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Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee

Wednesday 16 January 2013 at 10.00 am

To be held at the Town Hall, Pinstone Street, Sheffield, S1 2HH

The Press and Public are Welcome to Attend

Membership

Councillor Mick Rooney (Chair), Sue Alston, Janet Bragg, Katie Condliffe, Roger Davison, Tony Downing, Adam Hurst, Cate McDonald, Pat Midgley, Jackie Satur, Diana Stimely, Garry Weatherall and Joyce Wright

Sheffield Local Involvement Network
Anne Ashby, Helen Rowe and Alice Riddell (Observers)

Substitute Members
In accordance with the Constitution, Substitute Members may be provided for the above Committee Members as and when required.

Sheffield City Council

PUBLIC ACCESS TO THE MEETING

The Healthier Communities and Adult Social Care Scrutiny Committee exercises an overview and scrutiny function in respect of the planning, policy development and monitoring of service performance and related issues together with other general issues relating to adult and community care services, within the Neighbourhoods area of Council activity and Adult Education services. It also scrutinises as appropriate the various local Health Services functions, with particular reference to those relating to the care of adults.

A copy of the agenda and reports is available on the Council's website at www.sheffield.gov.uk. You can also see the reports to be discussed at the meeting if you call at the First Point Reception, Town Hall, Pinstone Street entrance. The Reception is open between 9.00 am and 5.00 pm, Monday to Thursday and between 9.00 am and 4.45 pm. on Friday, or you can ring on telephone no. 2734552. You may not be allowed to see some reports because they contain confidential information. These items are usually marked * on the agenda.

Members of the public have the right to ask questions or submit petitions to Scrutiny Committee meetings. Please see the Council's website or contact Democratic Services for further information.

Scrutiny Committee meetings are normally open to the public but sometimes the Committee may have to discuss an item in private. If this happens, you will be asked to leave. Any private items are normally left until last. If you would like to attend the meeting please report to the First Point Reception desk where you will be directed to the meeting room.

If you require any further information about this Scrutiny Committee, please contact Emily Standbrook-Shaw, Scrutiny Policy Officer on 0114 27 35065 or email emily.standbrook-shaw@sheffield.gov.uk.

FACILITIES

There are public toilets available, with wheelchair access, on the ground floor of the Town Hall. Induction loop facilities are available in meeting rooms.

Access for people with mobility difficulties can be obtained through the ramp on the side to the main Town Hall entrance.

HEALTHIER COMMUNITIES AND ADULT SOCIAL CARE SCRUTINY AND POLICY DEVELOPMENT COMMITTEE AGENDA
16 JANUARY 2013

Order of Business

1. **Welcome and Housekeeping Arrangements**

2. **Apologies for Absence**

3. **Exclusion of Public and Press**
   To identify items where resolutions may be moved to exclude the press and public

4. **Declarations of Interest**
   Members to declare any interests they have in the business to be considered at the meeting

5. **Minutes of Previous Meeting**
   To approve the minutes of the meeting of the Committee held on 21 November 2012

6. **Public Questions and Petitions**
   To receive any questions or petitions from members of the public

7. **Non-Clinical Circumcisions**
   Report of the NHS Sheffield Clinical Commissioning Group

8. **Right First Time Update**
   Report of the Right First Time Programme Manager

9. **Safeguarding Adults**
   Report of the Director of Business Strategy, Communities Portfolio

10. **Care and Support Update**
    Presentation by Robert Broadhead and Karla Henry, Communities Portfolio

11. **Work Programme and Forward Plan**
    Report of the Policy Officer (Scrutiny)

12. **Monitoring Advisory Board Minutes**
    Information Item

13. **Date of Next Meeting**
    The next meeting of the Committee will be held on Wednesday 20 March 2013 at 10.00 am.

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ADVICE TO MEMBERS ON DECLARING INTERESTS AT MEETINGS

New standards arrangements were introduced by the Localism Act 2011. The new regime made changes to the way that members' interests are registered and declared.

If you are present at a meeting of the Council, of its executive or any committee of the executive, or of any committee, sub-committee, joint committee, or joint sub-committee of the authority, and you have a **Disclosable Pecuniary Interest** (DPI) relating to any business that will be considered at the meeting, you must not:

- participate in any discussion of the business at the meeting, or if you become aware of your Disclosable Pecuniary Interest during the meeting, participate further in any discussion of the business, or
- participate in any vote or further vote taken on the matter at the meeting.

These prohibitions apply to any form of participation, including speaking as a member of the public.

You **must**:

- leave the room (in accordance with the Members' Code of Conduct)
- make a verbal declaration of the existence and nature of any DPI at any meeting at which you are present at which an item of business which affects or relates to the subject matter of that interest is under consideration, at or before the consideration of the item of business or as soon as the interest becomes apparent.
- declare it to the meeting and notify the Council's Monitoring Officer within 28 days, if the DPI is not already registered.

If you have any of the following pecuniary interests, they are your **disclosable pecuniary interests** under the new national rules. You have a pecuniary interest if you, or your spouse or civil partner, have a pecuniary interest.

- Any employment, office, trade, profession or vocation carried on for profit or gain, which you, or your spouse or civil partner, undertakes.

- Any payment or provision of any other financial benefit (other than from your council or authority) made or provided within the relevant period* in respect of any expenses incurred by you in carrying out duties as a member, or towards your election expenses. This includes any payment or financial benefit from a trade union within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992.

  *The relevant period is the 12 months ending on the day when you tell the Monitoring Officer about your disclosable pecuniary interests.

- Any contract which is made between you, or your spouse or your civil partner (or a body in which you, or your spouse or your civil partner, has a beneficial interest) and your council or authority -
  - under which goods or services are to be provided or works are to be executed; and
  - which has not been fully discharged.

- Any beneficial interest in land which you, or your spouse or your civil partner, have and which is within the area of your council or authority.

- Any licence (alone or jointly with others) which you, or your spouse or your civil partner, holds to occupy land in the area of your council or authority for a month or longer.

- Any tenancy where (to your knowledge) -
  - the landlord is your council or authority; and
  - the tenant is a body in which you, or your spouse or your civil partner, has a beneficial interest.

- Any beneficial interest which you, or your spouse or your civil partner has in securities of a body where -

  (a) that body (to your knowledge) has a place of business or land in the area of your council or authority; and

  (b) either
  - the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body; or
  - if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which you, or your spouse or your civil partner, has a beneficial interest exceeds one hundredth of the total issued share capital of that class.

Under the Council's Code of Conduct, members must act in accordance with the Seven Principles of Public Life (selflessness; integrity; objectivity; accountability; openness; honesty; and leadership), including the principle of honesty, which says that 'holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest'.

If you attend a meeting at which any item of business is to be considered and you are aware that you have a **personal interest** in the matter which does not amount to a DPI, you must make verbal declaration of the existence and nature of that interest at or before the consideration of the item of business or as soon as the interest becomes apparent. You should leave the room if your continued presence is incompatible with the 7 Principles of Public Life.

You have a personal interest where –

- a decision in relation to that business might reasonably be regarded as affecting the well-being or financial standing (including interests in land and easements over land) of you or a member of your family or a person or an organisation with whom you have a close association to a greater extent than it would affect the majority of the Council Tax payers, ratepayers or inhabitants of the ward or electoral area for which you have been elected or otherwise of the Authority's administrative area, or

- it relates to or is likely to affect any of the interests that are defined as DPIs but are in respect of a member of your family (other than a partner) or a person with whom you have a close association.

Guidance on declarations of interest, incorporating regulations published by the Government in relation to Disclosable Pecuniary Interests, has been circulated to you previously, and has been published on the Council's website as a downloadable document at -http://councillors.sheffield.gov.uk/councillors/register-of-councillors-interests

You should identify any potential interest you may have relating to business to be considered at the meeting. This will help you and anyone that you ask for advice to fully consider all the circumstances before deciding what action you should take.

In certain circumstances the Council may grant a **dispensation** to permit a Member to take part in the business of the Authority even if the member has a Disclosable Pecuniary Interest relating to that business.

To obtain a dispensation, you must write to the Monitoring Officer at least 48 hours before the meeting in question, explaining why a dispensation is sought and desirable, and specifying the period of time for which it is sought. The Monitoring Officer may consult with the Independent Person or the Council's Standards Committee in relation to a request for dispensation.

Further advice can be obtained from Lynne Bird, Director of Legal Services on 0114 2734018 or email **lynne.bird@sheffield.gov.uk**

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SHEFFIELD CITY COUNCIL

Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee

Meeting held 21 November 2012

PRESENT: Councillors Mick Rooney (Chair), Sue Alston, Janet Bragg, Katie Condliffe, Tony Downing, Adam Hurst, Jackie Satur, Diana Stimely, Garry Weatherall, Joyce Wright and Sioned-Mair Richards (Substitute Member)

Non-Council Members (LINK):-

Helen Rowe

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1. APOLOGIES FOR ABSENCE

1.1 Apologies for absence were received from Councillor Cate McDonald and Councillor Sioned-Mair Richards attended as a substitute Member, and Anne Ashby (LINk).

