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

- Keep people safe from abuse
- Knows what to do when abuse happens
- Work together to prevent abuse

# Annual Report 2017/18

Rotherham
Safeguarding Adults

# **Introduction by Sandie Keene** (CBE)
## Rotherham Safeguarding Adults Board Independent Chair

**As Independent Chair of the Rotherham Safeguarding Adults Board I am pleased to present the Annual Report for 2017/18 and to report on the continued commitment from all partner agencies. Partners consistently show their strong support to help deliver the priorities of the board and ensure that vulnerable adults are protected and safeguarded. As a Board we maintain our commitment to the citizens of Rotherham and have a zero tolerance to adult abuse.**

This year the board has prioritised work to publicise Safeguarding so that people are aware of how to report abuse, that the public have a knowledge of what safeguarding means and the different types of abuse that are covered by Safeguarding Adults. The board is committed to continue to raise public awareness through Safeguarding Awareness Week, public consultation, further work with the voluntary sector and public forums and ensuring the public voice is heard at Board level.

Together the partners of the board are keen to learn from Safeguarding Adult Reviews. We recognize that by reviewing where we have not achieved best practice in the past, we can learn for the future and use the information to help improve services and implement change when needed. We celebrate good practice and positive outcomes for the residents of Rotherham and will support people to make informed choices to live safely and free from harm.

In the year ahead the Rotherham Safeguarding Adults Board will prioritise raising the voice of people in receipt of Safeguarding services and ensuring that staff have sufficient guidance and support to undertake their responsibilities. A work plan has been developed which will continue our commitment to make Rotherham a safe place and contribute to make vulnerable adults free from abuse.

# Message from Cllr David Roche
## Chair of the Health and Wellbeing Board

**This Safeguarding Annual Report for 2017/18 highlights the strong partnership working from all board partners and gives reassurance that safeguarding is embedded in all organisations and at all levels.**

The work of the board needs true partnership working across all agencies and the Rotherham Safeguarding Adults Board ensures that partners are held to account by assessment and challenge and each agency provides the board with regular updates on their developments.

Safeguarding is everyone's business and only by working together will we raise the awareness of safeguarding and ensure that the vulnerable and those who lack the mental capacity to make the right decisions are supported, safeguarded and protected from harm.

May I take this opportunity to acknowledge the commitment of all the board partners including the statutory, independent and voluntary community sector. Rotherham needs everyone to work together to safeguard its citizens and to continue to raise awareness of safeguarding.

**Recognise • Respond • Report**

# Keeping people safe from abuse is everyone's business

## RECOGNISE • RESPOND • REPORT

**The Rotherham Safeguarding Adults Board works to protect adults with care and support needs from abuse and neglect.**

The RSAB's objective is to ensure that local safeguarding arrangements and partnerships act to help and protect adults at risk or experiencing neglect and/or abuse. The RSAB is a multi-agency strategic, rather than operational, partnership made up of senior/lead officers within adult social services, criminal justice, health, housing, community safety, voluntary organisations.

It coordinates the strategic development of adult safeguarding across Rotherham and ensures the effectiveness of the work undertaken by Partner Agencies in the area. The Rotherham Adult Safeguarding Partnership Board [RSAB] aims to achieve those objectives whilst supporting individuals in maintaining control over their lives and in making informed choices without coercion.

### Who is at risk?

**An adult at risk is someone who is aged 18 or over who:**

- Has needs for care and support
- Is experiencing or is at risk of abuse or neglect, and is unable to protect themselves

### What is abuse?

**Abuse can be:**

- Something that happens once
- Something that happens repeatedly
- A deliberate act
- Something that was unintentional, perhaps due to a lack of understanding
- A crime

**Abuse can happen anywhere, at any time and be caused by anyone including:**

- A partner or relative
- A friend or neighbour
- A paid or volunteer carer
- Other service users
- Someone in a position of trust
- A stranger

### Types of abuse:

***Physical abuse***
Hitting, kicking, punching, kicking, inappropriate restraint

***Domestic abuse***
Psychological, physical, verbal, sexual, financial or emotional abuse by a current or former partner or family member

***Organisational abuse***
Poor treatment in a care setting

***Financial or material abuse***
Theft, fraud, misuse of someone else's finances.

***Sexual abuse***
Being made to take part in a sexual activity without consent

***Discriminatory abuse***
Harassment based on age, gender, sexuality, disability, race or religion

***Neglect***
Failure to provide care or support

***Psychological abuse***
Shouting, ridiculing or bullying

***Modern slavery***
Human trafficking and forced labour

***Self-neglect***
Declines essential care support needs, impacting on their overall wellbeing


*Doing nothing is not an option!*

# Rotherham Safeguarding **Adults Review** of 2017/18

**During 2017/18 Rotherham's Safeguarding Adults Board (RSAB) has been continuing to work to promote and protect vulnerable adults in Rotherham, another busy and successful year building and developing the board. The board continued to meet bi-monthly to ensure the hard work of the previous year was built upon and all partnership working was developed and strengthened in the sub groups.**

August 2017 saw two Safeguarding Adults Reviews published and recommendations made by the independent authors were developed into action plans. The board will monitor the action plans through the Performance and Quality sub group to ensure learning is shared and all actions are completed. The board also contributed to a review led by NHS England following the death of a young man in a Learning Disabilities care home. The review will be published early in 2018/19 and Rotherham will embed the learning identified and work with partners to ensure safeguarding is embedded in all Learning Disability services.

Rotherham have been working with Sheffield, Doncaster and Barnsley to revise and relaunch the South Yorkshire Safeguarding Procedures, working in consultation with all partners across the borough and South Yorkshire to ensure the procedures are fit for purpose and fully encompass the Care Act. Work will continue into the new financial year and will hopefully see a launch early in January 2019.

September 2017 the board appointed a permanent Board Manager after having an interim manager for in post since January 2016.

Work began in January 2017 to plan for a South Yorkshire Safeguarding Awareness Week in July 2017. The four Safeguarding Adults Boards, Rotherham, Sheffield, Barnsley and Doncaster along with the four Children's Boards planned a week of activities to promote and raise awareness of Safeguarding.

Priority was given to develop strong links with other Boards in Rotherham including the Health and Well Being Board, Children's Safeguarding Board and Safer Rotherham Partnership. The chairs of these Boards are now meeting on a regular basis to discuss cross cutting themes and ensure we are working together. A planned development will be the development and implementation of a joint self-assessment and challenge programme between the Children's and Adults Safeguarding Boards, this will benefit all partners and remove duplication.

The Board continued to focus on customers and their experience during safeguarding processes, the Independent Chair has spent time attending meetings with the Voluntary Services and local action groups including the Rotherham Older Peoples Forum. This work will continue into the future and the board will encourage representation and participation from customer groups to help shape the work of the board.

Discussions at board during 2017/18 have brought experts to discuss issues including:

- LeDer (Learning Disabilities Mortality Review)
- Self Neglect
- Suicide Prevention
- Operation Stovewood (Historical Child Sexual Exploitation)
- Care Quality Commission, Roles and Responsibilities

## The priorities for the board were:

| Priority | Resulting Action |
|---|---|
| Development of policy and practice in the consistent application of thresholds for safeguarding alerts. | The Board held a Development Day in May 2017 that brought together partners to examine the current thresholds.<br>Resulting in;<br>• Threshold guidance developed<br>• Escalation policy introduced<br>The group also looked at the need for clear information around Lasting Power of Attorney<br>Healthwatch Rotherham will work together with the Rotherham Safeguarding Adults Board to improve and promote customer involvement and participation at board meetings and sub group meetings as appropriate. A Customer Involvement Charter has been agreed at board with plans for implementation during 2018/19. |
| Increase the voice of users and carers in the work of the Board. | Healthwatch Rotherham will work together with the Rotherham Safeguarding Adults Board to improve and promote customer involvement and participation at board meetings and sub group meetings as appropriate. A Customer Involvement Charter has been agreed at board with plans for implementation during 2018/19. |
| Identification of joint work with the Community Safety Partnership concerning human trafficking/modern day slavery. | Rotherham Safeguarding Adults Board and the Safer Rotherham Partnership will receive written updates to present to their boards. RSAB board manager will set up update reminders and ensure a regular agenda item on future RSAB Agendas. |
| Adopt and adapt information sharing protocols to ensure the Boards implementations of Safeguarding Procedures are fully and appropriately informed. | Rotherham has developed a Safeguarding Protocol that was signed off at the Children's and Adults Safeguarding Boards and the Safer Rotherham Partnership and the Health and Wellbeing Board. All Boards have agreed to work together to promote Safeguarding and the vulnerable. |

The Safeguarding Adults Board has four sub groups to ensure the priorities of board are actioned, the Sub -Groups each have a work plan and during 2017/18 they were able to deliver the following specific pieces of work:

### Performance and Quality Sub Group

| Priority | Resulting Action |
|---|---|
| Continue to develop the annual self-assessments of all member organisations. | A Peer Review took place in May 2017. The review concentrated on Making Safeguarding Personal (MSP) and how partners have embedded MSP into their day to day working.<br>Examples of good practice were:<br>• Safeguarding Champions across the RMBC workforce<br>• SYFR – Risk assessment questions are available on hand held tablet to prompt all officers<br>• Good working relationships between the Vulnerable Persons Unit (SYP) and Safeguarding teams. |
| Commission an Independent Case File Audit. | In January 2018 an independent review was commissioned to carry out the case file audit, recommendations included:<br>• RSAB should undertake research with people who have been subject to a safeguarding enquiry to establish whether they consider that they were appropriately supported or would have benefitted from an advocate<br>• Rotherham Safeguarding Adults Board should consider how the outcome of safeguarding enquiries should be categorised and include clear guidance regarding this within the procedures. |
| Continue to develop the performance reporting framework for Safeguarding. | Work continued during 2017/18 to develop the Performance Dash Board and the new style report will begin for in 2018 /19. |

