	<b>Title:</b>	<b>Waiver Rotherham Healthwatch</b>
<b>4.</b>	<b>Directorate:</b>	<b>Neighbourhood and Adults Services</b>

**5. Summary:**

**Rotherham Healthwatch is commissioned for and behalf of Rotherham Health and Wellbeing Board (HWBB).**

**Parkwood Healthcare Ltd were formally advised in writing of the intention and timeline to novate the contract to the Social Enterprise of Rotherham Healthwatch (RHW). Novation of contract was formally challenged by Parkwood Healthcare Ltd on 8<sup>th</sup> August 2014. Following advice from RMBC Legal team the Council entered into a deed of termination agreement with Parkwood Healthcare to ensure that delivery of the service could commence by the Social Enterprise Rotherham Healthwatch Ltd on 1<sup>st</sup> September 2014 as agreed.**

**The termination process was successfully completed by 31<sup>st</sup> August 2014 and a new contract was established with Rotherham Healthwatch Ltd, the Social Enterprise, on 1<sup>st</sup> September 2014.**

**Legal advised that the challenge from Parkwood necessitated a retrospective waiver of Council Standing Orders to contract with the newly established Social Enterprise.**

**6. Recommendations**

**That the Cabinet Member for Adult Social Care and Health**

**6.1 Waive (in accordance with Standing Order 49 - Tender invitation and Receipt of tenders) for delivery of Healthwatch Rotherham.**

## **7. Proposal and Details**

### **7.1 Service Delivery**

Healthwatch Rotherham (HWR) was commissioned by Rotherham Borough Council on behalf of the Health and Wellbeing Board as the consumer champion for health and social care services in Rotherham.

Parkwood Healthcare Ltd was awarded the Healthwatch Rotherham (HWR) contract following an open tender process. The contract commenced on the 1<sup>st</sup> April, 2013 for a contract period of 2 years with an option to extend for a further 1 year dependent on central government funding.

As set out in the tender process and in the contract it was always the intention, , that once Parkwood Healthcare Ltd had established Healthwatch Rotherham that the contract would novate to HWR to enable HWR to operate as an independent Social Enterprise. The intention to novate the contact by September 2014 was approved by the Health and Wellbeing Board on the 26th March, 2014

Parkwood Healthcare Ltd were formally retold in writing of the novation intention and timeline. Negotiations commenced and were conducted in an open, transparent and affable environment.

The Chair, Board of Directors and management staff of RHW were supported to set up a Social Enterprise to deliver the services as set out in the original specification and contract and existing staff have been TUPE'd into the Social Enterprise.

Novation of contract was formally challenged by Parkwood Healthcare Ltd on 8<sup>th</sup> August 2014. Following advice from RMBC Legal team the Council entered into a deed of termination agreement with Parkwood Healthcare to end any rights and obligations under the existing contract with Parkwood Healthcare Ltd (Confidentiality and National Audit requirements notwithstanding) and to ensure that delivery of the service could commence by Rotherham Healthwatch Ltd (Social Enterprise) on 1<sup>st</sup> September 2014 as agreed. The termination process was successfully completed by 31<sup>st</sup> August 2014 and a new contract was established with Rotherham Healthwatch Ltd on 1<sup>st</sup> September 2014 until 31<sup>st</sup> March 2015.

The challenge requires a waiver of Standing Orders to contract with the newly established Social Enterprise. This is retrospective as prior to the challenge the novation clause in the contract was deemed sufficient to be relied upon to achieve the transfer of obligations and undertakings.

We are seeking a waiver from Standing Orders to not undertake a competitive tendering exercise on the basis of:-

- Cost effectiveness – only Parkwood Healthcare Ltd (the outgoing provider) was evaluated has having the necessary skills and experience to deliver Healthwatch Rotherham at the last round of competitive tenders
- Parkwood Healthcare have surrendered future rights and obligations of the contract

- Delivery of the service will be conducted using the same members of staff under the same terms and conditions and original specification.
- Novation of the contract to a Social Enterprise was previously agreed by HWBB on 26th March 2014.

## **8. Finance**

The value of the Healthwatch Rotherham contract is £215,000 per annum. The contract with Rotherham Healthwatch Ltd is £125,417 (7 months) to 31<sup>st</sup> March 2015 with an option to extend for a further year (if the funding is available). The budget continues to be monitored by the RMBC commissioning team.