2. EXCLUSION OF PUBLIC AND PRESS

2.1 No items were identified where resolutions may be moved to exclude the public and press.

3. DECLARATIONS OF INTEREST

3.1 Councillor Mick Rooney declared (a) a personal interest in Item 7 on the agenda (Birch Avenue/Woodland View - Update) and (b) a disclosable pecuniary interest in Item 10 on the agenda (Grenoside Grange West Wing), as a non-executive Director of the Sheffield Health and Social Care Board. He left the room during the consideration of Item 10 and Councillor Roger Davison took the Chair for this item.

4. PUBLIC QUESTIONS AND PETITIONS

4.1 There were no petitions submitted or questions raised by members of the public.

5. MINUTES OF PREVIOUS MEETING

5.1 The minutes of the meeting of the Committee held on 17th October 2012, were approved as a correct record, subject to (a) the removal of Councillor Sue Alston from the list of Members interested in taking part in the Working Group to be convened in order to scrutinize the provision of food in hospitals and (b) the deletion of the words “City Council’s” in the fourth line of paragraph 6.6 of Item 6 – Partnership Review – Sheffield City Council/Sheffield Health and Social Care NHS Foundation Trust and, arising therefrom:-

(i) with regard to the Nutrition and Hydration in Hospitals Working Group, convened to scrutinize the provision of food and drink in hospitals, the Scrutiny Policy Officer stated that:-

(A) she had contacted Sheffield Teaching Hospitals (STH), further to the Committee's request for her to investigate why the LINk Action Plan and subsequent recommendations on hospital food had not been implemented by STH, and had informed Anne Ashby, LINk, of such discussions; and

(B) the first meeting of the Working Group would hopefully be arranged for December 2012; and

(ii) the Scrutiny Policy Officer stated that, in the light of the apparent confusion as to whether details on the briefing on Memory Services had been circulated, she would circulate such information to Members of the Committee and the Sheffield LINk representatives following this meeting.

5.2 RESOLVED: That, in the light of the withdrawal of Councillor Sue Alston from the Nutrition and Hydration in Hospitals Working Group, Councillor Roger Davison be appointed as a Member of the Working Group.

6. BIRCH AVENUE AND WOODLAND VIEW - UPDATE

6.1 The Committee received an update on the current position regarding the Birch Avenue and Woodland View Care Homes, and in attendance for this item was Tim Furness, Chief of Business, Planning and Partnerships, NHS Sheffield Clinical Commissioning Group (CCG).

6.2 Roger Bolsover, relative of a resident in Woodland View, expressed his concerns with regard to the lack of staff in the cottages at Woodland View, as well as the high number of temporary staff.

6.3 Tim Furness stated that he accepted that staffing at Woodland View remained an issue and that he would be seeking assurances from Sheffield Health and Social Care NHS Foundation Trust that the Trust would take the necessary action to resolve the issues at the earliest possible opportunity.

6.4 Members of the Committee and representatives of LINk raised questions and the following responses were provided:-

- Further to the recommendations of this Committee relating to the views that, following the operation of the Care Homes by the South Yorkshire Housing Association (Birch Avenue) and the Sheffield Health and Social Care NHS Foundation Trust (Woodland View), the Care Homes would become Centres of Excellence, it had been determined that, whilst the model of care was different to that at other care homes, the Primary Care Trust (PCT) had not commissioned the Homes to be Centres of Excellence on the grounds of affordability, for example, regarding the cost of staff training other homes. It

was expected that the Foundation Trust would continue sharing best practice, but it was important that the new role of the Homes was firmly "bedded in" before offering to share best practice.

- Although the Foundation Trust only took over the operation of Woodland View with effect from 1st July 2012, it had been hoped that a Manager would have been appointed by now, and Tim Furness would seek assurances from the Trust that a Manager would be in post as soon as possible.

6.5 RESOLVED: That the Committee:-

(a) notes the contents of the report now submitted, together with the information now reported and the responses to the questions raised; and

(b) requests the Scrutiny Policy Officer to make arrangements for a visit by Members of the Committee and representatives of LINk to Birch Avenue and Woodland View, and agrees that further discussions on the proposals regarding the Care Homes becoming Centres of Excellence, take place following the visit.

7. END OF LIFE CARE

7.1 The Chief Operating Officer, NHS Sheffield, submitted a report providing an update on progress towards achieving an increase in the preferred place of death for Sheffield residents.

7.2 Kate Gleave, Senior Commissioning Manager, End of Life Care, NHS Sheffield, stated that the report had been prepared following a request by the Committee at its meeting held on 21st November 2011, and contained details of the progress made since that date. Ms Gleave added that, as part of the progress of work undertaken, an outline business case, based on the new End of Life Care (EOLC) Home Care Model, had been produced and would be submitted to NHS Sheffield for approval in December 2012, and to the City Council's Cabinet in March 2013. It was envisaged that the new model would be in place by October 2013.

7.3 Ms Gleave also referred to the actions taken to address the prioritised problems and details of the comparisons between the current arrangements and the new model for End of Life Home Care, which were attached Appendices 1 and 2, respectively, to the report.

7.4 Members of the Committee and representatives of the LINk raised questions and the following responses were provided:-

- Using a set of prognostic indicators, health workers were able to identify when the majority of patients were in, or entering their last year of life and would be expected to discuss this directly with the patient and/or their carer or family at this point. In cases where patients were likely to lose their mental capacity prior to their last year of life, such as suffering from dementia, such discussions should take place earlier, in order to ensure that they could fully understand the position. NHS Sheffield was encouraging

clinicians to commence such discussions as early as possible, as well as giving them the required confidence to raise such delicate issues with patients and/or their carers and families and to detect when patients/carers did not want to discuss this.

- For some patients, there may come a point when their condition was so severe that it made it impossible for them to be cared for at home.

- The level of support and care could increase as a patient's condition worsens, but such care and support would vary for different patients. Even if a patient's condition was viewed to be stable, they or their carer could suffer some form of crisis, which would require the care they required to be increased in order to meet their needs on an as and when basis. For this reason, it had been identified that there was a need for a more flexible model.

- It was accepted that informing patients about end of life care was a very delicate and emotional issue and in the light of this, NHS Sheffield had invested in communications training to all health and social care staff in the City. This would include the necessary training to ensure that health care staff have fully explained the position to the patient and that the patient has fully understood the position that they were in. It was also accepted that a large proportion of people did not wish to know, or accept the fact that they were nearing the end of their lives and informing them of this fact was seen by many as a reason to give up any hope.

- There were measures in place to deal with those cases where patients or their families had expressed a wish to spend the remaining time of their lives in the comfort of a hospice or by receiving care at home, rather than undertaking constant visits to hospital, which could cause unnecessary upset and inconvenience for both patient and family. The planned implementation of the Assessment, Management, Best Practice, Engagement, Recovery Uncertain (AMBER) care bundle at STHFT would further support identification of such patients.

- The Electronic Palliative Care Communication System (EPCCS) was designed to improve communication between hospitals and GPs about patients in their last year of life. In the long-term, it was hoped that this system would be used to communicate information to members of the wider team involved in a patient's care, such as their care home and Accident and Emergency staff. The timing of this development is dependent on technical issues and resolving how best to obtain patient consent.

- There had been considerable debate on the issue of confidentiality, particularly with regard to patients' details being included on lists of those people in their last year of life. Currently, the EPCCS only communicated information which should be on a normal clinic or discharge letter between secondary and primary care, that is what patients would expect to be shared routinely. The sharing of this information with a wider group of clinicians involved in the patient's care would require patient consent and NHS

Sheffield was currently exploring how this could be done appropriately. It was considering developing a patient communications leaflet which fully explained the position relating to patient confidentiality.

- Whilst research had concluded that 63% of people in Yorkshire wanted to die at home, between 2008 and 2010, 57% of deaths in Sheffield had occurred in hospital, which was significantly higher than the England average of 54.5%. It was hoped that, by implementing a joint health and social care model, the number of deaths in hospitals could be reduced in the future. The service providers of this model would work closely with the Integrated Care Teams, which comprised a broader range of health and social care professionals.

- There were a number of national campaigns to get more people to talk about death and dying. One group involved in this was the Dying Matters Coalition, who organised an Awareness Week in May every year. In addition, NHS Sheffield had developed a media campaign, and had already advertised on local radio, with plans for further advertisements and announcements in the local media. It was also writing to various charities, requesting them to display information on their media communications on this issue.

- Whilst the new care model was aimed at people aged 18 or over, a need to introduce similar measures in terms of people under 18 had been identified. STHFT was in the process of developing a Limitation of Treatment Agreement (LOTA), in consultation with patients' families. There were also transition arrangements in place when such patients reached the age of 18.