### Training and Development

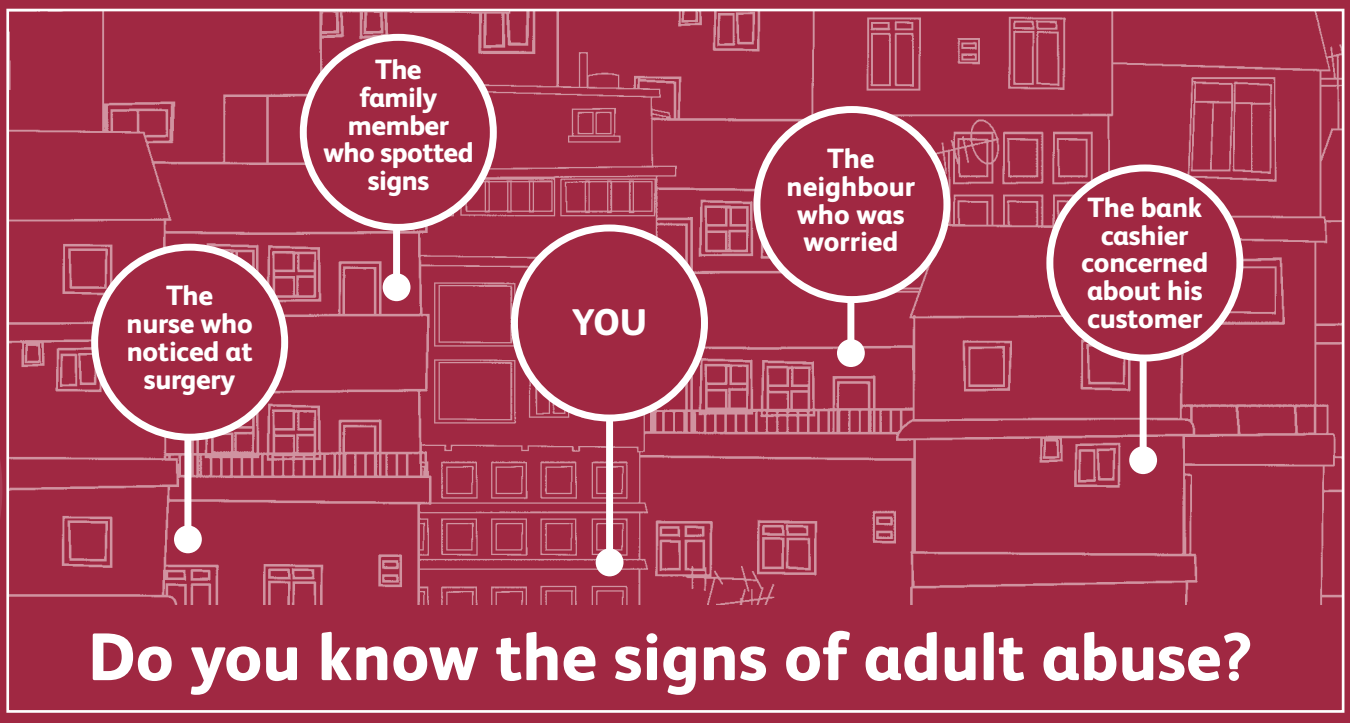
| | |
|---|---|
| Continue to identify areas where cross sector training would enhance the application of the safeguarding process and achieve improved outcomes for Service Users. | The safeguarding training plan and strategy was published in April 2017. The decision to begin a Training Needs Analysis was made in January 2018 and this work will continue into 2018 /19. |

### Policy and Procedures

| Priority | Resulting Action |
|---|---|
| Work across the South Yorkshire Region to develop an easy read guide to Safeguarding Procedures. | During 2017/18 the South Yorkshire Region made the decision to revise the South Yorkshire Procedures, work has begun to rewrite an overarching policy that the four boards and local authorities will sign up to. |

**Safeguarding Adults Review**

| Priority | Resulting Action |
|---|---|
| Commissioning and overseeing Safeguarding Adults Reviews (SAR's) and any other reviews agreed by the Chair. | During 2017/18 1 Safeguarding Adults Review was completed and published.<br>The board worked in co-operation with NHS England following the death of a young man placed by a neighbouring authority in Rotherham. The case was extremely complex involving three local authorities and three Clinical Commissioning Groups.<br>A further complex case was held in abeyance awaiting the coroner's inquest decision. |
| Ensure that recommendations arising from each SAR are communicated to all agencies and are subject to review of implementation. | Action plans following the completion of a SAR are developed by the sub group and partners and will be managed through the Performance and Quality Sub Group.<br>Recent action plans have addressed issues such as:<br>• Test out using auditing processes that communication between professionals, service users and their families is robust<br>• Look at a range of mechanisms and develop protocols for the use of care coordinators in complex cases in the community setting<br>• There are appropriate written communication tools in use between care homes and GP practices. |
| Develop a Safeguarding Adults Review Protocol. | The Safeguarding Adults Review Protocol was signed off at the RSAB in July 2017. |



# **Looking forward** to 2018/19

**The Rotherham Safeguarding Adults Board and its sub groups will now meet every quarter and have introduced an Executive Sub Group that will meet in between the board meetings, they will work to set challenging and relevant agendas for the board and will ensure the members of the board are working together to achieve priorities.**

A review of the position of the Deprivation of Liberty's (DoL's) Sub Group has resulted in the group no longer being a formal subgroup of the Safeguarding Adults Board but will continue to report performance and any relevant issues to the Board through the Performance Dashboard.

Rotherham Safeguarding Adults Board in 2018 have committed to the following actions which we will continue to progress to conclusion in 2018/19.

These are:

- Refresh the Rotherham Safeguarding Adults Board Strategic Plan for 2019/21.
- Ensure the South Yorkshire Procedures and Local Safeguarding Procedures are up to date and embedded in service.
- Develop a 'Story Board' to share with RSAB. Using partners case studies, bring the customer story to RSAB using video, actors or consider bring the customer to the board meeting.
- Develop a Public Involvement strategy. Promote Safeguarding Awareness Week across Rotherham.

The board's responses in respect of performance, training, policy and practice and learning lessons from SAR's will be taken forward through the sub group structure with the following priorities.

### Performance and Quality

- Work with Children's Services to develop a joint assessment tool for the partners of the Adults and Children's Safeguarding Boards.
- Continue to develop the RSAB Issues Log, ensuring all partners are aware of any risk that may impact on the performance of the board.
- Ensure the Advocacy Service offered to the residents of Rotherham is appropriate and is being utilised correctly.
- Developing intelligence led analysis of key safeguarding priorities to inform future action planning.
- SAR action plan monitoring.

## Training and Development

- Complete a Training Needs Analysis to inform the RSAB of the safeguarding Training needs and identify multi agency training.
- Develop a mechanism to measure the success of Safeguarding.

## Policy and Practice

- Work with the South Yorkshire Region to finalise a South Yorkshire Safeguarding Procedure.
- Develop guidance, policy and practice in respect of Self-Neglect.
- Ensure Safeguarding is embedded within the Learning Disability service.

## Safeguarding Adults Review

- Continue to make timely recommendations to the Chair in respect of whether a review should be commissioned.
- Commissioning and overseeing SAR's and any other reviews agreed by the Chair.
- Continue to ensure that recommendations arising from each SAR are communicated to all agencies and are subject to review of implementation.

Appendix 1

# Key Partnership Contributions 2017/18

## Safeguarding Adults Investigation Team

The specialist team of highly qualified social workers track and manage all safeguarding concerns from initial concern, screening, decision making meetings, further enquiries and outcome meeting, ensuring risk is reduced or removed and individual outcomes are achieved.

To achieve best practice and outcomes for our service users, the safeguarding adult team work closely and have good strong professional relationships with the Clinical Commissioning Group, Rotherham Hospital leads, the Public Protection and Safeguarding Adults Team, Police, Fire and Rescue, the Ambulance Service and our counterparts in the mental health sector (Rotherham, Doncaster and South Humber RDaSH) to name a few.

The Safeguarding Adults Team remain focused delivering outcomes for the adults at risk and ensuring the source of harm is held accountable using legislation, supporting disciplinary/practice sanctions, referring to the disclosure and barring service and other governing bodies such as the HCPC or NMC etc.

The Safeguarding Adults Team recognises the importance 'of family life', where cases of abuse occur they will conduct investigations with sensitivity and proportionality.

The Safeguarding Adults Team are all experienced qualified social workers who, through experience have honed skills in their chosen area such as the field of financial matters, organisational issues, matters attaining to Court of Protection and workers dedicated to a busy duty response team as well as Safeguarding concerns within the community.

The Safeguarding Team manage all first point of contact for Safeguarding concerns raised, which supports with accurate recording and gives a strategic overview of all safeguarding concerns reported. The team also hold and manage all section 42 concerns involving provider services such as domiciliary care, residential and nursing establishments, this has proven valuable as intelligence gathering and supported greatly with preventative work.

Making Safeguarding Personal (MSP) was introduced in to practice in April 2015 after the implementation of the Care Act 2014. This continues to be developed to ensure safeguarding tailors its approach to the requirements of the individual, focusing on achieving individuals outcomes and reducing or removing risks.

In 2017/18 2,113 alerts were reported to the safeguarding team. 724 of these alerts became section 42 enquires, this is where an investigation begins and further enquires are made. From the investigations that progressed to a Decision Making Meeting (DMM), 10 cases continued to an Outcome meeting.

The Safeguarding Adults Investigation Team seeks to maintain a high expectation in standards of provider services, continue to forge good working relationships with providers and work on preventative measures when low level Safeguarding trends occur. To achieve this, the team work closely with contracting compliance officers as well as the commissioning sector and the Care Quality Commission (CQC).

Bi monthly meetings with Safeguarding, Commissioning, Contracts, CQC, Health and RDaSH ensure information is shared to support with raising standards of providers and supporting with the prevention of providers declining in their duty of care thus resulting in Safeguarding concerns being raised.

## Case Study

The Safeguarding Team received contact from a CQC officer requesting an urgent meeting, a meeting was pulled together the same day. The CQC officer disclosed that after a visit to a residential unit, they have serious concerns for the safety of the residents. Details were shared and an emergency risk assessment was completed.

Social workers and district nurses were dispersed into the home to carry out urgent welfare checks, ensuring people were safe, supported and risk was mitigated. Due to findings at the home, several individual safeguarding concerns were logged and an organisational safeguarding concern was screened.

The home agreed to work to a Special Measures Improvement Plan (SMIP) developed by the Contract Compliance Officers (CCO) and a default and suspension of placements made.

Within 24 hours staffing rotas were addressed, dependency tools were being used and all required referrals for the residents were made. A decision Making Meeting was held and attended by all relevant professionals as well as family members and advocates. Due to the engagement of the home and the support of the CCO and Safeguarding, the organisational concern was able to close along with many of the initial individual concern, only two individual cases were required to be investigated.

