Committee Name and Date of Committee Meeting
Health Select Commission – 26 June 2025

Report Title
Adult Social Care - Adult Contact Team Referral Pathway

Is this a Key Decision and has it been included on the Forward Plan?
No

Strategic Director Approving Submission of the Report
Ian Spicer, Strategic Director of Adult Care, Housing and Public Health

Report Author(s)
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Ward(s) Affected
Borough-Wide

Report Summary
This report provides an overview of the Adult Contact referral pathways, team structure, and referral routes. The report outlines service improvements being implemented, based on customer feedback and good practice.

Recommendations:

That the Health Select Commission:

1. Note the contents of this report.
2. Note the areas of development currently underway to further enhance the service offer.

List of Appendices Included
Appendix 1: Supporting Independence Team Information Leaflet

Background Papers
Rotherham Adult Social Care Strategy

Consideration by any other Council Committee, Scrutiny or Advisory Panel
None

Council Approval Required
No

Exempt from the Press and Public
No

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1. Background

1.1 The Adult Contact Team (ACT), previously known as First Contact, was created as part of the Adult Social Care Target Operating Model in 2019.

1.2 ACT's purpose is to receive, triage and prioritise referrals for assessment, prevention, safeguarding and occupational therapy input for Adult Social Care.

1.3 More recently, the service has been subject to a redesign, which concluded in April 2025, and is currently in the implementation stage. This report outlines the improvements being implemented to support the increasing levels of demand and to ensure the service remains fit for purpose.

2. Key Issues

2.1 The ACT is responsible, as the single point of contact for Adult Social Care, for screening and triaging all service contacts. This includes:

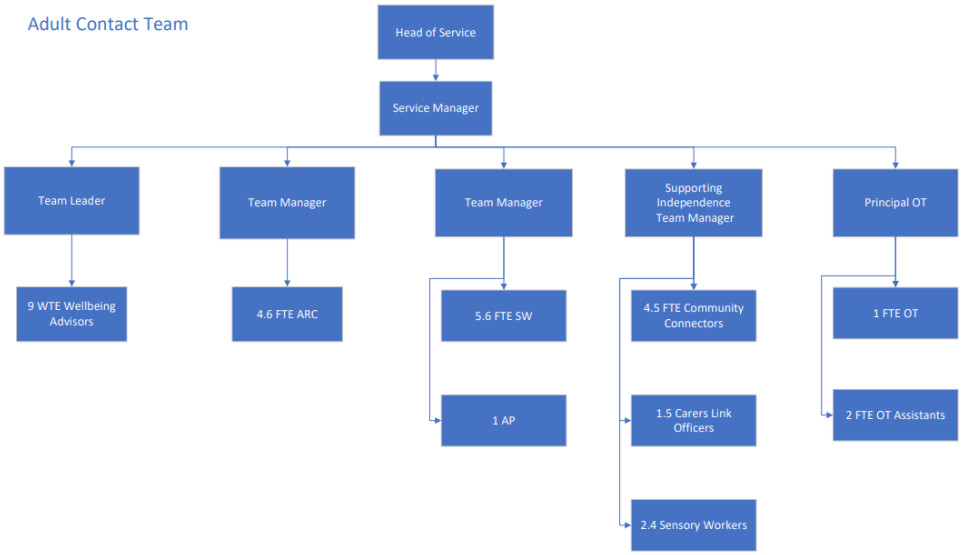
- Localities
- Safeguarding
- Learning Disabilities
- Mental Health
- Community Occupational Therapy (COT)
- Prevention (Supporting Independence Team [SIT])
- Sensory Services
- Carers
- Preparing for Adulthood (PfA – Transitions)
- Complex Lives and Domestic Abuse including the vulnerable adults pathway.

2.2 ACT receives on average 3,000 calls per month, this was 2,778 in March 2025 and an additional 1,833 enquiries were received via email.