- Although the number of people over the age of 80 in the City was likely to rise in future years, this would not necessarily have a direct effect the numbers of people entering the final year of their lives. There was a need, however, to ensure that plans were in place now to ensure that the correct approach was taken in respect of such people and to ensure that the health and social care system was working effectively so that the needs of the increasing numbers of people over 80 in the City could be met.

- In terms of the recent issues and concerns raised in the national press regarding the Liverpool Care Pathway, such issues had been discussed at a meeting of the Local End of Life Care Planning Commissioning Group and it had been identified that, regardless of the Government's views on the Liverpool Care Pathway, there was a need for improvements in terms of communication with patients and their relatives.

- The reference to the word 'inequitable', when describing the main barriers in terms of access to Home Care support, referred to the fact that there were about 40 different providers commissioned to provide different levels of care at different points in the patient's last year. It was hoped that the problems arising from this would be addressed under the new Home Care Model.

- Good End of Life Care ought to be part of the revalidation of GPs. The GP

Quality Outcomes Framework (QOF) does require GPs to have a register of Palliative Care patients and to meet them every three months. It was possible that these two requirements would be developed further for 2013/14.

- The decision on when to stop providing patients with food and drink was taken by clinicians and based on the individual circumstances of each patient. Health staff would not stop providing food and drink if it resulted in the patient suffering in any way.

7.5 RESOLVED: That the Committee:-

(a) notes the contents of the report now submitted, together with the responses to the questions raised; and

(b) requests:-

(i) that the business case for the new End of Life Care Home Care Model be referred to the Clinical Commissioning Group and the City Council's Cabinet for approval;

(ii) the Scrutiny Policy Officer to arrange a joint meeting of this Committee and the Children, Young People and Family Support Scrutiny and Policy Development Committee to discuss the issues regarding End of Life Care for children up to the age of 18;

(iii) that consideration be given to how the issues relating to the End of Life Care could be included in the revalidation process regarding GPs;

(iv) Kate Gleave to attend a future meeting of the Committee in 12 months to provide a further update on the new End of Life Care Home Care Model, including an update on local and national data; and

(v) the Council's Communications Service to look at how the Council could publicise the 'Talk About Death' campaign.

8. INTERMEDIATE CARE - PROGRESS ON NEW BUILD FACILITY

8.1 The Committee received a report of NHS Sheffield reviewing the position with regard to the planned intermediate care facility, identifying the factors influencing progress and containing a proposed timetable for reviewing the requirements for such a facility.

8.2 Tim Furness, Chief of Business, Planning and Partnerships, NHS Sheffield, presented the report.

8.3 In response to questions from Members of the Committee, Tim Furness stated that the figure of 120 beds had been suggested around five years ago, following analysis in terms of demand and cost-effectiveness. He also confirmed that, although discussions had been held with Council Planning Officers, a suitable site

for the facility had not yet been identified.

8.4 RESOLVED: That the Committee:-

(a) notes the contents of the report now submitted, together with the responses to the questions now raised; and

(b) requests the Scrutiny Policy Officer to facilitate discussions, as a matter of urgency, between Councillor Leigh Bramall, Cabinet Member for Business, Skills and Development, Planning officers and the Clinical Commissioning Group, together with any other Council officers who would be responsible for identifying a suitable site for the construction of the intermediate care facility.

9. GRENOSIDE GRANGE WEST WING

9.1 The Committee received a report from NHS Sheffield setting out the case for the decommissioning of Grenoside Grange West Wing, and seeking its views on the proposals.

9.2 Tim Furness, Chief of Business, Planning and Partnerships, NHS Sheffield Clinical Commissioning Group (CCG) presented the report and indicated that the NHS Sheffield CCG had identified, in the course of reviewing the effectiveness and efficiency of all services it commissioned, that the outcomes for people referred to Grenoside Grange West Wing could be improved, and subsequent savings made, by providing rehabilitation at home for those people who could benefit, and with interim care in a care home for those who need interim care rather than rehabilitation.

9.3 Members of the Committee and representatives of LINk raised questions and the following responses were provided:-

- People leaving West Wing would either return home, with rehabilitation, where appropriate, or would move to long-term care, as most patients currently do on discharge.

- NHS Sheffield CCG planned to consult LINk on the proposals following this meeting.

- The audit undertaken in October 2012 of patients in West Wing had shown that the care required could have been provided elsewhere at a significantly reduced cost. The comparisons had been made with an independent care home, providing a similar package of care, and which managed to get more people back home, at a cost considerably lower than at West Wing.

- The service was not meeting the needs of the client group it was originally intended for. Whilst it could not be confirmed where those people who were originally anticipating going to West Wing were being cared for, it was believed that they were receiving care elsewhere, from services such as Community Intermediate Care Services (CICS) or the Short Term Intervention Team (STIT), or other similar services.

- It was agreed that the decommissioning of West Wing could have a detrimental effect in terms of an increase in the length of a patient's stay in an acute hospital. Any increase would be likely to be for a much smaller length of time than the average time people spend on West Wing, so that people would overall get home sooner. It was agreed that the question needed further investigation before a decision could be made.

- It was not believed that the decommissioning of West Wing would have a detrimental effect on the other Wing at Grenoside (G1). Discussions had been held with the Care Trust on this issue and they had not raised any concerns in terms of finances or any other issues.

- There had been no discussions with the Care Trust regarding alternative use of the Ward, although it was likely that an alternative use for West Wing would be found.

- As indicated in the report now submitted, approximately 40 patients a year were discharged from West Wing, with approximately six patients being discharged home. This was around half the number of patients discharged home from the independent care home, which had been used as a comparison as part of the audit undertaken in October 2012. The outcomes, particularly regarding how patients were discharged, were considerably better within the independent sector.

- It was possible that patients had been discharged from West Wing when they were not ready to leave. The majority of patients were discharged into care homes and were generally well enough to do so.

9.4 RESOLVED: That the Committee:-

(a) notes the contents of the report now submitted, together with the responses to the questions raised; and

(b) requests that the issues now raised as part of the question and answer session be referred to the Clinical Commissioning Group, for consideration as part of the consultation.

10. 'HOW DID WE DO?' - SHEFFIELD'S LOCAL ACCOUNT OF ADULT SOCIAL CARE SERVICES 2012

10.1 The Committee received a report of the Executive Director, Communities Portfolio, on Sheffield's first Local Account of Adult Social Care Services.

10.2 Howard Middleton, Development Manager, Planning and Performance, Communities, introduced the report and referred to the booklet 'How Did We Do?' – Sheffield's Adult Social Care Service 2012, which had been circulated prior to the meeting, stating that the booklet was still in draft form, and welcomed Members' comments on its format and contents prior to final print in December, 2012.

10.3 Mr Middleton stated that from this year, all Councils must produce a Local Account of how their Adult Social Care and Support Services were performing, which would comprise an annual report to the public, providing information on the performance of such services, together with details on priorities and outcomes. The need to produce a Local Account had come about following the Department of Health's framework for Adult Social Care, published in 2011, which confirmed the intention to open up information on Adult Social Care and to make available more information on what Councils achieved for local people.

10.4 Members of the Committee and representatives of LINk raised questions and the following responses were provided:-

- There were approximately 20 people on the Readers Group, who had helped to shape the contents of the booklet and Howard Middleton had met individually with members of the Group to discuss the contents in more detail.

- The draft booklet had also been tabled at the Quality Live event which had been commissioned by the Service Improvement Forum, and at which approximately 70 people had attended.

- Though the report is essentially the Council's account of adult social care performance, councils across the region had agreed some common features for future editions, including providing the opportunity for HealthWatch to be included in its production.

- It was acknowledged that there were no pictures of older people on the front of the booklet, and arrangements would be made to ensure an older person was featured on one of the small photographs on the front page.

- It was appreciated that some people may consider that details of negative issues, such as areas of poor performance, were 'hidden' in the booklet, so future editions would focus on how such issues had been addressed.

- Whilst one of the case studies featured someone with a learning disability in employment, it was acknowledged that the report could make a better link between this personal story and general progress on supporting people with learning disabilities into employment.

- Whilst the booklet was considered to be reasonably easy to read, consideration would be given to producing an "easy read" version to make sure the booklet was accessible for all.

- In terms of the contents appearing too general, officers would look at including specific themes or focuses in future editions.

- Contact would be made with the Sheffield Institute for the Blind in terms of including the contents of the booklet on their Talking News.

10.5 RESOLVED: That the Committee:-

(a) notes the contents of the report now submitted, the contents of the draft booklet 'How Did We Do?' now circulated, and the responses to the questions raised;

(b) requests that the issues now raised in terms of the contents of the booklet, as part of the question and answer session, be referred to Howard Middleton, for consideration in the final print in December 2012; and

(c) agrees to include early consideration of items for the 2013 report, as part of its Work Programme.

11. WORK PROGRAMME AND CABINET FORWARD PLAN

11.1 The Scrutiny Policy Officer submitted a report containing the draft Work Programme for the Committee, together with the latest version of the Cabinet Forward Plan.