## **9. Risks and Uncertainties**

That if we go out for a competitive tender we would not attract suitable submission from other providers other than Rotherham Healthwatch Ltd or Parkwood and the delays in the process would have a significant impact on a well-established service in Rotherham

## **10. Policy and Performance Agenda Implications**

Rotherham Healthwatch will contribute to the delivery of the Corporate Plan, in particular the following objectives:

CP1 Stimulating the local economy and helping local people into work

CP4 Helping people improve their health and wellbeing and reducing inequalities within the borough

The way we do business

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<b>ROTHERHAM BOROUGH COUNCIL – REPORT TO CABINET MEMBER</b>
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<b>1.</b>	<b>Meeting</b>	<b>Cabinet Member for Adult Social Care and Health</b>
<b>2.</b>	<b>Date</b>	<b>17 November 2014</b>
<b>3.</b>	<b>Title</b>	<b>Health Visiting and Family Nurse Partnership Development Funds – Section 7a Public Health Services – Proposals for Rotherham Services</b>
<b>4.</b>	<b>Directorate</b>	<b>Public Health</b>

### **5. Summary**

This paper proposes a programme of recurrently funded opportunities for Rotherham to increase the coverage of the Family Nurse Programme and support activity to promote maternal and children's public health by the Health Visiting Service (NB: This is additional to the current HV/FNP national expansion).

### **6. Recommendations**

- 1. That the recommended initiatives are supported as priorities for development.**
- 2. That the funding proposals are accepted and planning to implement activity is started in partnership with NHS England and The Rotherham Foundation Trust with immediate effect/as per schedule.**
- 3. That the implementation of these initiatives is led by the PH team in partnership with NHS England (South Yorkshire & Bassetlaw) as part of the transformation of HV and FNP services.**
- 4. In deciding to go ahead with this expansion it is essential to ensure there is long term commitment to these services, FNP expansion specifically requires written confirmation that the Local Authority will continue to run the programme and sustain the number of places for a minimum of 3 years post transition. Written confirmation to this effect will be required as part of firming up any expansion proposals**



## **7. Proposals and detail**

NHS England (South Yorkshire & Bassetlaw) have identified some development money, available to address inequalities across the NHS England area. For Rotherham, the proposal is to use this money as detailed below:

### **7.1 Family Nurse Partnership Coverage:**

Increase the capacity of the Family Nurse Partnership team to match that of the area where there is the best capacity and coverage – this would increase capacity so that 24% of first time, teenage pregnant women receive support from the FNP programme. Currently only 21.8% receive support.

### **7.2 Improve breastfeeding rates in Rotherham:**

#### **Baby Friendly Initiative**

The HV specification requires services to “achieve and maintain full accreditation of UNICEF Baby Friendly initiative”. This is the evidence based approach to increasing breastfeeding rates. All HV services in SY&B have achieved full Baby Friendly accreditation with the exception of Rotherham. To achieve Baby Friendly status, an Infant Feeding Co-ordinator is required to facilitate the process, plus significant training and other resources such as promotional materials and BFI assessment costs etc. TRFT (the provider) recognise that this work needs to take place, but the existing resource and capacity will create pressure in delivery of the full Child Health Programme and resulting public health outcomes. NHS England is offering a 50% contribution to this development and are seeking a commitment from TRFT to the remaining funding (this could be matched by the HV expansion funding already identified for TRFT). This proposal has been presented to TRFT and they are committed to supporting the match funding as described above, allowing them to maximise skill mix and opportunities for ensuring consistent and sustained support to the achievement of UNICEF BFI.

#### **BF Peer Support**

Existing Peer Support (Breast Buddies) is only funded until 31 March 2015. This service is crucial to support Breast Feeding mums and consists of a Peer Support Coordinator and paid part-time Peer Supporters who deliver support directly to women and also train volunteers to support women in the community. There are benefits to this being integrated into and managed by

the Health Visiting Service in the context of BFI. This proposal is supported by TRFT.

### **7.3 Implement Pregnancy, Birth and Beyond parent education in Rotherham:**

DH recommend Pregnancy, Birth & Beyond Parent (PB&B) Education for first time parents. This is currently offered in 2 other areas in South Yorkshire. Development would include co-ordination, training, development of materials, delivery staff and venues across the Borough as part of the integrated Foundation Years Best Start Service. PB&B has been endorsed by the Think Family Steering Group, but there are resource issues preventing progress with the initiative.

## **8. Finance**

Proposal	Cost (£)
Family Nurse Partnership expansion (1.0 wte)	36,630
Baby Friendly Initiative (0.5 wte) and skill mix/materials	24,167
Breastfeeding Peer Support coordination and delivery (wte to be confirmed)	39,628
Pregnancy, Birth & Beyond (0.5 wte plus resources)	23,074
Total	123,499

## **9. Risks and uncertainties**

Due to the national expansion of Health Visitor numbers, Health Visitors are hard to recruit. These proposals rely on successfully recruiting staff, the specialist nature of the staff should help attract applicants to the FNP and Infant Feeding Co-ordinator posts. The Peer Support and Parenting, Birth & Beyond do not necessarily need to be trained Health Visitors so these posts should not be too difficult to fill.