Due to the partners and providers engaging well and supporting practice, the residents of the home were safe and well cared for, mitigating any neglect and acts of omission and supporting the ethos of prevention

# Contract Compliance Team

During 2017/18 the Strategic Commissioning Team in the Adult Care, Housing and Public Health Directorate was restructured with 4 Heads of Service leading 4 commissioning strands under the themes of; Prevention and Early Intervention; Housing Related Support and Mental Health; Learning Disability and Autism and Adults and Older People. The Commissioning and Quality and Performance Team that sits under the Public Health Directorate is now aligned to the Strategic Commissioning Team.

The Contract Compliance Team is situated in strand 4 of the Strategic Commissioning Team, the Prevention and Early Intervention Theme. This Team is headed by a Principle Contract Compliance Officer leading 4 Contract Compliance Officers who work to ensure that services commissioned and contracted by the Council remain compliant with agreed standards of quality and safety throughout their contract term. The team is made up of officers who are knowledgeable, skilled and experienced in adult care and support.

## Quality Assurance Framework:

Following the restructure the work of the Contract Compliance Team was reviewed and a Quality Assurance Framework was developed. The work of the Contract Compliance Team is now effected through an intelligence led framework which comprises; contract concerns reporting database, reported risk matrix, focused audits, a range of service specific toolkits and information gleaned from surveys and customer experience testimony. The Contract Compliance Team collaborates with colleagues throughout social care, safeguarding and health to increase the scope of intelligence available. The intelligence gleaned is utilised by the Contract Compliance Team to inform a proportionate response to regain compliance when deviation from agreed standards has occurred.

The Quality Assurance Framework supports the reviewing process of providers using a risk based approach and predominately focuses attention on providers who are cause for concern. There is regular contact with all providers who self-report and this forms part of the Quality Assurance Framework to ensure light touch monitoring approach. This allows an appropriate use of the contract monitoring team resource and reduces the reviewing burden on providers where it is not necessary.

A range of new toolkits, auditing tools and survey tools have been developed and are being implemented and assist a wide range of stakeholders to provide feedback on service/provider quality. A number of multi-disciplinary meetings have taken place to discuss failing providers and agree further actions.

During 2017/18 the Contract Compliance Team has maintained its risk based programme of monitoring. The Team continues to work closely with the Adult Safeguarding Team and monthly Quality Assurance and Safeguarding Team meetings have been formalised. These meetings are attended by Commissioning Officers and Safeguarding to share information and intelligence about contracted services.

A number of focussed audits has been undertaken in response to trends identified through intelligence gathering from the Contract Concerns database, provider risk Matrix and the Safeguarding database. These have allowed preventative actions to be identified and implemented to address service shortfalls with regards to quality issues.

## Compliance Issues:

In 2017/18 contract enforcement action as a result of quality issues in the independent sector undertaken:

- Contract Default = 6 Care Homes, 3 Community and Home Care Services.
- Contract Termination = 1 Care Home, 1 Community and Home Care Service provider.

The Contract Compliance Team dealt with 611 Contract Concerns which involved providers across all care sectors. This is an increase of 41% on the previous year and is as a result of increasing collaborative work with colleagues throughout social care, safeguarding and health to increase the scope of intelligence available.

The majority of these concerns had multiple threads which required investigation by the Contract Compliance Officer and the Provider. Of the 611 concerns received approximately.

- 47% (289) related to Community Home Care Services (CHCS).
- 31% (191) related to Adult Residential and Nursing Care Providers.
- 6% (38) related to Specialist Day Services.
- 6% (37) related to Specialist Residential and Nursing Care.
- 10% (58) related to the remaining provider groups including the Voluntary and Community Sector (VCS).

The top 4 categories for Contract Concerns for 2017/18 were;

- **Late/Missed calls** – 116 concerns reported (all CHCS) ***- an increase of 68% on 2017/18.***
- **Quality** –166 concerns reported (Residential/Nursing 89, CHCS 46, Others 61), ***an increase of 66% on 2017/18.***
- **Medication** – 63 concerns reported (Residential/ Nursing 32, CHCS 13, Others 28), ***an increase of 34% on 2017/18.***
- **Staffing** – 50 concerns reported (Residential/Nursing 25, CHCS 13, Others 12), ***an increase of 28% on 2017/18.***

## Other Contract Compliance Activity:

- **Members Seminar:**

A Members Seminar took place in June 2017 to respond to concerns expressed by Elected Members regarding the quality of four care homes in Rotherham. Members were advised by the Strategic Commissioning Team about the contract monitoring and enforcement activity that is undertaken and offered context on the limitations of the Council in terms of enforcement of care home closure. The Care Quality Commission attended a later member's seminar to present to members details about their regulatory function. An update on the outcomes of contract enforcement activity on the four care homes was requested in April 2018 and at that time members were informed of the termination of contract with a care home in Maltby. The updates and information imparted were well received by members.

- **Focussed Audit:**

The contract compliance team have carried out a number of focused audits over the year. An audit took place in December 2017 on the arrangements in place for the use of restraint in care homes which scrutinised:

- Restraint Policies,
- Training (MCA/DoLS and use of restraint)

The audit covered a number of areas and specific to Older People's Residential and Nursing providers, the following applied:

- 87% were able to provide copies of their Restraint policy and the remaining
- 13% did not have a specific restraint policy in place, but had appropriate guidance in place within their MCA and DoLS policies and within their Safeguarding procedures.

Providers who delivered care and support to people experiencing the symptoms of dementia were able to provide comprehensive references within their Violence and Aggression policy, in particular the appendix "Distressed Reactions De-escalation and Safe Holding Standard Operation Procedures".

100% were able to evidence, through Training Matrix's and Internal reports, appropriate training for all staff. This included the initial training provided during induction periods, and the subsequent ongoing and refresher training. Topics included MCA and DoLS training and Safeguarding Training (at levels relevant to the post holder's responsibility). Providers report that varying numbers of staff have attended Positive Behavioural Support Training, focusing on diversion and de-escalation techniques and activities that promote positive behaviours is preferred, with this being a common "thread" throughout other training, such as

Dementia, Dignity, Equality and Diversity and Person-Centred care training.

Where providers fell short of the standard actions these were undertaken through action plans specific to each provider.

- **Public Health:**

Work undertaken by Contract Compliance and Public Health colleagues, in response to Infection Prevention and Infection control issues has seen the development of a local network of Infection Prevention Champions. Work with these representatives of our commissioned providers will continue to develop and improve this aspect of care provision.

## Quality Board:

Led by the Strategic Commissioning Team, the Quality Board was established in September 2017, meets bi-monthly and has met 4 times to date. The Quality Board has a focus on the quality, safety and effectiveness of independent sector and voluntary sector who deliver regulated services commissioned by Rotherham Metropolitan Borough Council and Rotherham CCG.

The Board has the responsibility for the monitoring of commissioned services relating to adults and systematically brings together the different parts of the system to share information and will be a proactive forum for collaboration. The main purpose of the Quality Board is to encourage:

- a shared view of risks to quality through sharing intelligence;
- an early warning mechanism of risk about poor quality;
- opportunities to coordinate actions to drive improvement,
- ongoing strategic and operational liaison between organisations and
- a conduit between the statutory bodies and the provider market.

The Quality Board aims to enhance integration and partnership between bodies from the Rotherham Council, Rotherham NHS Foundation Trust, Public Health and Rotherham CCG.

# Vulnerable Persons Team

The Vulnerable Person's Team work to and promote the prevention and wellbeing principles of The Care Act (2014). In summation, The Vulnerable Person's Team seek to ensure an individual's physical, mental, and emotional wellbeing as well as protection from abuse and neglect. The team also works with carers/families, providing the required support. The Vulnerable Person's Team act as change agents by seeking to improve the lives of those they work with, connecting people to the necessary support, often working with partner agencies including the voluntary sector.

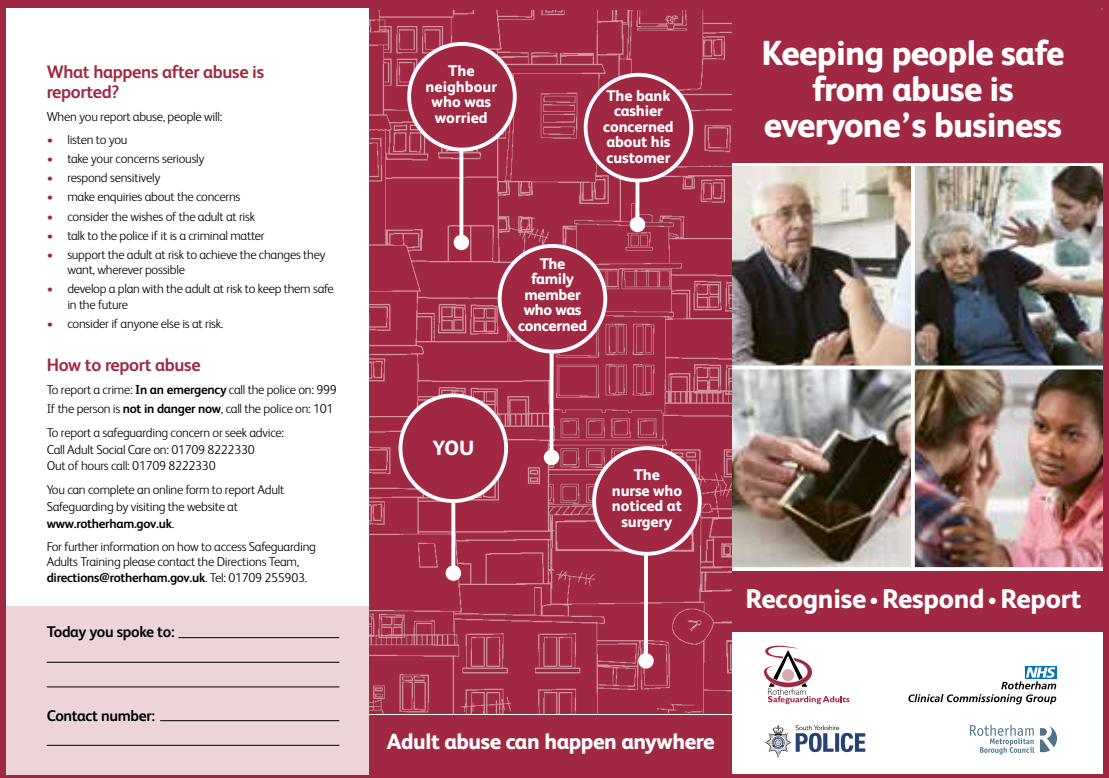
The Vulnerable Person's Team promote a positive engagement model which seeks to reduce multiple negative contacts with services. The ultimate aim is for good outcomes built on a partnership, helping to reduce chaotic lifestyles and subsequent risks to vulnerable people.