11.2 Arising therefrom, Emily Standbrook-Shaw reported that (a) a report on the 'Right First Time' programme was scheduled to be submitted to the Committee's meeting to be held in January 2013 and (b) she would hopefully be arranging a meeting of the Nutrition and Hydration in Hospitals Working Group in December 2012, and raised the issue as to whether a representative from the Sheffield Children's Hospital should be included on the Working Group.

11.3 RESOLVED: That the Committee:-

(a) notes the contents of the report now submitted, together with the additional information now reported; and

(b) agrees that the Sheffield Children's Hospital should not be represented on the Nutrition and Hydration in Hospitals Working Group on the basis that the Working Group should focus mainly on the needs and requirements of older people, but that the Hospital should be given an opportunity to have an input to the work of the Working Group through a desktop review.

12. DATE OF NEXT MEETING

12.1 It was noted that the next meeting of the Committee would be held on Wednesday, 16th January 2013, at 10.00 am, in the Town Hall.

Report to the Healthier Communities and Adult Social Care Scrutiny & Policy Development Committee 16 January 2013

Report of: NHS Sheffield CCG

Subject: Non-Clinical Circumcisions

Author of Report: Tim Furness, Chief of Business Planning and Partnerships

Summary:

In line with guidance from the Department of Health, Sheffield CCG is proposing to cease funding for non-clinical circumcisions.

This paper sets out the proposal and plans for engagement, and seeks the views of the Committee.

Type of item: The report author should tick the appropriate box

Reviewing of existing policy	**x**
Informing the development of new policy	
Statutory consultation	
Performance / budget monitoring report	
Cabinet request for scrutiny	
Full Council request for scrutiny	
Community Assembly request for scrutiny	
Call-in of Cabinet decision	
Briefing paper for the Scrutiny Committee	
Other	

The Scrutiny Committee is being asked to:
Comment on

a) the proposal to cease funding for non-therapeutic circumcisions
b) the CCG's engagement plans

Category of Report: OPEN

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Sheffield Clinical Commissioning Group

Commissioning of Non-therapeutic Male Circumcisions

Briefing Note

12 December 2012

Sheffield CCG is currently developing commissioning intentions for the 2013/14 financial year and prioritising the focus of its £740m budget.

As part of this process this specific proposal will be considered by the Shadow Governing Body in January when all of the commissioning intentions and priorities will be formally agreed.

It is proposed that circumcisions for non-therapeutic reasons should no longer be locally NHS funded. (Note: circumcisions for medical reasons will still be funded).

The Department of Health website states that this intervention is not funded where it is requested for non-medical reasons. However, commissioning arrangements across the UK are not always consistent with this.

Sheffield Clinical Commissioning Group has a remit to commission interventions where there is a clinical need and a local policy for circumcisions for medical reasons has been in place for several years.

Sheffield Clinical Commissioning Group proposes to cease to commission circumcisions for non-medical reasons as this diverts funding away from mainstream health activity.

It is acknowledged that there may be an impact on those seeking this intervention for non-medical reasons and so a number of mitigating actions have been proposed below. It is also understood that this decision would have a particular impact on the Muslim community and, indirectly, therefore have a differential impact on certain ethnic groups.

Discussions with Sheffield Children's Hospital

The clinical lead and management team at Sheffield Children's Hospital are exploring the potential to develop a service which will provide care under local anaesthetic on a private basis and paid for by the child's parents.

The cost of a service offered by SCH may be unattractive to families and SCH may decide not to proceed for that reason. However, if it is not possible for SCH to provide this service they are willing to host guidance on their website which will support parents to make an informed decision with regard to where they might source this service.

Engagement

An engagement plan has been developed which will allow local leaders and community groups to advise on how best to implement the recommendations. This will also provide

an opportunity to raise any issues or concerns so that the shadow governing body can be confident that these have been considered before the issue is discussed at a public session of the CCG.

It should be noted that local service users come from a number of ethnic backgrounds and are not a single homogenous group and so can be difficult to reach. Please see the attached draft engagement plan for details of how we plan to engage. A number of approaches will be utilised to 'maximise coverage'.

The engagement will focus on two broad areas:

1. Enabling any issues to be raised and discussed
2. Confirming the information parents need to make an informed/safe choice and it is proposed that this is based on guidance taken from the joint statement from the Royal Colleges[1] that,
    - The operation should be performed by or under the supervision of doctors trained in children's surgery
    - The child must receive adequate pain control during and after the operation
    - The parents and, when competent, the child, must be made fully aware of the implications of this operation as it is a non-reversible procedure
    - This operation must be undertaken in an operating theatre or an environment capable of fulfilling guidelines for any other surgical operation
    - The person responsible for the operation must be available and capable of dealing with any complications which may arise
    - There should be close links with the patient's GP and community services for continuing care after the operation

The engagement will also attempt to understand from a local perspective what language and format for this information would be most useful and where this should be made available.

Tim Furness
Chief of Business Planning and Partnerships
NHS Sheffield CCG
12 December 2012

[1] http://www.rcseng.ac.uk/media/medianews/statementonmalecircumcision

SHEFFIELD OVERVIEW AND SCRUTINY COMMITTEE

RIGHT FIRST TIME - PHASE 1 REPORT

16 JANUARY 2013

Introduction

The purpose of this report is to report on the Right First Time programme and its progress and achievements over the last 12 months.

- Section 1 describes delivery to date
- Section 2 describes the impact of the programme at an organisational level
- Section 3 recommends the need to move away from reporting and scrutiny of the programme at an organisational level toward a focus on the impacts to the whole system.
- Section 4 provides some reflection on the lessons learnt from the first phase of the programme and describes some of the challenges to be considered in the development of phase 2

SECTION 1 - Phase 1 key projects and processes

Over the past 12 months phase 1 of the Right First Time programme has been split into 3 projects which have begun to deliver real benefits to patient care and the start of the transformation journey across the health system.

- **Project 1** has focused on the development and prototyping of integrated care teams (ICTs) that align with the emerging GP Practice Associations, enabled by Risk Stratification, Assistive Technology and Self Care.

  Discussions around the concept of GP Practice Associations have been taking place over the last year and practices are now starting to align themselves into groups of between 30,000 – 40,000 patients with a view to creating more integrated working with other Health and Social Care resources within the community. 16 associations have been identified across the 4 CCG Localities Hallam and South, Central, West and North). The emerging associations have started to meet and early discussions have identified some opportunities for working together.

  District Nursing services been reorganised around the emerging GP Practices associations and these will form part of the core of the new integrated care teams. A reorganisation of the Assessment and Care Management Services (SCC) has also taken place aligning with GP Practices. Further work has now commenced to explore the next phase of development for the Integrated Care Teams and how they will incorporate Social Care activities. Initial discussions have also taken

place with Community Mental Heath and Community Pharmacy to try to identify possible links and ways of working.

Project 1 is working closely with a number of ongoing pilots across the city (including Low Edges, Batemoor and Jordanthorpe) and supporting the development of other prototypes within GP Associations, for example the recruitment of Community Support Workers to provide the interface between Health and Social Care.

The combined predictive model of risk stratification has been rolled out to 98% of GP practices, allowing them to identify patients of high and emerging risk of admission to hospital and to work with other health and social care professionals to put interventions in place to support these patients. Further analysis is required to understand what actions practices are taking as a result of using this tool and impact on patient care and outcomes.

- **Project 2** has focussed on redesigning the 'front door' response at Sheffield Teaching Hospitals by reducing the number of elderly admissions and by completing comprehensive assessments at the point of referral and developing consistent thresholds for admission. Detail of the impact of these changes on STH is provided in the next section.

  In conjunction with project 1, developing services to provide better response to crises, particularly for residential/nursing homes and the investment and expansion of the falls service (the number of interventions rising from 1,682 to 3,364 in12/13). Q1 data shows falls admissions down by 29%

- **Project 3** has focussed on facilitating discharges for people no longer requiring acute medical care. It has done this through a series of non recurrent investments (SCELS, Home of Choice, Dementia Services and Intermediate Care) and the development of a new integrated health and social care process for transferring care from hospital to intermediate care and community services which is due to go live at the end of October. The development of the Transfer of Care documentation and processes has brought together nursing, therapy and social care assessments and enabled trusted assessors to access more services (irrespective of their profession) reducing duplication of assessments and opening up pathways through a single referral process, acceptable to multiple services, thereby simplifying documentation and ultimately reducing delays of transfer.

SECTION 2 - Impact of RFT on organisations

In summary the operational benefits of RFT have been felt mainly by Sheffield Teaching Hospitals acute directorates. Community and social care services have faced the opposite with increased workload due in part to higher

numbers of patients coming through but also due to the increased complexity and levels of dependency of the people they are seeing. Right First time is a long term programme and it is therefore not surprising that the planned benefits have not been realised in all areas yet.