2.3 The ACT comprises of a team of Wellbeing Advisors (WBA) who provide the initial screening of telephone calls and appropriate signposting. Assessment and Review Coordinators (ARCs) and Social Workers (SW) provide support with more complex enquiries including safeguarding referrals. The team has an Occupational Therapy duty function to respond to urgent requests such as moving and handling, supported by experienced team managers. The team also has an Advanced Practitioner who provides complex case management support and supports the team with practice support.

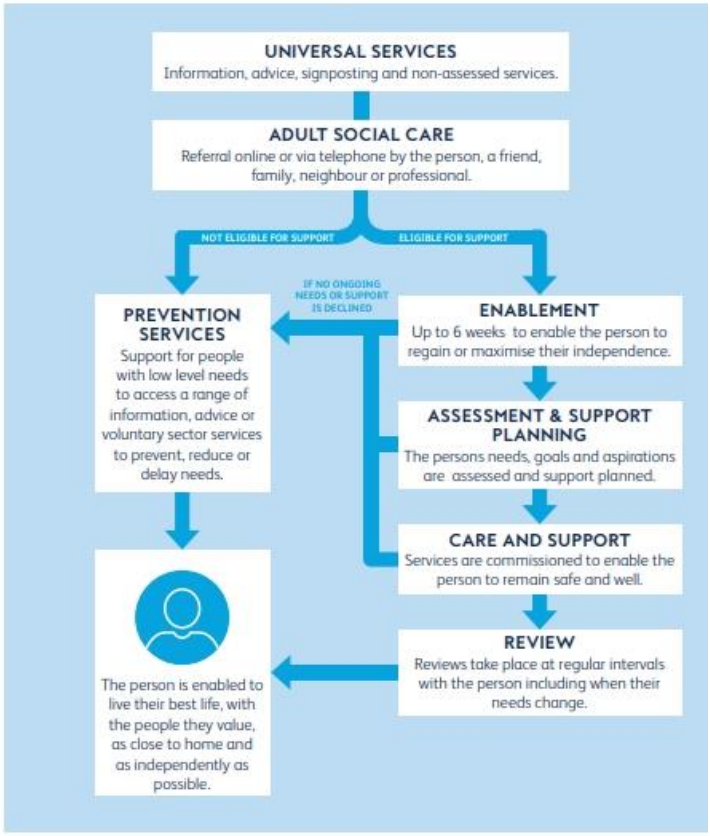
2.4 Within the ACT, the Supporting Independence Team (SIT) support people who are unlikely to meet the eligibility threshold within the Care Act but do need support with other factors, such as social isolation and support to access community groups. In addition, the SIT provide support to unpaid carers and people experiencing sensory loss. The SIT was first

established in October 2024 in Adult Social Care to ensure a robust preventative response for people presenting to the service.



2.5 The ACT has responsibility to support people with No Recourse to Public Funds (NRPF) where they are vulnerable and have social care needs. The team also administer Public Health funerals for people who have passed away and have no next of kin, or, whose next of kin, are unable to make the necessary arrangements for a funeral.