Archetypically, The Vulnerable Person's Team work includes working with individuals who may need assistance with the following, repeat non-engagers, issues with finances or debts, risk of eviction/ASB issues and or homelessness, supporting those leaving prison, issues of self-neglect/hoarding, concerns regarding current/historical CSE, substance misuse and those who may have mental health issues or a learning disability.

The Vulnerable Persons Team is looking to work more closely with housing, specifically with the co-located neighbourhood teams which also includes anti-social behaviour officers and neighbourhood policing teams in order to provide a collaborative response.

Furthermore The Vulnerable Persons Team are looking to work more closely with younger adults who have been known to leaving care as it has been acknowledged that there is a service gap and this links in to the ongoing work of Vulnerable Care Leavers Risk Management Pathway which was initiated by children's services.

The Vulnerable Persons Team continues to prove itself as a valuable resource and has supported many individuals to improve their lives by providing wrap-around support; the case study example is testament to this.



## Case Study

D first came to the attention of Adults Safeguarding via a referral from another local authority. D had been receiving bereavement counselling for the last 4 years and during this time disclosed historical sexual abuse by deceased family members and members of the public (alleged to be professionals) he also reported regular taunting by his mother and physical abuse from siblings whom he lived with.

D has a mild learning disability and is dyslexic.

D has never at any point spoken to the police in spite of Public Protection Unit being made aware of the disclosures. Background checks were completed on family members who D had alleged as his abusers. D also disclosed that he was regularly assaulted by his brother and his friends. His brother had previously spent time in prison for attempted murder of a former wife. A referral was completed by The Vulnerable Person's Team (VPT) and D also received support from an Independent Domestic Violence Advocate. His case was heard at a Multi-Agency Risk Assessment conference (MARAC), the outcome of this was the police required more information to put a safety plan in place, but unfortunately D refused talk to them. From the police point of view, little could be done without more information/disclosures from D himself.

D was formally assessed as having mental capacity to make a decision regarding his residence and who he should live with, this left Adult Services with a dilemma making it difficult to exercise a duty of care to keep him safe. He was supported by VPT to find alternative accommodation; he was made a priority by housing. D was offered numerous properties which he declined stating he didn't deserve it (a house of his own) and he "can't imagine it ", but continued to speak of the abuse he was experiencing. His counsellor informed us that he had previously attempted suicide which were described as serious attempts.

Following legal advice the Local Authority commenced court proceedings to seek an inherent jurisdiction, D was represented in court and agreed to move to a safe house with the support of VPT. The court also granted an order preventing the family of D making contact with him.

D resided in the safe house for approximately 8 months and has recently been offered a tenancy of his own in an area of his choice. During this time D has grown in confidence and engages well with support from the VPT and is currently engaging which mental health services following a referral from VPT. D was supported to attend appointments to help address his Post Traumatic Stress Disorder, something which he previously refused to do. D is currently settling into his new accommodation, making plans to decorate and purchasing new furniture.

# Domestic Abuse Service

The Independent Domestic Violence and Advocacy Service (IDVAS) are integrated within Safeguarding Adults in Rotherham. This has ensured that Domestic Abuse is seen as a local Safeguarding priority, also reflecting that Domestic Abuse has been added under the new category of abuse in The Care Act 2014.

The Independent Domestic Violence Advocates (IDVA's) have 4 SafeLives qualified IDVA's of which 3 work full-time and also a part-time IDVA support worker. Furthermore, the IDVA team hold trainer qualifications and deliver the training program. The training explores what domestic abuse is and its impact on its victims, to introduce good practice and risk assessment. It also explores and challenges some commonly held beliefs, attitudes and assumptions about domestic abuse and to increase understanding of domestic abuse services in Rotherham, domestic abuse risk assessment and The MARAC process.

More recently, Rotherham IDVA's are working with their counterparts in Doncaster and Sheffield in order to develop a generic training package, incorporating recent government guidelines. The IDVA's are committed to promoting awareness amongst partner agencies in order to enhance the safety of individuals and the support they receive. Additionally the IDVAS will visit services offering advice, guidance and support to other agencies to recognise domestic abuse and how to complete risk assessments.

The IDVA's are looking to enhance the skills of the service; it has been identified that it would be beneficial for some of the IDVA's in the future to undertake the Young Person's Domestic Violence Advocate (YPDVA) and Independent Sexual Violence Advocate (ISVA) qualifications. All IDVA's will be taking part in accredited SafeLives training relating to responding to older people affected by domestic abuse as research shows that older people are underrepresented in domestic abuse services.

Between April 2017 and March 2018 the service received 435 referrals and supported 436 Multi Agency Risk Assessment Conference cases (MARAC). The IDVA's also provide court support to individuals in which they seek to make the court process more understandable as well as providing emotional support, putting special measures in places and supporting clients to express their wishes to the court.

## Case Study

C, 56 was referred into IDVAS in February 2018 following a high risk repeat incident with her ex-partner. The abuse has been ongoing for 15 years and involved physical violence and persistent stalking and harassment. C is disabled and has epilepsy, diabetes, arthritis, deformity in her feet; she requires carers daily. She reported feeling low in mood relating to the abuse she has suffered.

C didn't feel safe where she was living due to her ex-partner attending her property uninvited and she also reported feeling isolated in her current location. IDVA contacted the housing officer and advocated for her to be re-housed, her case was referred to the housing panel and she was awarded priority. C has now moved to a safe location, she is closer to her family and friends and feels safer and happier. IDVA has completed a referral for extra security on this home. C's ex-partner was charged with breach of restraining order and pleaded guilty; IDVA liaised with magistrate's court to establish the outcome and passed this onto C.

IDVA has referred her to Rotherham women's counselling service and Rotherham Rise for continued support for the abuse she has experienced. IDVA has liaised with C's social worker to ensure they are aware of the situation and in order to offer support where required.

# Rotherham NHS Foundation Trust

TRFT's Adult Vulnerabilities Team provide a service across all Trust disciplines to ensure that adults that we care for are safe and are protected from harm.

To achieve this, it is our role to ensure that our staff receive appropriate training to equip them with the skills and knowledge that they need to enable them to recognise and respond to concerns regarding an adult at risk. Training is provided which addresses all aspects of adult safeguarding, including the Mental Capacity Act and Deprivation of Liberty Safeguards, Learning Disability, Dementia, the Mental Health Act and Prevent, which is the Government's response to reducing the risk of vulnerable people being drawn into supporting or committing acts of terrorism.

## Partnership Working

TRFT Adult Vulnerabilities Team is an active partner in ongoing work with Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH) to ensure the safe and lawful application of the Mental Health Act within the Trust.

TRFT provides representation at Multi-Agency Risk Assessment Conference (MARAC) and has been involved in working toward improved services for victims of domestic abuse in Rotherham as a partner in the Safer Rotherham Partnership.

## Support

The Adult Vulnerabilities Team offer advice and support to all TRFT staff in managing adult safeguarding concerns about vulnerable people.

## Governance

A significant amount of work has been undertaken to embed a robust Trust safeguarding and external governance structure. As part of the Trust's governance arrangements, an internal audit of adult safeguarding was undertaken, which identified strong assurance regarding these arrangements with extremely positive feedback received. No recommendations were made following the review.

Policies have been developed which clarify the responsibilities of all TRFT staff and volunteers. These are updated as required to reflect changes in legislation and practice.

Key Performance Indicator (KPI) information is shared with our partner agencies quarterly, who have the opportunity to scrutinise and question Trust practices.

## Development

The position of Lead Nurse in Learning Disability is now embedded and continues to contribute to improvements in this service area.

TRFT have completed several projects designed to improve the implementation of the Mental Capacity Act throughout the Trust, including the provision of training in addition to the mandatory requirement.

The Lead Nurse in Learning Disabilities was nominated by the Sheffield Hallam University students she mentors for an Inspirational Mentor award. This nomination was successful and the Lead Nurse received the award.

## Case Study

Mr Y had a hospital inpatient stay for unstable diabetes. The District Nurse (DN) visited 3 days after discharge and found that he had a pressure area to his buttock. The DN had not been informed of the discharge by the ward but when they visited Mr Y he did have a pressure relieving cushion at home and was independently mobile.

He did explain to the DN that whilst on the ward he had been receiving regular treatment for the pressure ulcer, which was present on admission, from the nursing staff.

DN's noted Mr Y to have capacity to make decisions regarding his care. They commenced an individualised care plan, made a referral to the Tissue Viability Nurse, completed an internal incident report and with Mr Y's consent, a safeguarding concern was raised as per policy.

In response to the safeguarding concern the Ward Manager from the discharging ward was asked to complete a section 42 enquiry and document the outcome of this on a safeguarding form 2.

The Ward Manager contacted Mr Y by telephone to discuss the concern that follow up care by the DN had not been arranged by the ward as would be expected.

She apologised to Mr Y and explained that when he was discharged from hospital a DN should have been arranged to visit him at home. Mr Y accepted the apology but noted that the ward was very busy however he said the staff "were lovely" and he was pleased with the quality of care he had received and said that staff had provided treatment to the wound whilst he was on the ward. He explained that he already had a pressure relieving cushion in place at home and that DN had now provided a mattress for him.

Mr Y accepted that the lack of referral to DN was an oversight but that he had received appropriate care whilst he was in hospital and that follow up care for the wound was in place from the DN team now that he had returned to the community.

Mr Y expressed he had no on-going concerns that he felt required further investigation. As Mr Y's outcomes had been met and he was in agreement, the concern exited the safeguarding process at this point.

This process is consistent with the principles laid out in the Care Act 2014 which highlights the Making Safeguarding Personal approach.

# NHS England Yorkshire and Humber

NHS England is the policy lead for NHS safeguarding, working across health and social care and leading and defining improvement in safeguarding practice and outcomes. It is the responsibility of NHS England to ensure that the health commissioning system as a whole is working effectively to safeguard children and adults. Key roles are outlined in the Safeguarding Vulnerable People Accountability and Assurance Framework 2015.

NHS England Yorkshire and the Humber has an established Safeguarding Network that promotes shared learning across the safeguarding system. Representatives from this network attend the national Sub Groups, which have included priorities around Female Genital Mutilation (FGM), Child Sexual Exploitation, Children Looked After, Mental Capacity Act (MCA), Modern Slavery and Trafficking and Prevent. NHS England Yorkshire and the Humber works in collaboration with colleagues across the North region on the safeguarding agenda. A review of the Yorkshire and the Humber safeguarding network has established local safeguarding network meetings bi-annually in the 3 Sustainability and Transformation Partnerships areas (some now named Accountable Care Partnerships) in addition to a bi-annual safeguarding commissioners and providers network event.