Sheffield Clinical Commissioning Group (CCG)

There are several areas where the impact of the programme is having a positive impact:

- Length of stay and reduced excess bed day payments are better than plan
- Delays for transferring into longer term care are continuing to fall and are now at very low numbers
- The improvements achieved in the Frailty Unit (increased short stay admissions, reduced hospital mortality rate and reduced readmission rate) are being sustained. In particular the readmission rate for geriatric admissions discharged from the Frailty Unit has halved since May

There remain concerns from a CCG perspective regarding the impact of the programme on:

- Emergency admission rates
- A+E attendance rates
- Financial impact of emergency admissions, in particular the ratio between short stay and full spell admissions

Sheffield Teaching Hospitals (STH)

The process redesign work within Geriatric and Stroke Medicine (GSM) at STH is delivering:

- Increase in the discharge rate for short stay (days 0 and 1) patients by around 40% for GSM patients.
- Reduction in overall length of stay in GSM from a historic level of around 19 days to currently just over 16.
- Reduction in hospital deaths for GSM (proportion dead at discharge reduced from an average of 11% to 9.5%)
- Decrease of 3% in readmission rates to GSM from all specialities.
- In addition to the 28 beds closed in the middle of June, STHFT closed a further 28 beds in August. These are both winter pressure wards that in previous years had not closed through the summer months
- The numbers of delayed discharges are reasonably static (decreasing slightly) but the processes for managing them have improved.
- Overall rate of emergency admission to geriatric admissions is higher than planned and the case mix for contract monitoring indicates that more patients are attracting a full tariff than expected.
- Investments (described in the table above) have gone into the Community Care group of STH.

Sheffield City Council (SCC)

The improvements in patient flow at STH have inevitably impacted on social care. There has been an increase in the numbers of people accessing social care, sooner than previously and an increase in the number of people entering long term residential care as a result of the Home of Choice initiatives. Increasing numbers entering long term care is contrary to the national and local policy direction of optimising independence and care at home, rather than institutional environments. People transferring to STIT are now requiring more intensive care packages compared to previous years (13hpw compared to 10 hpw). It is not yet clear whether this reflects higher levels of need/dependency or more 'cautious' sizing of the package by non social care 'trusted assessors'.

There is a recognised need to shift appropriate care currently delivered in a hospital setting into community locations and to redesign a structure through which integrated community services could be delivered at a reasonable scale, whilst at the same time improving quality of care and better access for patients. With this in mind, we have been able to start the shift of some appropriate hospital based resources into intermediate care and community assessment and care management teams.

Sheffield Health and Social Care (Dementia Services)

Three band 6 mental health nurses, funded through the Accelerated Dementia Discharge Team (ADDT) are providing input into STH's Front Door Response Team (FDRT) and have provided (at least) one nurse per day, Monday to Friday and are moving to seven days per week cover from 13/10/12. Averages of four patients per day are being seen, assessing mental health, cognitive impairment and risk, and arranging post-discharge mental health care. In addition to this, advice and consultation to FDRT staff is provided on approx three to four cases per day. Additional nursing capacity is also being used across the existing ADDT and Liaison Psychiatry functions with a more proactive approach to case finding being undertaken taking an earlier and more assertive role in discharge planning.

RFT has funded a temporary Speciality Grade Psychiatrist who has been working across both Older People's Liaison Psychiatry and Dementia Rapid Response Teams since the end of August and band 5 nurses into Dementia Rapid Response, however, these staff are yet to take up post.

The integration of RFT, ADDT and Liaison Psychiatry functions has moved apace, primarily because working as a single team has been the only way to ensure clinical resources are allocated in an efficient and justifiable way. Work with STH colleagues on a joint approach to information relevant to this service commenced today and it is anticipated that information regarding lengths of stay in STH, emergency readmission and mortality will be available by the end of December.

SECTION 3 - Performance Monitoring in Phase 2 - Balanced Scorecard Development

RFT is adopting a systematic approach to develop a suite of measures aimed at aligning the delivery process with target goals and outcomes. This approach is called the public sector scorecard (PSS) methodology, which a development of the balanced scorecard adapted for use in the public services. The PSS aims to achieve an alignment between organisation capability (workforce / skills / capacity), its delivery processes (operational / services / projects) and the key target outcomes sought. The PSS does this by mapping the delivery system onto seven key elements of organizational excellence as set out below.

The procedure begins with the identification of outcomes that: i) reflect service user needs plus other stakeholders as appropriate, e.g. carers, ii) the strategic aims of the organization(s), and iii) financial and quality objectives. The delivery processes are then examined – or designed / reviewed – to ensure consistency with achieving the objective outcomes. The capacity and capability requirements of the organization (RFT programme) as set out in the graphic above are then mapped onto the operational needs. The resulting mapping identifies the causal linkages and value drivers in the programme (the 'strategy map') from which key measures can be identified that critically reflect the chain of delivery.

It is proposed that once developed, this scorecard becomes the basis for a dashboard for monitoring and performance managing the RFT Programme of work.

SECTION 4 - Reflections / Lessons Learned – challenges ahead

The reflections below are lessons learnt at a programme level. There needs to be additional discussion to understand lessons learnt by each organisation

- Overreliance on organisations to cascade messages to own staff and services.

- Differential speeds of change in different parts of the system leading to potentially unsustainable developments.

- Lack of clear programme mandate and scope and therefore lack of change control processes leading to scope creep.

- By hosting the RFT Programme Team within one of the organisations it becomes perceived as part of that organisation rather than an autonomous programme – this should be considered in review of the team in Phase 2 and the governance arrangements for RFT.

- The difficulties in identifying and allocating realistic financial savings to the programme when there is insufficient data and modelling available.

- Subsequent reporting on RFT should be at a system level rather than at an organisational impact level.

- The need to more vigorously pursue an approach which works on the premise that primary and community care is the organising principle of the whole operating model. With hospital and/or other care being the focus only for people who have either the need for short term specialist interventions or who have life threatening or highly complex conditions which cannot be addressed in the community.

- The importance of pro-actively designing and shaping solutions with expert patients, carers and people who use services.

- The significance of drawing on new business models operating in sectors outside of the NHS and social care, which reflect how a modern, digitised society works.

Steven Haigh, RFT Programme Manager
On behalf of Kevan Taylor, Chief Executive and Programme Director

December 28, 2012

Working together to transform Sheffield's health and social care services

Sheffield Overview and Scrutiny Committee

16 January 2013

Phase 2 RFT Programme

1. Introduction and Context

At the October Transforming Sheffield Health Steering Group (now the Programme Board for RFT) initial discussions confirmed that:

- All parties supported the revised scope and breadth of RFT in Phase 2
- The relationship between the children's "future shape" work and the children's content of RFT would need to be clarified to avoid duplication
- All organisations would support Kevan Taylor in his role as leader of the city wide Programme Executive
- The details of an organisational development programme still needed to be finalised in order to underpin delivery of the next phase; and that this included translating RFT strategic goals into everyday reality for frontline staff.
- The governance arrangements were signed off by all organisations

The RFT Programme Executive has now met on two occasions since the October TSHSG meeting and this paper summarises the progress made with the development of Phase 2 goals within the context of the original Programme Initiation Document (PID) that was authorised in June 2011. The original objectives for the Programme PID remain relevant, but this paper reshapes Phase 2 to include:

- The original component parts for unscheduled care and long terms conditions that have been part of Phase 1.
- Component parts of the elective care programme.
- The unscheduled care components of the Children's Future Shape Programme.
- Component parts of adult mental health.

2. System Modelling: Population needs (PN) Workstream

It is recognised that success of the RFT programme will see a development of primary and community services in Sheffield and that that development will depend on a shift of resources from hospital to community. Managing such a transformational shift will require confident leadership and detailed planning, neither of which can happen without a clear view of the required 'end-point'.

One of the main aims of the PN workstream is to quantify need for health and social care at its different levels in Sheffield. The first stage in that process is to try to quantify 'need' for emergency hospital beds.

The model is based on a population of NHS Sheffield patients of all ages who experienced an emergency hospital admission in the financial year 2011/12. It uses

ICD 10 primary diagnostic coding and estimates the potential for reductions in emergency bed use at three separate points in the system:

- Reduced emergency admissions at the 'front door' according to the evidence based list of ambulatory emergency care sensitive conditions produced by the NHS Institute for Innovation and Improvement.
- Reduced emergency admissions due to ambulatory care sensitive conditions (ACSCs) from the community by bringing 'admissions per level of need' in more poorly performing GP practices towards that in the better performing practices.
- Reducing average length of stay for emergency admissions in Sheffield to that of the best performing PCT in the core cities.

The opportunity for the programme is clear, up to 15500 avoidable admissions (for approximately 12000 patients) where alternative care provision in the community would deliver better outcomes. The RFT Programme Board has now agreed that a more detailed plan to deliver the strategic goals described in section 3 should be delivered over the next three years.