## **10. Policy and Performance Agenda Implications**

Breastfeeding initiation and maintenance at 6-8 weeks are part of the Public Health Outcomes Framework. Rotherham's performance is poor and a Performance Clinic is being held on 5<sup>th</sup> November 2014. Breastfeeding has numerous health benefits for Baby and Mum, and is recognised as a key priority in ensuring a Best Start in Life in Marmot.

The Family Nurse Partnership programme is an evidence based programme to support first-time teenage parents. It is linked to a range of indicators in PHOF and the CYPS performance framework, including reduction of NEETs.

Pre- and post-natal parenting education supports the Best Start initiative and early intervention/prevention agendas. It helps to ensure engagement with services and the 0-5 Child Health Programme.

### **11. Background Papers and Consultation**

Further details of reference materials available on request.

### **12. Officers:**

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Public Health 01709 255852 [joanna.saunders@rotherham.gov.uk](mailto:joanna.saunders@rotherham.gov.uk)

Caroline Burrows, Public Health Commissioning Manager, NHS England (South  
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**Keywords:** Breastfeeding, maternal health, infant health, early intervention and prevention, Best Start, integrated Foundation Years Service

### **Director:**

Dr. John Radford, Director of Public Health, RMBC

<b>ROTHERHAM BOROUGH COUNCIL – REPORT TO CABINET MEMBER</b>
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<b>1.</b>	<b>Meeting:</b>	<b>Cabinet Member for Adult Social Care and Health</b>
<b>2.</b>	<b>Date:</b>	<b>17 November 2014</b>
<b>3.</b>	<b>Title:</b>	<b>South Yorkshire Declaration on National Crisis Care Concordat</b>
<b>4.</b>	<b>Programme Area:</b>	<b>Neighbourhoods and Adult Services</b>

### **5. Summary**

This report seeks approval from the Cabinet Member for Adult Social Care and Health to join partner organisations in South Yorkshire in formally agreeing to the principles in the national Concordat for Mental Health Crisis Care.

The Concordat is available as a background paper, and the Declaration Statement, which partners in NHS England have prepared to outline commitment to improve outcomes for people experiencing mental health crisis is attached as Appendix 1.

### **6. Recommendations**

**That the Cabinet Member for Adult Social Care and Health:**

- **Receives the information contained in this report and appendix.**
- **Agrees and endorses the commitment of the Local Authority to the Declaration and approves the involvement of Council officers in implementing the recommendations contained in the Concordat within the Better Care Fund Action Plan.**
- **Agrees the onward progress of the report to Health and Wellbeing Board, CYPS DLT, and Cabinet Member for Children and Education Services for information and support for the Action Plan.**

## 7. Background

- 7.1 The DH 'Mental Health Crisis Care Concordat – Improving outcomes for people experiencing mental health crisis' was published in February 2014. The Concordat includes all age groups from 16 years and beyond.

The following national organisations are signatories to the Concordat:

Association of Directors of Children's Services  
Association of Police and Crime Commissioners  
British Transport Police  
Care Quality Commission  
College of Emergency Medicine  
College of Policing  
The College of Social Work  
Department of Health  
Health Education England  
Home Office  
Local Government Association  
Mind  
NHS Confederation  
NHS England  
Public Health England  
Royal College of General Practitioners  
Royal College of Nursing  
Royal College of Paediatrics and Child Health  
Royal College of Psychiatrists

- 7.2 Signatories to this Concordat have made a commitment to work together to support local systems to achieve continuous improvements for crisis care for people with mental health issues across England:

*"We commit to work together to improve the system of care and support so people in crisis because of a mental health condition are kept safe and helped to find the support they need – whatever the circumstances in which they first need help – and from whichever service they turn to first.*

*We will work together, and with local organisations, to prevent crises happening whenever possible through prevention and early intervention. We will make sure we meet the needs of vulnerable people in urgent situations. We will strive to make sure that all relevant public services support someone who appears to have a mental health problem to move towards Recovery.*

*Jointly, we hold ourselves accountable for enabling this commitment to be delivered across England.”*

- 7.3 A Declaration document has been developed by NHS England and sign up at a locality level by partner organisations has been canvassed at a sub-regional level.