## Sharing learning from safeguarding reviews

In order to continuously improve local health services, NHS England has responsibility for sharing pertinent learning from safeguarding serious incidents across Yorkshire and the Humber and more widely. A North region newsletter is now circulated weekly to safeguarding professionals. Learning is also shared with GP practices via quarterly Safeguarding Newsletters, and annually safeguarding newsletters for pharmacists, optometrists and dental practices across Yorkshire and the Humber are produced.

An annual North region safeguarding conference is hosted by NHS England North for all health safeguarding professionals, this year's event included learning on neglect, hoarding and asylum seekers. Due to the success of last years named GP conference in Yorkshire and the Humber NHS England North also held a conference for named GPs to share good practice and learning; topics included homelessness, domestic violence, travelling families and safeguarding.

## Safeguarding Serious Incidents

All safeguarding serious incidents and domestic homicide's requiring a review are reported onto the national serious incident management system – Strategic Executive Information System (STEIS). NHS England works in collaboration with CCG designated professionals to ensure a robust oversight of all incidents, recommendations and actions from reviews. Prior to publication of any reviews NHS England communication team liaise with the relevant local authority communications team regarding the findings, recommendations and publication.

## Training and Development

Designated safeguarding professionals are jointly accountable to CCGs and NHS England and oversee the provision of safeguarding training for primary care medical services. The main source of training for other primary care independent contractors is via e-learning training packages.

NHS England, in 2017/18, updated and circulated to health colleagues the Safeguarding Adults pocket book which is very popular amongst health professionals and has launched the NHS Safeguarding Guide App and a North region safeguarding repository for health professionals. A training needs analysis has also been undertaken to ensure all NHS England employees receive appropriate levels of safeguarding training.

A number of leadership programmes for designated safeguarding professionals have been commissioned by NHS England in addition to a 2 day resilience course. The CSE training provided by BLAST 'Not Just Our Daughters' has also been provided for front line health professionals.

Link below to the safeguarding app:-
http://www.myguideapps.com/nhs_safeguarding/default/

## Assurance of safeguarding practice

NHS England North developed a Safeguarding Assurance Tool for use with CCGs across the North Region, which was implemented in 2016/2017.An online version has been piloted in 2017/18 by NHS England in order to develop a national assurance tool for CCG's. A primary care version of the online assurance is also being piloted by a couple of CCGs in Yorkshire and the Humber.

## Specialised Commissioning

NHS England North Specialised Commissioning service providers are, via the contracting process, required to demonstrate compliance with all relevant safeguarding policies and legislation and work in partnership with other agencies regarding all aspects of safeguarding.

Within Specialised Commissioning the Heads of Quality review all serious incidents and liaise with the appropriate CCG to review all incidents and work through actions with the provider. Where NHS England North Specialised Commissioning is the lead or sole commissioner they work directly with the provider, monitor actions and share outcomes with other commissioners.

## Health and Justice

NHS England North Health and Justice service providers are, via the contracting process, required to demonstrate compliance with all relevant safeguarding policies and legislation and work in partnership with other agencies e.g. Prison, Police regarding all aspects of safeguarding.

In addition, there is a Quality Framework in place which requires all providers to report on a quarterly basis regarding any safeguarding concerns, incidents, reviews (including themes and trends). An annual audit of Combined Adults and Children's Safeguarding Standards and an annual safeguarding report are also submitted for review to the NHS England local office Quality Surveillance Group.

## Care Homes

NHS England Yorkshire and the Humber have appointed an Independent Care Sector (ICS) Lead to support organisations in the delivery of the Enhanced Health in Care Homes framework. The key work streams in this programme for the ICS leads are the delivery of the red bag scheme and the roll out of an electronic bed state tool.

## Complaints and Concerns

NHS England Customer Contact Centre review all complaints and concerns received and identify those containing a safeguarding element for appropriate action. Following receipt of complaints and concerns at NHS England North local offices these are reviewed again and any safeguarding concerns identified are referred to the safeguarding lead for review and appropriate action.

Priorities in 2017/18 around complaints were:

- NHS England North regional safeguarding team in partnership with NHS England local offices reviewed and agreed a standard process for the management of safeguarding concerns within complaints.
- NHS England North regional safeguarding team has delivered safeguarding training to the required standard and level to all complaints staff in accordance with relevant national guidance.

## Prevent

NHS England North have two Regional Prevent coordinators who work across the North region to support Prevent implementation, they are part of the National and regional safeguarding and Quality team.This year has seen an increased focus and scrutiny on Prevent implementation within health and safeguarding.

A national task and finish group has been established chaired by the Director of Nursing for NHS England to oversee the progress that is being made with Prevent implementation. Particular focus has been on training with an expectation that all organisations will be able to demonstrate 85% compliance by the end of March 2018 .

We are working closely with providers, commissioners and regulators to support and monitor the work being undertaken to ensure that all health care organisations can meet their statutory duty for Prevent.

Across the Yorkshire and Humber we have funded a number of projects to enhance understanding of Prevent and to support staff including work with partners in North Yorkshire in the development of a graphic novel titled 'Hurt by Hate' an interactive training package designed to raise awareness of a variety of issues surrounding Prevent and safeguarding .

Following a regional research project to scope the current, attitudes, awareness and practice amongst GP colleagues we are now working with the Home Office to extend the research nationally.

We have worked to develop a Prevent training framework and e learning packages specifically for health and have shared guidance across the network for mental health practitioners.

In December 2017, the 3rd North Regional Prevent conference was held in Harrogate; delegate feedback demonstrated the positive attitude to Prevent in health agencies and their commitment to continue to develop their knowledge.

## Transforming Care

In April 2015 The Transforming Care national programme announced a radical transformation of the delivery of Learning Disability and Autism services. This model included significant reductions in learning disability inpatient beds and a greater focus on the provision of early intervention and crisis preventative community services. The collective vision and ambition to deliver an integrated co-produced set of principles and standards was fundamental to delivering care closer to home, avoidance of unnecessary hospital admissions and the prevention of missed opportunities for people with a Learning Disability and or Autism to have happy and productive lives within the community of their choice.

The 6 Transforming Care Partnerships across Y&H continue to work collaboratively to achieve Building the Right Support for patients in our area.

## Learning Disabilities Mortality Review (LeDeR) Programme

In November 2016 the national LeDeR Programme was introduced in to the Transforming Care Programme following the Confidential Enquiry into the Premature Deaths of People with Learning Disabilities (CIPOLD).

All NHS regions have been asked to establish the LeDeR process locally to undertake the reviews. LeDeR also complements the NHS Operational Planning and Contracting Guidance for 2017/19 which contains 2 'must-dos' for people with learning disabilities:

- "Improve access to healthcare for people with a learning disability so that by 2020, 75 % of people on a GP register are receiving an annual health check.
- Reduce premature mortality by improving access to health services, education and training of staff, and by making reasonable adjustments for people with a learning disability and/or autism.

The LeDeR Programme is not a formal investigation or a complaints process and will work alongside any statutory review processes that may be required.

The LeDeR Programme recognises it is important to capture the extent of personalised services, including the use of reasonable adjustments, choice and control and the well-being of people with learning disabilities. A number of learning events have taken place in Yorkshire and Humber to share the early findings of the reviews already completed.

# NHS Rotherham Clinical Commissioning Group RCCG

NHS Rotherham Clinical Commissioning Group (NHSR CCG) firmly believes that every person has the right to live a life free from abuse and neglect. With this in mind NHSR CCG will continually develop the organisation's Safeguarding arena, with Safeguarding Adults high on that agenda.

Robust governance arrangements are in place to ensure that the CCG's own safeguarding structures and process are evident and that the agencies from which they have commissioned services meet the required standards. A plethora of measures are utilised for monitoring NHSR CCG commissioned services including Safeguarding Standards and KPI's (Key Performance Indicators)

NHSR CCG continues to publish an annual safeguarding report which demonstrates how the NHSR CCG continues in its commitment to safeguarding and promoting the welfare of all residents in the Borough. NHSR CCG also strives towards the highest possible standard of care, taking on board the national and local drivers for change in safeguarding. It provides assurance that commissioned health services are working collaboratively to safeguard those at risk. More so it provides assurance of how NHSR CCG carries out its safeguarding roles and responsibilities.

NHSR CCG continues to work within NHS England's key document "Safeguarding Vulnerable People in the NHS Accountability and Assurance Framework (2015)" which underpins the CCG's responsibilities for Adult Safeguarding. The much awaited Safeguarding Adults: Roles and competences for health care staff – Intercollegiate Document was not published during the year 2017/18 and is still eagerly awaited.

## Training

Sub groups of the Safeguarding Adult Board continue to grow and develop with NHSR CCG remaining a committed and active member to all five groups. The CCG advisor to the Board member continues to chair the Training and Development sub-group with achievements of the RSAB Training Strategy and Plan agreed in the summer 2017.

August 2017 saw the CCG complete its yearly Safeguarding Update (Children and Adults) as per NHS England guidelines. Topics covered include CSE (Child Sexual Exploitation) and Operation Stovewood, Modern Slavery and Human trafficking and Prevent. The update was delivered to all CCG staff including Governing Body members.

**Key Achievements 2017/18**

- NHSR CCG has remained firm in its commitment to the board at a senior and executive level.
- Participation at regional and local Safeguarding Networks to share best practice.
- Participation at RSAB and sub groups, including chairing the Training and Development sub-group.
- Safeguarding assurance sought at provider Contract Quality meetings.
- Attendance at TRFT Strategic Safeguarding meetings.
- Updates made, in line with legislation, to the Safeguarding Policy to incorporate FGM, Prevent and Modern Slavery.
- Participation in Domestic Homicide Review meetings requirements.
- Domestic Abuse – facilitated peer review and safeguarding supervision sessions, supporting GP practices to take steps to safeguard vulnerable people.
- Professional Challenge/Discussion forum addressing health and wellbeing of alleged perpetrators and their families.

In November 2017 NHSR CCG addressed a politically sensitive area – the health and wellbeing of alleged perpetrators. The National Crime Agency's Stovewood agenda has seen a combination of investigations both for historic and emerging abuse continue to progress at a level and pace understood by those involved directly, but what about those indirectly involved? From the start of the Stovewood investigation agencies have worked together to highlight and deliver on support systems, processes and services for victims/survivors of this horrific abuse. We are now starting to see increasing numbers of identified perpetrators and our GPs tell us that they are seeing survivors and perpetrators and respective family members almost side by side in their waiting rooms which must be the same for many services.