3. Phase 2 Strategic Goals, Deliverable and Measures of success

The RFT Programme Executive has developed a range of strategic goals, deliverables and measures of success that are described below. They build on the early achievements of Phase 1 and will develop to ensure that the opportunity identified from the PN modelling can be realised.

Strategic Goal	Key Deliverables	Measurable Outcomes
1. Optimise admission avoidance for Ambulatory care Sensitive Conditions (ACSCs)	1. Embedding the Integrated Care Teams with primary care at a locality level. 2. Developing the use of Combined Predictive Model to proactively manage patients at emerging risk 3. Deliver interventions in primary, community services that address the causes for ACSC admissions 4. Deliver a coherent self care strategy. 5. A joint health and social care strategy for Assistive Technology	1. All patients identified as moderate, high or very high risk of admission have an appropriate level of care planning and coordination. 2. Reduction in ACSC. 3. Cost of community interventions versus unplanned hospital admissions (with the aim to make them more cost effective)
2. Reduce LOS for emergency admissions to the upper quartile for core cities and reduce the numbers of going into long term care	1. Transform the discharge process from assess to discharge to discharge to assess. 2. Develop a system where the community (ICT and IC) pull patients out of hospital. 3. Develop the model of community care where the core ICT and intermediate care manage the step up and step down care	1. The initial 4 day maximum delay guarantee improves to 1 day by July 2014. 2. There is sufficient capacity within community health and social care to maintain flow and it is able to flex according to the peaks of demand.

	needs. 4. Following robust demand and capacity modelling to ensure there is sufficient capacity in and out of hours to maintain system flow	3. Assessment for care needs is undertaken in the community. 4. Reduced numbers requiring long term care (health or social care funded). 5. Reduced LOS for STHFT, IC, and SHSC acute beds.
3. Develop a capable level of response to unscheduled care needs that supports the reduction of avoidable admissions, signposts patients effectively and provides a consistent response 24/7	1. Expand the Frailty Unity Model to all acute admitting specialties, targeting those that receive patients with ACSCs. Develop the model of refer to assess, rather than refer to admit 2. Develop and implement a primary care stream that deflect patients from A+E services and offers a 24/7 alternative linking the current, WiC, GP OOH and primary care services 3. Develop the concept of virtual wards across the city that draw on primary, community and secondary care resources that keep people at home when their care needs escalate	1. The proportion of emergency referrals for assessment and transfer back to the community increases., with a commensurate 29% reduction in ACSC admissions 2. 30% of A+E attendances are managed through the primary care stream that is more cost effective. 3. The “virtual ward”/ Intermediate Care model delivers the majority of step up care for ACSC avoidable admissions
4. Planned care services will be optimised to ensure that Out Patient Services are transformed and the efficiency of hospital services are optimised	1. To implement a programme of work that optimises the use of Choose and Book. 2. IT developments that include e-discharge, e-consultations and other digital innovations 3. A number of commissioner led workstreams that will determine future service model shaping	1. Significant reduction in O/P follow ups, particularly for LTCs 2. More referrals managed as a single, one stop shop, advisory service
5. Reduce inequalities in the morbidity and mortality rates for people with severe mental illness (SMI)	1. “Staying well” care plans for all patients with SMI (agreed within ICT) 2. Cross city sign up to “Time to Change” 3. Joint approach with Mental Health Commissioning plans	1. To be in the upper quartile for all elements of the National Audit of Schizophrenia 2. Annual health checks for all with SMI 3. Measurable reduction in premature mortality for SMI
6. The unscheduled care response for children in Sheffield reduces avoidable admissions to hospital	Under the auspices of the Future Shapes Programme 1. The current consultant led triaging of GP referrals for admission expands. 2. A single pathway for childrens urgent care is developed in and out of hours	1. 30% reduction in paediatric admissions for the under 5’s

5. Interdependencies

There are a range of cross cutting workstreams that were identified in the initial PID for the RFT Programme in 2011. They remain relevant and need further development to ensure that that the strategic goals for Phase 2 are deliverable.

- **Commissioning intentions, financial flows and contracting assumptions** need to reflect the level of ambition stated in section 3
- **Workforce development** needs to reflect that for many staff in the future their skills will be utilised in the community rather than in a hospital setting
- **OD/ culture change and staff communication** needs to clearly share the message that more care will be provided in the community
- **Informatics** as a workstream will need to join up the different parts of the system and make it easier for clinicians and practitioners to make the right decisions
- **Assistive Technology** will be a key enabler to supporting people to stay at home and manage more of their own care
- **Medicines management** is perhaps one of the simplest interventions to helping optimise people's health and reduce avoidable admissions

The Programme Executive will need weave these cross cutting workstreams into the delivery of Phase 2 strategic goals.

6. Programme structure for delivery of Phase 2

It is highly likely that the current structure for RFT Phase 1 will need to change and the RFT Programme Executive will take responsibility for this. The key issue will be to ensure that the whole system of care delivery is mapped out and the inputs to deliver system change across self care, primary care and the ICT, intermediate care and the acute hospital. The Programme Board will be advised of the changes to the RFT Phase 2 programme management arrangements at the April meeting.

Steven Haigh, RFT Programme Manager
On behalf of Kevan Taylor, Chief Executive and Programme Director

December 28, 2012

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Report to Healthier Communities and Adult Social Care Scrutiny & Policy Development Committee

Report of: **Director of Business Strategy - Communities Portfolio**

Subject: **Safeguarding Adults Annual Report 2011/12**

Author of Report: **Head of Quality and Safeguarding Communities Portfolio**

Summary:

The report provides selected analysis and summarises the main issues in relation to Adult Safeguarding activity across Sheffield in 2011/12. The information is drawn from the Safeguarding Adults report. These Annual reports are presented to Scrutiny.

Type of item: *The report author should tick the appropriate box*

Reviewing of existing policy	
Informing the development of new policy	
Statutory consultation	
Performance / budget monitoring report	
Cabinet request for scrutiny	
Full Council request for scrutiny	
Community Assembly request for scrutiny	
Call-in of Cabinet decision	
Briefing paper for the Scrutiny Committee	**x**
Other	

The Scrutiny Committee is being asked to:

Review the work undertaken under Adult Safeguarding, as set out in the Annual Report for 2011/2012, and note the current priorities for action.

Background Papers:
Protecting Vulnerable Adults in Sheffield
Safeguarding Adult Safeguarding Partnership Annual Report 2011-2012

Category of Report: OPEN/~~CLOSED~~

Report of the Director of Business Strategy Communities Portfolio

Safeguarding Adults Annual Report 2011/12

1. Introduction

This is the annual report to Scrutiny of activity related to Adult Safeguarding during the year 2011/12. It contains information on the level of Safeguarding Alerts and Referrals, including trend comparisons with the preceding year. The report also looks at sources of Safeguarding reports and the locations where abuse or neglect may have occurred. Other issues covered include ethnic breakdown of Safeguarding cases, audit work to quality assure the Safeguarding process and the outcomes for those at risk and perpetrators.

An update is also provided on Deprivation of Liberty Standards and other mechanisms for supporting vulnerable adults including the Vulnerable Adults Risk Management Model, the Vulnerable Adults Panel, and 'Safe in Sheffield', all multi agency initiatives. Measures to raise awareness of Safeguarding including training and development are also covered. The report concludes with a summary of current priorities

Appendix 1 - Explains the Safeguarding process and roles.
Appendix 2 - Provides brief information on the Mental Capacity Act
Appendix 3 - Sets out the governance structure for Adult Safeguarding

A copy of the full annual report is also included, providing more detailed information and analysis, including individual contributions from all the agencies in the Adult Safeguarding Partnership

2. Issues

2.1 In 2011/12 there has been an increase in the number of Safeguarding Alerts and subsequent Referrals into Safeguarding.

This increase is attributable to a higher level of awareness of Adult Safeguarding following a high profile awareness raising campaign during the year. Whilst there is no evidence that the level of abuse itself is increasing Adult Safeguarding continues to provide an essential mechanism for identifying and effectively managing abuse where it occurs.

2.2 Instances of potential and actual neglect abuse in care settings remains an issue. The Quality in Care Homes Board was established to provide a more strategic focus in tackling underlying issues in care homes. Adult Safeguarding Board has direct oversight of this work and receives regular reports from the Quality in Care Homes Board. An improved performance and risk management framework has been introduced to more effectively monitor care home performance and identify triggers for early intervention.

2.3 Adult Safeguarding is a multi-agency partnership. In addition to the Council partners include NHS Sheffield, Sheffield Teaching Hospitals NHS Foundation Trust, Sheffield Health and Social Care NHS Foundation Trust South Yorkshire Police Fire Service, South Yorkshire Probation Board, Yorkshire Ambulance Service NHS Trust, Sheffield Homes, Voluntary, community and faith sector representatives, the independent sector, and representatives of users of our services

The Safeguarding Adults Office continues to promote Safeguarding best practice through extensive training and awareness raising across these sectors.