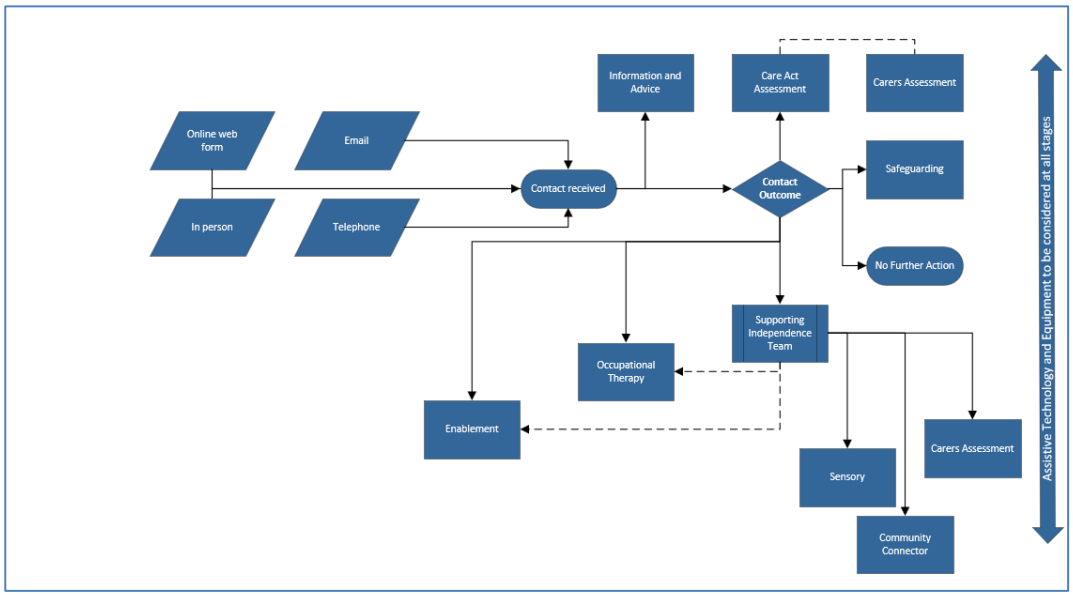
2.6 The high-level Adult Social Care pathway was refreshed in 2024, as part of the Rotherham Adult Social Care Strategy (2024 – 2027):



2.7

When a person contacts Adult Social Care via ACT, they may be supported with information and advice including signposting to the voluntary and community sector, referred into enablement, OT or SIT, or receive a statutory Care Act Assessment or safeguarding enquiry. A referral can be made via the web, in person, via email or telephone. The referral can be made be the person, a professional or other source.

2.8 The following pathway depicts these outcomes and the process in more detail.

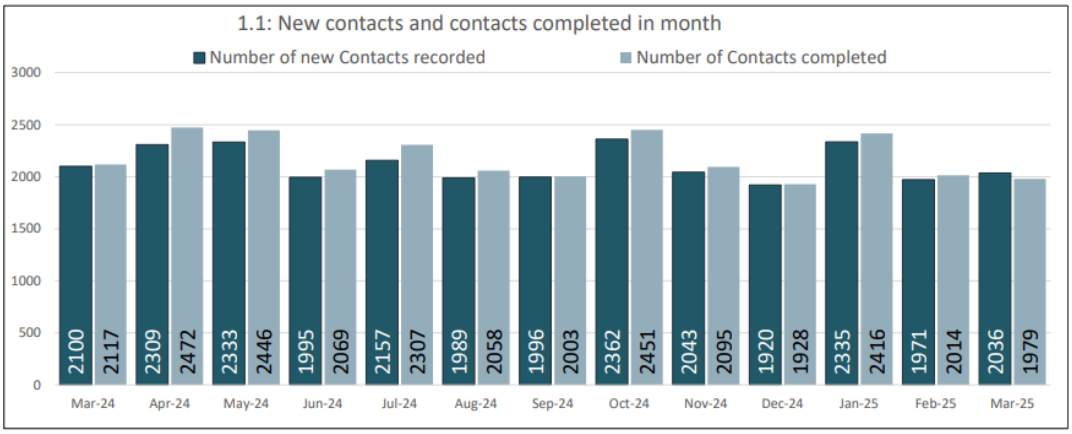


2.9 ACT screen and triage incoming requests, they consider all information gathered about the persons presenting needs and then pass the referral onto the most appropriate team. SIT and OT/AT provision will be the first consideration. If a person has a need for personal care and is not currently receiving service, the referral will be screened for enabling potential to work with someone to regain some independence and then have a Care Act Assessment if ongoing care and support is required.

2.10 Where SIT/enablement/OT/AT are not appropriate the referral would be passed to a community team to undertake an assessment.