In Rotherham we have often felt that we are leading the way with a lot of this work in the absence of a clear evidence base and this prompted the professional challenge session entitled "Perpetrator Challenges, Understanding our responsibilities and limitations". Previously we have hosted sessions for GP practice staff and multiagency groups covering aspects of recognising signs of abuse/referral pathways for survivors and the focus should continue to be on survivors, keeping them at the centre of what we are trying to achieve for them.

24 multi-agency staff attended this event with excellent feedback. Discussion points included:

- Joint working
- On-going investigations
- Survivors and their families
- Perpetrators and their families
- Why does it take so long to get to court?
- Why do some alleged perpetrators need to move out of the family home and some don't?
- What are GPs seeing and what the impact of health and welfare is?

A plan was put together from the event and actions have been taken forward.

In 2017 NHSR CCG undertook a 3 step learning process focusing on "Domestic Abuse". This approach significantly supported GP practices in assessing their processes for recognition and signposting/ referral of individuals affected by domestic abuse. Recognising that GPs, as frontline practitioners, are ideally placed to identify or have someone disclose that they are suffering domestic violence or abuse, the GP quick reference guidance was updated and shared with practices, providing information to increase knowledge and skills when responding to domestic violence or abuse.

**Domestic Abuse 3 Step Learning Process:**

- **Step 1** – self-assessment - 30 practices out of 31 completed (97%).
- **Step 2** – GP Peer Review to share learning and respectfully challenge practice and processes. This developed into a shared learning event with Domestic Abuse experts providing direct support. 70 staff covering 27 GP practices attended the event.
- **Step 3** – GP Safeguarding Leads attended supervision sessions with the Named GP for Safeguarding for Vulnerable Clients.
- Continuity – The Named GP for Safeguarding continues to provide on-going safeguarding supervision to GP Safeguarding Leads within practice, to enable them to provide education, support and supervision to peers and junior colleagues in practices. The sharing of best practice information also continues to take place.

Our work around domestic abuse has been shared across South Yorkshire and Bassetlaw and was extremely well received. Other areas are now planning to do a similar audit.

In 2017/18 NHSR CCG furnished staff and GP practices with information on key developments in the safeguarding arena. Safeguarding updates and current trends/information were shared via the CCG Newsletter (circulated to GP practices and CCG staff) along with emails to safeguarding leads and practice managers.

## Prevent

The Prevent Duty remains a high priority for the CCG with mandatory Healthwrap training for all staff with 3 yearly updates as stipulated in the NHS England Prevent Framework. GP practices receive regular updates regarding their training requirements and how to access the NHS England Prevent eLearning package. NHS England set a target for providers (not including primary care) of 85% compliance with Healthwrap training by March 2018. NHSR CCG are assured that all providers achieved this. Monitoring of training and other Prevent data via Unify 2 will be compulsory from April 2018 for all providers to NHS England and shared with the Home Office.

## Safeguarding Adult Reviews

The past year has seen the publication of two Safeguarding Adult Reviews (SARs) to which the CCG have been involved. Action plans are monitored via the Performance and Quality sub group with the CCG engaged as appropriate.

## Learning Disabilities Mortality Review

(LeDeR) Programme was commenced in November 2016 following the Confidential Enquiry into the Premature Deaths of People with Learning Disabilities. During 2017/2018 NHS RCCG have established a LeDeR process with 11 Rotherham residents referred onto the programme. The reviews will highlight best practice; potentially avoidable contributory factors and action plans/lessons learnt necessary to change health and social care service delivery for those with a learning disability.

## Next Steps

The world of Adult Safeguarding is constantly developing in terms of case law, legislation and categories of abuse. NHSR CCG will continue to work in conjunction with statutory partners and be responsive to changes and developments. The CCG will not be complacent in its commitment to safeguarding which is demonstrated by including Safeguarding as one of the four priorities in the commissioning plan 2016/20 Your life, Your health:

www.rotherhamccg.nhs.uk/Downloads/Commissioning Plan 2016-2020.pdf

- For the year 2018/19 plans are already underway for a NSHR CCG Safeguarding Event primarily for GP practice staff focusing on issues that affect males in our society including male domestic abuse, modern slavery / trafficking and sexual exploitation.

NHSR CCG will continue to be an engaged partner to ensure that statutory duties are met, keeping Safeguarding very much on the agenda of all we do.

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

Safeguarding is at the heart of everything we do within RDaSH. In order to prevent or minimise the risk of abuse occurring and to help protect those most at risk in our communities we believe a partnership approach is essential. We are represented at a senior level on all key forums providing specialist health and safeguarding advice and as a Trust we remain fully committed to ensuring we meet our statutory duties and responsibilities for safeguarding. We continue to ensure that our staff listen and respond to what adults with care and support needs (and their carers) tell us about what they want to happen to safeguard them and live their lives as independently as possible in their own homes.

A culture of "Safeguarding is everybody's responsibility" permeates across the teams and individuals within Rotherham Care Group and the wider Trust. Over the last 12 months a significant amount of work has been undertaken to ensure there is a robust safeguarding adults governance structure. The capacity of Safeguarding Adults Lead Professionals has been strengthened and a Nurse Consultant for Safeguarding has been recruited into post, this has resulted in greater visibility and the forging of stronger relationships across partnerships within Rotherham. The Safeguarding Adults Leads have also provided guidance and supervision in respect of the wider safeguarding agenda including PREVENT, Modern Slavery, Female Genital Mutilation (FGM), Hate/Mate Crime and Self-Neglect. The governance arrangements oversee and facilitate the implementation of safe practice across our workforce. There is a strong culture of learning and sharing of good practice based on appreciative enquiry and safeguarding trainingis delivered in line with research and best practice. There continues to be a clear vision to achieve the highest standards of quality and safety and to embed safeguarding principles, dialogue and a culture of early intervention / prevention in safeguarding into all areas of practice.

There continues to be established oversight, assurance and governance mechanisms for managing safeguarding issues with the Safeguarding Adults Leads working closely with all staff to ensure that safeguarding incidents are reported and effectively managed to keep patients safe and protect their human rights. The Safeguarding Adults Team has oversight of serious incidents via STEIS and IR1 reports, these are all reviewed to ensure safeguarding is threaded through investigations and wider subsequent learning. In response to the Department of Health and Social Care – safeguarding adults protocol "Pressure Ulcers and the Interface with a Safeguarding Enquiry" (Jan 2018) a member of the Safeguarding Adults team is now a member of the Trust's pressure ulcer forum and contributes to the learning and development in this area.

# South Yorkshire Fire and Rescue Service (SYFR)

GOVERNANCE

South Yorkshire Fire and Rescue has completed a number of Self-Assessments and attended Challenge Meetings across the county to provide evidence and assurances that the service is compliant with statutory safeguarding requirements.

An internal SYFR Safeguarding Executive Board and Reference subgroup continues to provide internal governance and a number of related action plans demonstrate ongoing learning and improving in our multiagency working e.g. Child Fire Setters, Business Fire Safety relating to care homes, coordination of referrals from IDVAS and SYP Domestic Abuse Advisors and High (Fire Risk) Practice group.

AUDIT AND CASE MANAGEMENT

A newly created Case Tracker can now be used for quarterly auditing and the adult related internal case – work has increased three fold in the last 4 years. Less than a third of cases meet the criteria for a Safeguarding Enquiry, the majority are concerns about health and wellbeing. Over half of the cases are related to fire risks and self- neglect and SYFR has contributed to the development of the Hoarding and Self Neglect policies across the county.

TRAINING

A new SYFR Safeguarding Concern form together with an e learning support package has been developed to enable the workforce to differentiate between safeguarding, fire risk, health and wellbeing and to gather the required information to make effective referrals or raise concerns.

PLANS AND PRIORITIES

The SYFR Safeguarding Action Plan sits within the Community Safety Plan under the SYFR Integrated Risk Management Plan Priority 1: – COMMUNITY: – Making People Safer – working to prevent emergencies

The Safeguarding priorities for the coming 12 months:

- Preparation for HMICF&R Inspection – there is a specific theme of enquiry relating to the identification of those with vulnerabilities
- Ongoing preparation for GDPR
- Contribution to the National Fire Chief Council Safeguarding work stream

# South Yorkshire Police

Vulnerability, including adults are prioritised through our daily tasking process and allocated to resources accordingly. This is a priority in all of our tasking and led by Rotherham Borough Command Team on a daily basis. South Yorkshire Police are fully engaged with the statutory referral process and case management in cases of identified adult vulnerability.

The re-establishment of dedicated Neighbourhood resources to strengthen the PCSO teams are now embedded in all areas within Rotherham. This gives us the best opportunity to take community feedback, identify cases of vulnerability and to protect potential victims of crime and anti-social behaviour. The co-location of these local Police enforcement services with Local Authority counterparts has been achieved in the Central Neighbourhood area and will be completed for the North area based at Rawmarsh and in the South at Maltby in September 2018. Once embedded, the development of these services will look to expand the teams to include other partners where it is sensible to do so.

A new innovation also on line since May 2018 is the Safer Neighbourhood Service whose vision is to work in partnership, to listen to and work with the public, community groups and businesses to reduce crime, protect the vulnerable and enhance community safety through integrated problem-solving approaches. This fully supports the mission of the Safeguarding Adults Board and its' key objectives. The Safer Neighbourhood Service is very much about early identification and intervention in cases where vulnerability is found. Working with partners to case manage and appropriately problem solve the case, bringing a sustainable solution using all partnership resources.

Vulnerable adult victims of crime are prioritised, within that cohort of victims there may be particular features that need focussed attention. Hate crime, sexual abuse, financial abuse, missing persons and repeat and vulnerable victims of anti-social behaviour, all have dedicated staff case managing and problem solving to reduce vulnerability protecting victims and bring perpetrators to justice.

## Case Studies

**Financial exploitation.** An elderly victim had carers going into his home every day, he had a fall and went into hospital and then into a care home and had dementia. The Social Worker alerted the Police months later that someone had been withdrawing thousands from his bank account during the last year. The Vulnerable Persons Unit investigated around 10 carers who had access to the victim's home prior to the victims fall. Eventually identified one carer as suspect and secured a conviction at Crown Court for burglary and fraud.