In September 2014 a formal request was made to Rotherham Council to agree to sign up to the South Yorkshire Crisis Care Concordat Declaration (template attached as Appendix 1), and to join with partner organisations to develop local area action plans to implement the recommendations contained in the Concordat.

Essential stakeholders for South Yorkshire are:

- Sheffield CCG
- Doncaster CCG
- Doncaster Council (Social Care Commissioners)
- Rotherham CCG
- Rotherham Metropolitan Borough Council (Social Care Commissioners)
- South Yorkshire and Bassetlaw Area Team (Primary Care Commissioners)
- The South Yorkshire Police Service
- South Yorkshire Police and Crime Commissioner
- Yorkshire Ambulance Service
- RDaSH NHS
- SWYPFT NHS Trust
- Barnsley Hospital NHS Foundation Trust
- The Rotherham Foundation Trust
- Sheffield Teaching Hospitals NHS Foundation Trust
- Sheffield Health and Social Care NHS Foundation Trust
- Doncaster & Bassetlaw Hospitals NHS FT

The deadline for uploading declarations to the national Crisis Care Concordat website is December 2014 and has been set by the Department of Health.

- 7.4 Once the commitment to work collaboratively together is made via the regional declaration, local action plans will need to be developed to meet the ambitions of the Concordat.

The Yorkshire and the Humber Multi Agency Mental Health Collaborative is a group that meets every two months and already has senior representatives from a number of the key stakeholders in regular attendance. NHS England suggests that this group could help support the implementation of local action plans as well as be a forum to discuss specific problems and take actions back to their respective

organisations. A programme of reviewing action plans through this group could be arranged.

- 7.5 An event has been arranged for South Yorkshire Concordat members on Thursday 6<sup>th</sup> November. The target audience for the event is senior managers or directors with responsibility for driving improvements within their organisation in line with the Crisis Care Concordat. The event will give the representatives a chance to clarify any questions they have as well as interface with other local stakeholders who will be involved in local action plans.
- 7.6 The event will be hosted as a tripartite venture between the South Yorkshire Police, the Yorkshire Ambulance Service and the Strategic Clinical Networks, to facilitate a declaration for the whole of the South Yorkshire.
- 7.7 The event will only be successful if all stakeholders agree to the template declaration and also send a representative to the meeting to both demonstrate the organisations commitments to service improvement and the local action plans.
- 7.8 It is expected that an organisational logo from each organisation who has agreed to the declaration will be forwarded to the NHS England to upload onto the declaration following the event.

## **8. Proposal**

- 8.1 The Crisis Concordat is a key element of the Better Care Fund (BCF01) workstream, which is working to develop a Mental Health Liaison Service that supports the outcomes of the BCF and the principle of 'parity of esteem' between physical and mental health care.

It is therefore proposed that the Council supports the aims of the Concordat formally by becoming signatories to the South Yorkshire Declaration Statement.

- 8.2 A representative from Rotherham Council will attend the event on 6<sup>th</sup> November to feedback the detail of the commitment, and clarify the 'sign up' process.
- 8.3 The local action plan will be developed through BCF01, co-ordinated by the RCCG and RMBC leads for BCF01. Performance in relation to the action plan will be managed through the BCF Operational Group, the Systems Resilience Group, and the Health and Wellbeing Board.
- 8.4 Support with developing the action plan will be sought through attendance by RCCG and RMBC officers at the Yorkshire and the Humber Multi Agency Mental Health Collaborative.

8.5 This paper has been endorsed in principle by NAS DLT, and will be forwarded for information and support to CYPS DLT and Cabinet Member for Children and Education Services.

## 9. Finance

There are no immediate financial implications for the Council in signing up to the Declaration Statement. There may be implications arising from the action plan, but these will be managed through the BCF Programme.

## 10. Risks and Uncertainties

Failure to sign up to the Concordat:

- 10.1 Would not accord with the agreed ADCS and ADASS position.
- 10.2 May adversely impact on the care arrangements for people experiencing mental health crisis.
- 10.3 Would not accord with the partnership principles in the Rotherham Health and Wellbeing Strategy and the Adult Partnership Board.
- 10.4 May have implications for the delivery of BCF outcomes.

## 11. Background Papers and Consultation

- Department of Health - Mental Health Crisis Care Concordat – Improving outcomes for people experiencing mental health crisis (February 2014)
- Department of Health - No health without mental health; a cross-government mental health outcomes strategy for people of all ages. (February 2011)
- Better Care Fund Action Plan

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## APPENDIX 1

### **The 2014 South Yorkshire Declaration on improving outcomes for people experiencing mental health crisis [date of Declaration or of this DRAFT]**

We, as partner organisations in South Yorkshire, will work together to put in place the principles of the national Concordat to improve the system of care and support so that people in crisis because of a mental health condition are kept safe. We will help them to find the help they need – whatever the circumstances – from whichever of our services they turn to first.