2.11 Service Activity

2.12 The number of contacts received to the ACT increased slightly by 3.3% to 2,036 in March 2025 whilst contacts completed reduced by 1.7% to 1979. The overall number of open contacts with no decision at month-end fell by a further 1.5% to 324 in March 2025, when compared to 329 in February 2025.



2.13 The proportion of contacts supported at first point of contact (FPOC) increased slightly in March 2025 by 1.2% to 18.3%. Those progressing to a new case (assessment) increased by 4.8% to 49.4% in March 2025, the highest proportion reported since April 2024. 48 people were referred for Enablement support in March 25. 244 people were passed through to community teams for assessment.

N.B: not all enquiries need to be actioned by ACT as some enquiries require forwarding to other teams or workers where the person is known.

2.14 In March 2024, 350 safeguarding referrals were received. Of these, 120 progressed to an initial enquiry, and 59 progressed to full enquiry which were allocated to the relevant community team. ACT completed the initial making safe actions and links with the relevant duty team as required.

2.15 Since the establishment of SIT the team through to the end of March 2025, the team have supported a range of residents to meet their preventative, caring and sensory needs including:

- 101 people for sensory rehabilitation and dual sensory support
- 182 standalone Carers assessments
- 195 people with preventative support. Of these, only 8% required ongoing statutory support.

2.16 The multi-agency approach at the front door in Adult Social Care means that people's needs can be met more quickly and effectively. The co-location of Occupational Therapy (OT) led to 91 urgent referrals being responded to at the point of referral (March 2025).

2.17 In 2024/25, 25 people presented as needing support due to no recourse to public funds and the team supported 23 public health funerals.

2.18 Impact and Outcomes

The following section sets out several case studies to evidence the impact of ACT.

2.19 **Housing Case Study**

Housing requested involvement as they had completed a homeless assessment with AG. AG arrived in reception with visible bruises, limited mobility and had not eaten in two days. The homeless worker agreed to provide emergency accommodation. However, AG refused to sign the consent form (which would have prevented them from accessing the accommodation).

The social worker met with AG in private and rapidly built enough trust for AG to disclose that they could not read or write. The social worker supported AG to understand the consent form and asked supplementary questions to AG's understanding. The social worker identified AG's safeguarding outcome was to have a place of safety and advocated on their behalf with the Homeless Officer. The worker focused on the risks AG was facing if he continued to live on the streets. The homeless team agreed to provide emergency accommodation and AG consented to have a Care Act Assessment (CAA) in terms of mobility limitations which were impacting on daily living needs.

AG told us ***"This is the first time I've ever got anywhere - I've never felt so listened too and understood."***

2.20 **Supporting Independence Case Study**

A Community Connector worked with a 70-year-old resident who was referred in from Improving Access to Psychological Therapies (mental health service). There were several presenting issues, relating to mental wellbeing and hoarding.

Through gentle persuasion and support from family members, the Community Connector provided advice and guidance, encouragement and the resident accepted support.

The following feedback was received:

'Previous hoarding client has followed through with the deep clean, individual is over the moon and has stated it has changed their life! They now have friends over visiting, has replaced the mattress on the bed as the old one went in skip during the clean so this has enabled them to get better sleep!'

This person did not need further intervention from other services following SIT involvement.

2.21 **Occupational Therapy Case Study**

An initial Occupational Therapy (OT) assessment was completed after a self-referral by a resident who lives alone in a Council bungalow. They have a complex medical history leading to variable mobility, perceptual difficulties and fatigue. They mobilised around the home with a stick.

After discussion with the OT, the resident agreed to try a perching stool to allow them to rest while performing tasks in the kitchen, and a kitchen

trolley to safely transport food and other items around the home while being supported with their walking. A further perching stool was agreed for use in the bathroom to assist while undertaking personal hygiene tasks.

The resident was moving bedroom to make it easier for them to access the bathroom at night. It was identified that if the door opened the other way, then they would again have easier access and be better supported while tired at night. A grab rail was also recommended near to the toilet to prevent reliance on the radiator for transfers.