**Financial exploitation.** An elderly victim had a carer who came once a week to help with chores and was supposed to withdraw £100 a week and give to the victim. The carer had the victim's bank account for 4 years, withdrawing cash every week totalling over £20,000 without consent. The carer was spending the money on gambling. The Vulnerable Persons Unit investigated and secured a conviction of fraud x 2 at Crown Court.

**Suicide Prevention.** A young adult male whose younger brother and mother had took their own lives and was living a chaotic lifestyle was identified as a tangible risk of suicide. A number of emergency meetings were held with partners leading to quick responses to any information from his home address, an active suicide attempt was prevented and he was further supported by the partnership to help him get through a very tough period of his life.

A vulnerable trans female exhibiting sustained criminal behaviour and anti-social behaviour especially at local transport hubs was identified by the team. The relevant partners were engaged including the Transport Interchange at Rotherham to put in place a Criminal Behaviour Order to help curb her behaviour and reduce the vulnerability to herself and others. This young and vulnerable female is now engaging with various services to provide long-term solutions to her behaviour and reduce her vulnerability.

## 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.
- The nominated representative, who is the Chief Executive of Age UK Rotherham, attends 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.
- Each of the Safeguarding Adults sub-groups has representation from the voluntary and community sector. RSAB – Lesley Dabell, Training – Liz Bent, MSP – Karen Smith. Reports from subgroups are shared with the wider Voluntary and Community sector via ASC Strategic Representative meetings.
- VCS organisations continue to contribute to the Safeguarding Board and Development Days as partners; in addition they act as alerter's referring concerns appropriately.
- Individual VCS organisations have continued their work internally in respect of their own policies and procedures for Safeguarding, linking in to the wider Safeguarding Procedures in the Borough. Staff and Volunteers have attended training sessions raising awareness of Adult Safeguarding throughout the Borough.
- The Adult Services Consortium and Voluntary Action Rotherham have been promoted safeguarding week, and VCS groups are taking an active part during the week.
- VAR acts as an 'umbrella body', for administering and processing the 'Disclosure and Barring Service' (DBS) checks
- VAR promotes DBS and provide related advice and support, including carrying out the 'Enhanced DBS checks'
- VAR supports VCS with the development of Safeguarding Policies and procedures; including 'Safer Recruitment' support

**Recognise • Respond • Report**

## Learning and development

In 2017/18 the Training Sub-group ran a rolling programme of supportive training opportunities for staff, managers and volunteers on local policy, procedures and professional practice so that adults across Rotherham are protected from abuse and neglect and their wellbeing is promoted. 1,058 learners attended training courses, as detailed by agency in the table above.

| | |
|---|---|
| Local authority | 423 |
| Independent/ Voluntary sector | 580 |
| Health | 28 |
| Police/Probation | 0 |
| Service Users / Carers | 21 |
| Students | 6 |
| Other/Housing Partner | 0 |
| | **1058** |

The Training Sub-group finalised its Training Strategy and Training Plan for 2017/2020 to lead and manage training arrangements across Rotherham. The Strategy now provides the framework for establishing priorities and plans for multi-agency and specialist safeguarding adults training and resources in support of achieving the Strategic Plan of Rotherham's Safeguarding Adults Board. The Strategy sets out the vision, goals and principles for training and how these will be taken forward. The Plan supports and drives forward the Training Strategy's goals where training equips the workforce with the knowledge, skills and behaviours to carry out their role to safeguard adults from abuse and/ or neglect.

The Training Sub-group's objectives and priorities 2018/2019 are:

- Assessing multi-agency and specialist training needs /analysing gaps
- Development of an multi-agency and/or specialist training framework
- Development of models for evaluating training impact.

# Safer Rotherham Partnership

The Safer Rotherham Partnership is the borough's Community Safety Partnership with statutory responsibilities established under the Crime and Disorder Act 1998. The partnership has a legal responsibility to tackle crime, anti-social behaviour, drug and alcohol misuse and to enhance feelings of safety.

There are currently five responsible authorities on the SRP, who have a legal duty to work in partnership to tackle crime, disorder, substance misuse, anti-social behaviour and other behaviour adversely affecting the environment and to reduce re-offending.

The six responsible authorities are:

- Rotherham Metropolitan Borough Council
- South Yorkshire Police
- South Yorkshire Fire and Rescue Service
- National Probation Service
- Rotherham Clinical Commissioning Group

The SRP also brings together a range of interested parties from the public, private, community and voluntary sectors to help deliver the outcomes in the SRP Partnership Plan through our strategic and operational structures, as well as representation from the Office of the Police and Crime Commissioner.

The SRP has a statutory duty to develop an annual Joint Strategic Intelligence Assessment of the risks and threats that crime and disorder poses to the communities of Rotherham. The purpose of the assessment is to:

- Identify the partnerships priorities for the forthcoming year.
- Highlight performance, progress and achievements against the commitments made in the 2014/16 Partnership Plan.
- Identify key crime and disorder risks and threats to the community.

**Achievements:**

This year the Safer Rotherham Partnership has undergone two independent reviews.
The first of which related to overall governance and assurance with the second being specific in relation to Domestic Abuse. Both reviews provided broad assurance, alongside valuable learning, some of which will require continued efforts to strengthen links amongst the key partnerships, including the Safeguarding Adults Board.

There has been a continued rise in crime (20%), as reported in the previous year and this is due to crime reporting standards improving not just in South Yorkshire, but nationally. This has also caused a reduction in outcomes (-3%), as a percentage of the crime recorded. There has however been a slight (1%) increase in general satisfaction levels. The specific priority areas over the previous year were;

- Preventing Child Sexual Exploitation

This year has seen a reduction of 11% in current offences (not including historic offences) and a 100% completion of taxi licensing safeguarding requirements. There has additionally been an 8% increase in the use of abduction notices.

- Building Confident and Cohesive Communities

As a result of the continued work of partners and a commissioned project, there has been a 33% rise in reported hate crime, which is seen as positive, though is still likely to reflect under-reporting. Thousands of hours of awareness raising has been competed to hundreds of individuals.

- Reducing the Threat and Harm of Domestic Abuse

A strategy has been agreed by all partners and the SRP Board in relation to Domestic Abuse. There has also been a significant reduction in the waiting list for standard and medium risk victims, down to 0. The independent peer review in to this area again provided broad assurance however further work is required around training and data alongside assurance and governance. This work will link closely with the Safeguarding Adults Board.

- Reducing and Managing Anti-Social Behaviour

There has been a 27% reduction in Ant-Social Behaviour over the previous year. This is mainly due to a number of incidents that would have previously been classified as ASB, now being classified as crimes, which is positive in regards to more effective support for victims. There has however been an increase in deliberate fires and further work will be done on this matter. The Partnership has reviewed and strengthened partnership structures that support officer to tackle this type of behaviour. Additionally, enforcement services have moved to a co-located model. This will make the team more effective and better support victims and in particular, vulnerable victims

- Reducing Violent Crimes and Sexual Offences

There has been a 42% increase in Violence against the Person and a 23% increase in sexual offences. Again this is linked to crime recording however does present a concern and work continues to seek to address these areas of work.

Following a refined process, taking in much wider data set, the Safer Rotherham Partnership has adopted headline priorities as follows;

- Protecting Vulnerable Children
- Protecting Vulnerable Adults
- Building Confident and Cohesive Communities
- Reducing the Threat and Harm of Domestic Abuse
- Tackling Serious Organised Crime

Clearly the work of both partnerships continues to overlap and the SRP will seek only to enhance work where possible and cooperate with the Safeguarding Adults board in relation to the delivery of relevant priority areas.

Appendix 2

# Key Facts and Figures

## A Concern

A Concern 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.

A total of **2,113** concerns were reported through the new Safeguarding Adults Collection (SAC).

Each concern is looked at and the 3 point test is applied.

The safeguarding duties apply to an adult who:

1. Has needs for care and support (whether or not the local authority is meeting any of those needs)
2. Is experiencing, or at risk of, abuse or neglect
3. As a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

If the concern does not meet the criteria of the 3 point test the case may be signposted to a different team such as the vulnerable person's team or maybe a care assessment is needed. We will always ensure the person is safe and not in any danger.

## Section 42 Enquiry

A Section 42 Enquiry is the same as an Alert however it becomes an enquiry when the details progress and an investigation/assessment relating to the concerns begins.

At any point during this investigation a case can exit the safeguarding process.

The subject of the investigation must be aware and in most cases agree to the safeguarding enquiry unless capacity is lacking or a crime has been committed.

**724 Section 42 enquiries began 2017-18**

## Decision Making Meeting (DMM)

The DMM will bring all relevant people together to ensure that, if the investigation continues, the right questions will be asked of the right people. The voice of the person at risk of harm must be heard. Plan the way forward, look at who is best placed to investigate the concern.

This meeting may be held virtually, to ensure it happens in a timely manner.

**53 DMM's convened in 2017-18**

## Outcomes Meeting

The Outcome meeting will bring all interested parties together including the individual if they wish to attend. Support from friends, advocacy or family is also encouraged. The voice of the person at risk of harm must be heard throughout the meeting and they must be given the opportunity to tell their story.

The meeting will bring the investigation to a conclusion and recommendations must be agreed by all interested parties and timescales and expectations clearly identified.

**10 Outcome Meetings Convened 2017-18**

## Safeguarding Adults Review (SAR)

A Safeguarding Adults Review must be carried out if:

- A vulnerable adult dies (including death by suicide) and abuse or neglect is known or suspected to be a factor in their death. In such circumstances the SAB should always conduct a review into the involvement of agencies and professionals associated with the vulnerable adult.
- A vulnerable adult has sustained a potentially life-threatening injury through abuse or neglect, serious sexual abuse, or sustained serious and permanent impairment of health or development through abuse or neglect, and the case gives rise to concerns about the way in which local professionals and services work together to safeguard vulnerable adults.
- Serious abuse takes place in an institution or when multiple abusers are involved, the same principles of review apply. Such reviews are, however, likely to be more complex, on a larger scale, and may require more time. Terms of reference need to be carefully constructed to explore the issues relevant to each specific case.

The SAR is commissioned by the SAB and all partners who have had involvement with the subject of the enquiry will be required to participate in the review. The results of the review are published by the SAB in the form of a final report.

| Number of SAR's Commissioned 2017-2018 |
| --- |
| 0 SAR's was commissioned in 2017/18 |

| Number of SAR's Compleated 2017-2018 |
| --- |
| 1 SAR was completed in 2017/18<br>Published August 17 (Margaret) |

## SAR Margaret

Margaret was a 92-year-old who was a resident in a Nursing Care Home 2012 until her death in February 2015. Margaret had significant health needs with hypothyroidism, depression, dementia, contracture of lower limbs and anaemia.