2.4 There is a continued emphasis on making sure that where a Deprivation of Liberty Assessment is appropriate that this is recognised and actioned by practioners across the Partnership.

3. Safeguarding Adults

3.1 Safeguarding Alerts

The level of safeguarding alerts has continued to increase, up from 1586 in 2010/11 to 2069 in 2011/12. Of these alerts 709 were accepted into Safeguarding. We interpret this as a positive trend as it reflects an increased awareness of Safeguarding across the city. Of the alerts screened into Safeguarding just over 58% are older adults. Learning disabilities accounts for almost 20%, physical disability and sensory impairment fewer than 12%, and mental health over 7%.

Sheffield is broadly in line with national trends. There are some regional variations in relations to number of alerts generated and the proportion taken into Safeguarding. Consistency of practice in relation to what constitutes an alert and what gets accepted into Safeguarding is an on-going issue that we are addressing through the dissemination of best practice and use of audits to check impact. Progress will be reported to the Safeguarding Adults Partnership Board.

3.2 Safeguarding Referrals

Referrals are made from a number of sources. Major referring agencies include Primary and Secondary health care, and residential and nursing care. Individuals have also begun to self- refer as do family and friends. It is encouraging that Primary care referrals are increasing. There continues to be a targeted focus on raising awareness amongst GPs and nursing teams. The increase in referrals reflects the success of this approach. Referrals from the residential and nursing care sectors are also increasing. It is important we create an environment in which agencies feel comfortable in making referrals and not just view Safeguarding as a punitive process.

Overall the increase in alerts is a positive trend. A priority for 2011/12 was to raise awareness across the city. We ran an extensive publicity campaign

utilising public advertising space to get the message across to the public and those who are potentially at risk. We anticipate that this approach will continue to prompt further self- referrals.

3.3 Type and location of abuse

Multiple Abuse has risen by from 129 cases to 179 cases through 2011/12. A concern is the proportion of neglect cases relating to individuals in care settings. Although discriminatory abuse remains at what we consider an artificially low level the increase in reporting is welcome. Further work is underway to increase reporting through the Hate Crime Action Plan and within measures tackling Anti-Social Behaviour.

It is a concern that reported instances of neglect have risen by almost 66%. Reported instances of institutional neglect have also increased across a variety care settings. This does not necessarily mean instances of neglect or abuse are increasing. Of cases referred into Safeguarding approximately 2/3rds are not substantiated. It also reinforces the point about an increased willingness of institutions to report potential Safeguarding issues. However it is crucial that we make use of all available levers, including contracting, to get providers, across all sectors, to improve practices and prevent Safeguarding concerns arising.

Reports of Financial Abuse have risen by 7% in 12 months to 221. This is a modest growth but we might anticipate a further increase in the current 12 month period and beyond given the depressed economic position.

Neglect and abuse take place across a variety of locations; the largest single category is in the home, a total of 307 instances, up from 180 last year. In 123 cases the alleged perpetrator lived with the vulnerable adult. In 72 cases they were the main carer. Here issues relate to the motivation and state of mind of carers and whether the right level of support is provided to them.

Care settings have seen an increase, prompting the need for a still better understanding of adults care needs and how best these are met. In response to this issue the Adult Safeguarding Board has set up the Quality in Care Homes Board to address strategic issues in the quality of care provision throughout the city. A performance framework is in place to monitor and assess the performance and quality of care home providers. A suite of Key Performance Indicators is used to assess individual providers and inform continuous risk assessments aimed at identify those providers where intervention is required.

3.4 Safeguarding and ethnicity

There has been a 50% increase in the number of individuals from Black and Minority Ethnic [BME] groups brought into Safeguarding. The number of alerts screened into Safeguarding is the same proportion as for non BME individuals. Further work is required to understand an appropriate demographic profile is for Safeguarding. When assessed against the city profile it is apparent that BME are ‘under represented’. We can infer from this

that more work is required to make sure Safeguarding awareness levels are raised for BME communities and individuals from those communities and those who work with them. The availability of information and advice in community languages, accessed through the web site, will help individuals to access help and support. This remains a high priority for the Adult Safeguarding Board

3.5 Safeguarding Audits
Approximately 1/3rd of alerts are taken into Safeguarding as Referrals. This proportion has remained consistent year on year. To assure quality and consistency of practice across agencies a series of audits have been commissioned to test the quality of decision making at the Alert and Referral stage to ensure best practice is evidenced.

3.6 Outcomes
There has been an 8% increase in the number of cases where the outcome is alternative actions being taken. Actions range from increased monitoring, to a new assessment of needs and in a number of cases changes to care arrangements. Reviews of Self Directed Support packages will continue to grow as a result of policy changes in how care and support is accessed.

There has been a significant increase in defined outcomes for perpetrators. Outcomes here would include prosecutions and other police action, disciplinary action, referral onto specialist support, provision of counselling, treatment or training.

Where no further action is taken this is due, in most cases, to the effectiveness of the protection planning at earlier stages of the safeguarding process rendering additional action unnecessary. However these cases are at a higher level than comparable Local Authorities. The appointment of independent conference chairs provides greater scrutiny of outcomes.

4. Deprivation of Liberty Standards [DoLs]

One of the principles of the Mental Capacity Act (MCA) is that if a person lacks mental capacity to make a particular decision then whoever is making that decision or taking any action on that person's behalf must do this in the person's best interests.

The Deprivation of Liberty procedure aims to 'safeguard' the liberty of the incapacitate individual by ensuring that a rigorous and transparent procedure is followed prior to any deprivation of liberty. The aim is to ensure that those caring for, or involved with, incapacitate individuals are able to engage with decision-making involving questions about their liberty. DoLs is also aimed at ensuring that such decision-making is conducted carefully, and is subject to independent scrutiny.

Decision making on whether someone without capacity is moved into or out of home, care or hospital will generally have to demonstrate that best interests have been determined.

In care homes assessments have remained constant for 2011/12 compared with 2010/11, at 58 and 57 respectively. Of these the proportion authorised has declined from 34 to 28. In the health sector there has been an increase in number of assessments from 46 in preceding year to 61 in 2011/12. The number authorised has remained constant at 35, 1 more than in 2010/11. A greater proportion of cases are not being authorised.

When reassessments and reviews are included this year has seen a 25% increase in DoLs activity, across care homes and health settings combined, up from 175 to 235

There is a continued emphasis on making sure that where a Deprivation of Liberty Assessment is appropriate that this is recognised and actioned by practioners across the Partnership

5. Managing risk and collaborative working

5.1 Vulnerable Adults Risk Management Model [VARMM]

Practioners across the safeguarding partnership operate this model of working with adults who have capacity and actively self-neglect and/or decline services and support. The model facilitates an effective multi agency approach to managing risks associated with the behaviour of these individuals. It enables risk to be identified, accurately quantified and appropriately escalated, as well as delivering practical solutions tailored to an individual. Although successful there is evidence the model is under used. Currently only 25-30 VARMM cases are identified annually. To address this we are establishing a central register of VARMM cases to track activity and monitor progress. Where there is evidence of underuse we will address this directly with practioners through case studies, directed learning events and training.

5.2 Vulnerable Adults Panel

This is now established and running effectively**.** The Panel is jointly chaired by the Service Heads of Community Safety and Safeguarding and meets quarterly. The remit is to bring about practical collaboration between agencies to co-ordinate intervention for individuals at risk. Members include Health, Police, Social Care and Housing. The Panel is has developed a performance evaluation framework. This includes an assessment of cost savings as many of the cases considered by the panel consume significant level of resource often across agency boundaries.

5.3 Safe in Sheffield Scheme

Although this scheme initially focuses on adults with learning disabilities it is planned to extend it, subject to funding, to cover older adults with brain injuries cognitive and / or mental health issues. The scheme has been well received by those at risk and the number of agencies across all sectors signing up to the scheme has been excellent.

6. Awareness Raising Training and Development

The Safeguarding Adults Office delivers a core programme of multi- agency training. Developments in the year included new partnerships with Colleges and Universities, and training for GP's and their practice staff. The Safeguarding Partnership jointly developed and delivered Training for Trainers programme delivered into independent, private and voluntary sectors. This enables agencies to be more self-sufficient in identifying and meeting their training needs.

7. Current Priorities

The Safeguarding Adults Partnership Board has agreed the following priorities:

- Continue our relationship building with GPs, including the lead Adult Safeguarding GP and shadow Clinical Commissioning Group.
- Develop the Safeguarding Adults Board Policy and Practice in relation to financial abuse.
- Develop a Quality Assurance Programme across SASP to include standards, dignity and harm reduction, and links to the Quality Care in Care Homes Board.
- Develop a personalised outcome based approach to Safeguarding, including obtaining views on whether risk has reduced, to be integrated into the safeguarding pathway.
- Consider the under reporting areas, including Police, Criminal Justice and diversity characteristics, and develop best practice responses to the gaps following an assessment.
- Continue the service improvement in relation to transitions (progressions) for young people and Safeguarding and Mental Capacity Act

8. Recommendation

The Committee is asked to review the work undertaken under Adult Safeguarding as set out in the Annual Report for 2011/2012 and note the current priorities for action.