The resident also felt unsafe accessing the wheelie bin outside due to a step. A grab rail was recommended to give additional support. They also agreed to be referred for assistance to take the bin out to reduce the risk of falls. The OT team member also identified a flickering light in the property and an issue with parking permits in the area. The worker was able to contact colleagues in the Council to get further advice and support with these issues.

The resident was very grateful and expressed what a difference the OT intervention had made to her wellbeing.

2.22 **Service Improvements**

To ensure that the ACT can respond to the growing demand at the front door, the team is in the process of making a range of service improvements to further enhance the experience for residents and professionals who contact the service, including:

- An updated electronic referral form which will integrate with the case management system with the intention of streamlining processes and realise additional capacity to triage and respond to calls.

- A review of business processes to improve call response times and identify efficiencies to manage the presenting demand and complexity of referrals to ASC.

- Exploring opportunities to utilise Artificial Intelligence to increase staff capacity, and further improvement the residents experience.

- A refresh of the Safeguarding Pathway to strengthen the screening of referrals and associated timeliness.

- Allocate people presenting with No Recourse to Public Funds to the appropriate community team post screening of eligibility.

- A realignment of the Public Health Funeral function to the Court of Protection Team to increase capacity to respond to enquiries.

- Review the triage of OT referrals to manage the increasing demand on requests for OT assessment.

- Embedding strong links with the Mental Health Enablement service to ensure the most appropriate team supports people to maximise their independence.

- Expand the SIT offer to provide support to young people preparing for adulthood who do not meet the threshold for Adult Social Care support.

3. Options considered and recommended proposal

3.1 This report is intended to provide an overview of the Adult Social Care Contact Referral process and to give insight into the current challenges and developments planned to improve access to Adult Social Care and resident satisfaction with Access.

The Health Select Commission is asked to receive the report and note the contents of the report.

4. Consultation on proposal

4.1 Not applicable

5. Timetable and Accountability for Implementing this Decision

5.1 The planned service improvements will be delivered over the next 6 months.

6. Financial and Procurement Advice and Implications

There are no financial or procurement implications associated with this report.

7. Legal Advice and Implications

There are no legal implications associates with this report.

8. Human Resources Advice and Implications

There are no HR implications for this report.

9. Implications for Children and Young People and Vulnerable Adults

There are no direct implications for children and young people from this report.

10. Equalities and Human Rights Advice and Implications

The proposals in this report support the Council to comply with legal obligations encompassed in the:

- Human Rights Act (1998) - to treat everyone equally with fairness dignity and respect with a focus on those who are disadvantaged as a result of disability and;
- Equality Act (2010) - to legally protect people from discrimination in the wider society.

11. Implications for CO_2 Emissions and Climate Change

There are no implications for CO2 emissions or climate change directly arising from this report.

12. Implications for Partners

Adult social care actively engages with all partners including the voluntary sector when seeking to make improvements to a service and as part of effective service delivery.

13. Risks and Mitigation

13.1 The volume and complexity of concerns that people present with to ACT continues to increase.

The service improvement planned for ACT will significantly reduce the risk of not meeting demand and improve the experience of residents contacting Adult Social Care.

Accountable Officer(s)

Ian Spicer, Strategic Director of Adult Care, Housing and Public Health ian.spicer@rotherham.gov.uk

Approvals obtained on behalf of:

	Name	Date
Chief Executive		Click here to enter a date.
Strategic Director of Finance & Customer Services (S.151 Officer)	Named officer	Click here to enter a date.
Assistant Director of Legal Services (Monitoring Officer)	Named officer	Click here to enter a date.
Assistant Director of Human Resources (if appropriate)		Click here to enter a date.
Head of Human Resources (if appropriate)		Click here to enter a date.
The Strategic Director with responsibility for this report	Please select the relevant Strategic Director	Click here to enter a date.
Consultation undertaken with the relevant Cabinet Member	Please select the relevant Cabinet Member	Click here to enter a date.

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This report is published on the Council's website.