In February 2015 Margaret was admitted by the GP to The NHS Foundation Trust Hospital due to concerns regarding her poor condition. It was believed she was at this point in a myxoedema coma and was critically ill. Her temperature was unnaturally low and she was slightly blue. Margaret died nine days after admission.

Margaret's death certificate stated:

- Myxoedema coma
- Hypothyroidism
- Alzheimer's dementia

Subsequently the NHS Foundation Trust made a safeguarding referral due to concerns that Margaret was in a coma due to a thyroxine crisis and suggestions that she had not had her essential thyroxine medication for over 2 years and that this was more likely to be the cause of the poor physical condition that Margaret was in on admission. The outcome of the ensuing Section 42 Enquiry was that neglect by omission in respect of the medication that was not received by Margaret, led to her death.

**Findings/Recommendations**

1. Recommendations for the Local Authority:

That the Local Authority social care and contracts compliance team, in partnership with other agencies where appropriate, ensure:

a. Contract Compliance will be conducted through a targeted approach to contract compliance visits based on risk. For high risk settings contract compliance officers will identify that care plans and medication records within care homes are fit for purpose and demonstrate they are in keeping with the needs of the individual.

b. Social Care reviews of residents in care homes involves health and care staff where appropriate

c. Where clients are resident in settings that are non-compliant with CQC regulations and/or contracts, consideration should be given to review of care needs of residents dependent on the severity of the concern. This must include an audit trail that provides evidence that no resident has been missed. Consideration must be given to providing families with relevant information when appropriate

d. A review of the Local Authority Home Closure and Provider failure protocol to ensure that it remains fit for purpose in light of the above recommendations.

2. Recommendations for the CCG:

a. management of long term conditions by GP's within residential and nursing homes are subject to robust processes of monitoring and review.

b. there are appropriate written communication tools in use between care homes and GP practices.

c. the system for notification of the changed funding arrangement for an individual is reviewed and audited to ensure that any failure to successfully transfer responsibilities is flagged.

d. The CCG should provide support to GP practices across Rotherham to develop processes that take account of legislation, guidance and case law for when it is deemed clinically necessary to administer covert medication. Guidance should also include that Best Interest decisions are supported with agreed multi agency covert medication plans which are reviewed regularly.

3. Recommendation for CCG and Local Authority:

The CCG and Local Authority Contract compliance should gather information from relevant partners, including CQC, NHS Providers and local Care Home providers to establish whether there is evidence of uncertainty of roles and responsibilities in the provision of nursing care to nursing homes in the Borough. Dependent upon findings further recommendations should be made to address any issues found.

4. Recommendations for NHS England.

NHS England in Yorkshire and Humberside should:

a. Publicise the safeguarding learning from this review amongst GP's in the region.

b. Ensure the learning from this review is shared with the safeguarding lead nurses and GP's in the region.

5. Recommendations for Rotherham Safeguarding Adults Board (RSAB).

a. Where agencies have made their own recommendations in their review of Margaret's care, RSAB should seek assurance that action plans are underway and outcomes are impact assessed within those organisations.

b. RSAB to write to NHS England to request the consideration of project funding to incentivise medicines management support to care homes. This would be consistent with work in other areas to provide oversight and scrutiny by medicines management staff especially where there are medicines management compliance issues flagged by LA CC teams and/or CQC.

c. That the DoLs subgroup of RSAB, consider the learning from this review and ensure that where medication compliance is an issue and covert medication is being considered, these cases should be included in the list of cases that require prioritisation. I.e. Challenging behaviour requiring significant restrictions should be prioritised for full assessment for DoLs authorisation. Scrutiny of the prioritisation of DoLs applications will ensure the priorities are compliant with ADASS guidance.

   www.adass.org.uk/media/5297/additional-dols-safeguards-final.pdf

d. Arrangements should be made to share the learning with the Local Pharmaceutical Committee and CQC.

e. The RSAB Making Safeguarding Personal sub group should share the learning from this review in the form of a briefing across all its member agencies. Assurance should be sought as to how this has been disseminated to professionals in those organisations followed by case audit to provide evidence of impact e.g. change of practice or policy/procedure etc.

f. Evidence and assurance should be provided to RSAB performance sub group on the completion and/or ongoing audits of the recommendations as appropriate.

The actions have been developed into an action plan that is monitored by the Performance and Quality Sub Group, the chair of the group will report to the RSAB on progress and when all actions are completed.

## Mental Capacity Act and Deprivation of Liberty Safeguards

The DoLS continue to challenge the local authority in terms of numbers of referrals, however, this does reflect that care arrangements which amount to a deprivation of liberty are being acknowledged and the appropriate authorisation is being sought by the relevant managing authority's. Support in the form of advice and training needs to continue with care providers to ensure all deprivations of liberty are recognised and managed in line with statutory duties.

As can be seen in the table, the number of authorisations granted and not granted has gone down in the last reporting year, this can be attributed mainly to two factors:

- Changes to the tax regulations in April 2017 relating to independent assessors meant their employment status had to be reviewed, the result being that some assessors chose to no longer provide services to the local authority. Work to recruit independent assessors is ongoing, with positive results;
- A comprehensive audit of the quality of DoLS assessments took place between July and December 2017, the outcome of the audit found the quality of reports fell below that expected by the Supervisory Body. The allocation of assessments was pared back to allow for re-training of assessors.

| Mental Capacity Act and Deprivation of Liberty Safeguards | | | | |
|---|---|---|---|---|
| Year | No. of Applications | Authorised | Not Authorised | Screened unallocated cases |
| 2013/14 | 56 | 44 | 12 | |
| 2014/15 | 565 | 165 | 111 | |
| 2015/16 | 957 | 190 | 350 | |
| 2016/17 | 1128 | 452 | 524 | 480 |
| 2017/18 | 1190 | 227 | 4 | 738 |

In March 2018, Parliament responded to the Law Commission's proposals on the Liberty Protection Scheme to replace DoLS. The local authority is aware of the proposals and preparing for any impact on current policies and procedures.

# The Context of Safeguarding in Rotherham – 2017/18 data

No of concerns received - **2113**

No which progressed to enquiry - **724**

Concerns received have ***decreased*** in 2017/18 by approx.**16%** (**2113**, - 2017/18), (**2455** - 2016/17)

No of S42 Enquiries commencing in year has ***increased*** by approx.**12%** (**719** - 2017/18), (**640** - 2016/17)

Rotherham's conversion rate has ***increased*** to **34%** from **24%** (National Average 2016/17 was **41%**)

No of S42 Enquiries completed in year have ***increased*** by approx.**48%** (**645**, - 2017/18), (**435** - 2016/17)

**Demographics**

**19%**
of population aged **over 65**

**41%**
**increase in 85+ population** in past 15 years

**59%**
of **safeguarding concerns** relate to people **over 65**

**62%**
of **safeguarding enquiries** relate to **female adults**

**37%**
of **safeguarding enquiries** relate to **younger adults**

The table below shows % change in abuse types

| Concluded S42 Enquiries | | | |
|---|---|---|---|
| | **2017/18** | **2016/17** | **% change** |
| **Physical Abuse** | 155 | 80 | 93.8% |
| **Sexual Abuse** | 37 | 25 | 48% |
| **Psychological Abuse** | 90 | 35 | 157% |
| **Financial or Material Abuse** | 138 | 80 | 73% |
| **Discriminatory Abuse** | 2 | 0 | |
| **Organisaional Abuse** | 28 | 15 | 87% |
| **Neglect and Acts of Omission** | 340 | 210 | 62% |
| **Domestic Abuse** | 32 | 11 | 191% |
| **Sexual Exploitation** | 5 | 0 | |
| **Modern Slavery** | 3 | 1 | 200% |
| **Self-Neglect** | 16 | 5 | 220% |

Appendix 3

# Rotherham Safeguarding Adults Board Attendance

Date of Safeguarding Adults Board Meeting (excludes e-learning)

| | May 2017 | July 2017 | Sept 2017 | Nov 2017 | Jan 2018 | March 2018 |
|---|---|---|---|---|---|---|
| **South Yorkshire Police** | Apologies | Apologies | ✔ | ✔ | ✔ | ✔ |
| **The Rotherham Foundation Trust** | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ |
| **Clinical Commissioning Group** | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ |
| **RMBC Director of Social Services** | ✔ | ✔ | Apologies | ✔ | ✔ | ✔ |
| **RMBC Children's Service** | ✔ | Apologies | Apologies | Apologies | Apologies | ✔ |
| **South Yorkshire Fire and Rescue** | ✔ | ✔ | ✔ | ✔ | Apologies | Apologies |
| **NHS England** | ✔ | ✔ | Apologies | ✔ | ✔ | Apologies |
| **RDASH** | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ |
| **RMBC Services** | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ |
| **Healthwatch** | ✔ | ✔ | Apologies | ✔ | Apologies | ✔ |
| **Voluntary Sector** | Apologies | Apologies | ✔ | Apologies | ✔ | ✔ |
| **National Probation Service** | Apologies | ✔ | Apologies | ✔ | ✔ | ✔ |
| **Community Rehabilitation Company** | | ✔ | ✔ | Apologies | ✔ | ✔ |
| **Cabinet Member for Adult's Services** | Apologies | Apologies | Apologies | ✔ | ✔ | Apologies |

Rotherham Metropolitan Borough Council's Cabinet Member for Adults Services supports the work the Safeguarding Adults Board with a visible presence at events and discussions throughout the year and is provided with monthly updates on all safeguarding adults issues as well as the work of the board.


# Do you know the signs of adult abuse?


# Recognise • Respond • Report

Rotherham Council **01709 822330**
Police non emergency: **101** *or* emergency: **999**

**Keeping people safe from abuse is everyone's business**

**For more information about types of abuse**
**www.rotherham.gov.uk/abuse**

Rotherham Safeguarding Adults
NHS Rotherham Clinical Commissioning Group
South Yorkshire POLICE
Rotherham Metropolitan Borough Council

NHS The Rotherham NHS Foundation Trust
NHS Rotherham Clinical Commissioning Group
NHS England
Rotherham age UK
healthwatch Rotherham
NHS Rotherham
South Yorkshire POLICE
South Yorkshire FIRE & RESCUE
CROSS ROADS CARE North West
RDaSH leading the way with care
Rotherham Metropolitan Borough Council