We will work together to prevent crises happening whenever possible, through intervening at an early stage.

We will make sure we meet the needs of vulnerable people in urgent situations, getting the right care at the right time from the right people to make sure of the best outcomes.

We will do our very best to make sure that all relevant public services, contractors and independent sector partners support people with a mental health problem to help them recover. Everybody who signs this declaration will work towards developing ways of sharing information to help front line staff provide better responses to people in crisis.

We are responsible for delivering this commitment in South Yorkshire by putting in place, reviewing and regularly updating locally agreed action plans.

### **This declaration supports 'parity of esteem' (see the glossary) between physical and mental health care in the following ways:**

- Through everyone agreeing a shared 'care pathway' to safely support, assess and manage anyone who asks any of our services in South Yorkshire for help in a crisis. This will result in the best outcomes for people with suspected serious mental illness, provide advice and support for their carers, and make sure that services work together safely and effectively.
- Through agencies working together to improve individuals' experience (professionals, people who use crisis care services, and carers) and reduce the likelihood of harm to the health and wellbeing of patients, carers and professionals.
- By making sure there is a safe and effective service with clear and agreed policies and procedures in place for people in crisis, and that organisations can access the service and refer people to it in the same way as they would for physical health and social care services.
- By all organisations who sign this declaration working together and accepting our responsibilities to reduce the likelihood of future harm to staff, carers, patients and service users or the wider community and to support people's recovery and wellbeing.

**We, the organisations listed below, support this Declaration. We are committed to working together to continue to improve crisis care for people with mental health needs in South Yorkshire.**

### **Who should sign a local Declaration?**

Many local organisations want to support the Declaration because of their commitment to improve mental health care and may want to make a specific contribution within the action plan for continuous improvements.

In addition, certain organisations have a formal (statutory) responsibility and/or a professional duty of care regarding people presenting in mental health crisis:

- Clinical Commissioning Groups
- NHS England Local Area teams (primary care commissioners)
- Commissioners of social services
- The Police Service
- Police and Crime Commissioners
- The Ambulance Service

- NHS providers of Urgent and Emergency Care (Emergency Departments within local hospitals)
- Public / independent providers of NHS funded mental health services
- Public / independent providers of substance misuse services

## Glossary of terms used in this declaration

<p><b>Concordat</b></p>	<p>A document published by the Government.</p> <p>The Concordat is a shared, agreed statement, signed by senior representatives from all the organisations involved. It covers what needs to happen when people in mental-health crisis need help.</p> <p>It contains a set of agreements made between national organisations, each of which has a formal responsibility of some kind towards people who need help. It also contains an action plan agreed between the organisations who have signed the Concordat.</p> <p>Title: Mental Health Crisis Care Concordat – Improving outcomes for people experiencing mental health crisis Author: Department of Health and Concordat signatories Document purpose: Guidance Publication date: 18<sup>th</sup> February 2014</p> <p>Link: <a href="https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281242/36353_Mental_Health_Crisis_accessible.pdf">https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281242/36353_Mental_Health_Crisis_accessible.pdf</a></p>
<p><b>Mental health crisis</b></p>	<p>When people – of all ages – with mental health problems urgently need help because of their suicidal behaviour, panic attacks or extreme anxiety, psychotic episodes, or behaviour that seems out of control or irrational and likely to put the person (or other people) in danger.</p>
<p><b>Parity of esteem</b></p>	<p>Parity of esteem is when mental health is valued equally with physical health.</p> <p>If people become mentally unwell, the services they use will assess and treat mental health disorders or conditions on a par with physical illnesses.</p> <p>Further information: <a href="http://www.england.nhs.uk/ourwork/qual-clin-lead/pe">http://www.england.nhs.uk/ourwork/qual-clin-lead/pe</a></p>

<b>Recovery</b>	<p>One definition of Recovery within the context of mental health is from Dr. William Anthony:</p> <p>“Recovery is a deeply personal, unique process changing one’s attitude, values, feelings, goals, skills, and/or roles.</p> <p>It is a way of living a satisfying, hopeful, and contributing life.</p> <p>Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of psychiatric disability” (Anthony, 1993)</p> <p>Further information <a href="http://www.imroc.org/">http://www.imroc.org/</a></p>
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By virtue of paragraph(s) 3 of Part 1 of Schedule 12A  
of the Local Government Act 1972.

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