Appendix 1

Safeguarding Process:

Alert – Anyone who has contact with vulnerable adults, who has abuse disclosed to them, sees an incident, or has concerns about potential abuse or neglect, has a duty to pass the information on appropriately. The alerter may be a volunteer or worker but could also be a service user or a member of the public.

Referral – The process by which the alert is formally reported to:

- A Safeguarding Manager
- The relevant 'Council officer with Social Services responsibilities'
- The police

A safeguarding manager is a named person usually in a statutory agency that is responsible for overseeing the Safeguarding Assessment and its outcome. In most cases this will be a team manager in social care but may on occasions be a designated manager in the health service.

The person who makes this report is the referrer.

The Safeguarding Manager must make a decision within 24 hours to investigate or not.

Strategy Meeting – The Strategy meeting should be undertaken within 10 working days from the decision to investigate under safeguarding procedures. It's a multi agency meeting where the safeguarding investigation is planned. Also an interim protection plan is confirmed.

Investigation – Safeguarding investigation undertaken.

Case Conference – Multi agency meeting where decisions are made whether abuse had taken place on the balance of probability. Also a Protection Plan is confirmed.

Case Conference Review – Review of the effectiveness of the Protection Plan.

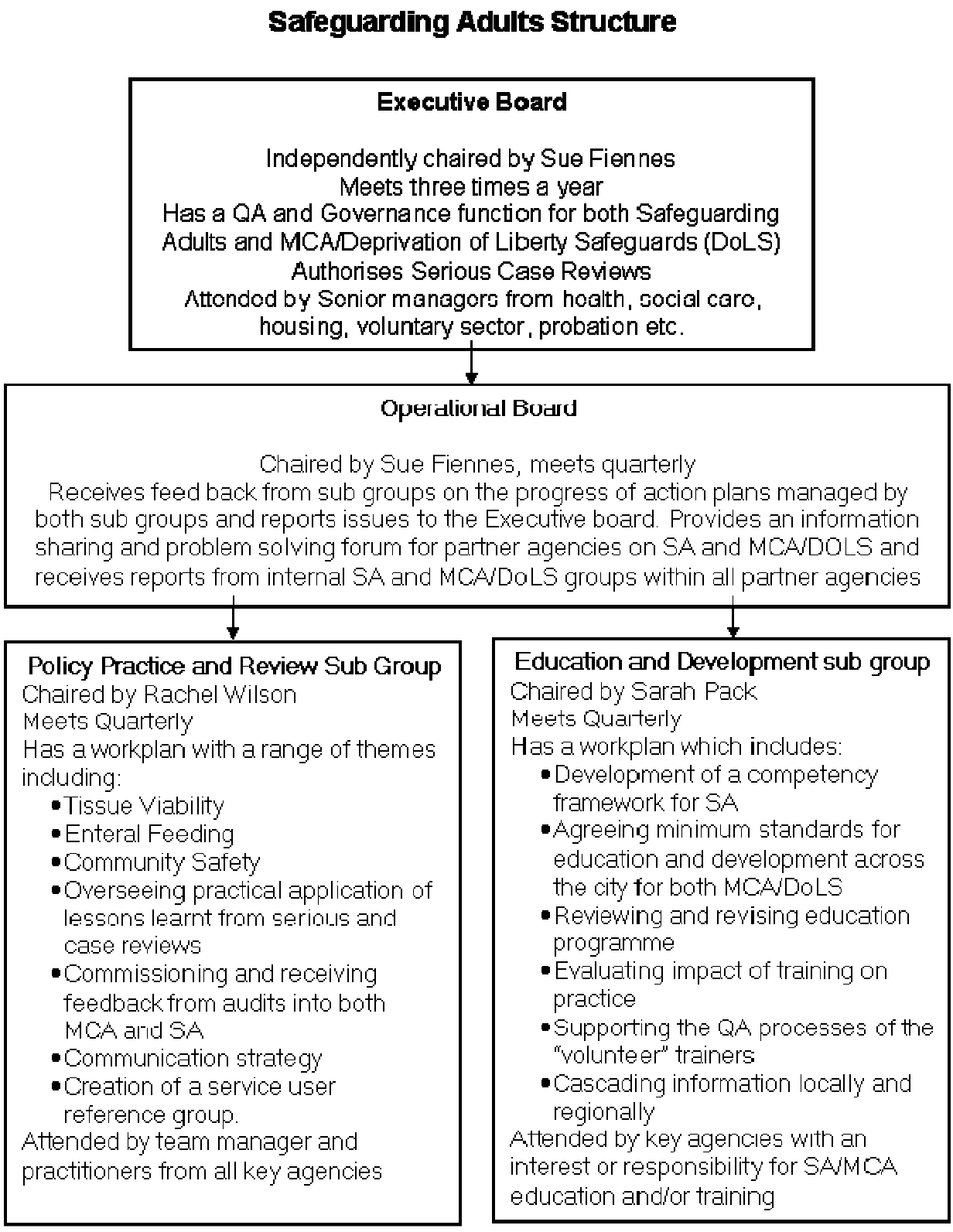
Appendix 2

Mental Capacity Act and Deprivation of Liberty Standards Process

The European Court of Human Rights (ECtHR) in its October 2004 judgement in the Bournewood case (HL v UK) highlighted that additional safeguards were needed for people who lack capacity and who might be deprived of their liberty in their best interests. As a result the Government amended the Mental Capacity Act 2005 and introduced the Deprivation of Liberty Safeguards.

These safeguards consist of a series of assessments which may lead to the authorisation of a deprivation of liberty where it is in the best interests of a person. This process strengthens the protection of a very vulnerable group of people. The Local Authority is currently the responsible body (Supervisory Body) for assessments in Care Homes and the PCT are the responsible body (Supervisory Body) for assessments in Hospitals.

Appendix 3
Safeguarding Adults structure



Protecting vulnerable adults in Sheffield

Sheffield Adult Safeguarding Partnership

Annual Report 2011-2012

SheffieldAdult SafeguardingPartnership

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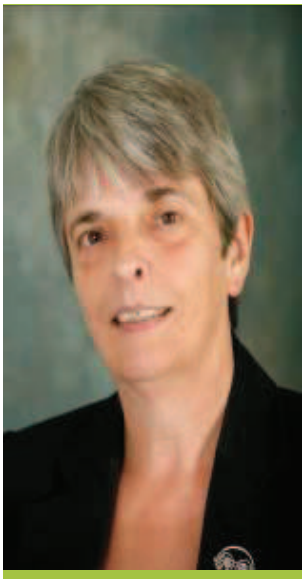

Sue Fiennes
Independent Chair

Dear Colleague

This annual report for Safeguarding Adults continues the improvement and development in this area of work.

Towards the end of 2011/12 the Board was able to implement the plan for independent chairs of case conferences. This will bring increased consistency, quality and, given the recent successful recruitment, very experienced practitioners to support decision making.

The use of VARMM has developed ensuring the same standard of multi agency consideration for vulnerable adults who may not meet service thresholds, but who may be at risk of harm or abuse. This approach is welcomed by practitioners and is bringing confidence to decision making and risk assessment in these circumstances.

The level of alerts of concern increased over the year and this demonstrates that awareness of abuse is leading to more determination to state concerns, however Sheffield is still below the figures for other comparable cities and this needs further analysis.

The Board continues to support conducting case reviews where there are significant concerns about practice, and these have led to improvements in practice and agency arrangements.

The Board has been able to sustain progress in difficult financial circumstances and to ensure continuity of agency contribution through organisational change.

I would particularly like to thank NHS Sheffield for ensuring that safeguarding leadership and capacity are robust going forward to the CCG accreditation later this year.

In addition, I would wish to thank all safeguarding leads in the partnership for their commitment and continued contribution to best practice and all the practitioners for taking safeguarding seriously.

Glossary

SASP - Sheffield Adult Safeguarding Partnership Board

SAO - Safeguarding Adults Office

Communities - Sheffield City Council portfolio that has responsibility for responding to Safeguarding Concerns

CQC - Care Quality Commission, regulates and inspects all adult health and social care providers

DOLS - Deprivation of Liberty Safeguards

Housing Solutions - Sheffield City Council department in Communities that responds to the needs of adults with housing issues

MCA - Mental Capacity Act

NHS Sheffield - Commissioner of health services in Sheffield City Council

SHSC - Sheffield Health and Social Care NHS Foundation Trust - provides a wide range of social care, inpatient and community services across the city including all age range services for Mental Well-Being, Learning Disabilities and Neurological Assessment and Rehabilitation. SHSC also provides a number of specialist Older Adults services and supports the Clover group of GP practices. SHSC have lead responsibility for providing Safeguarding services to vulnerable adults under the age of 65 who are experiencing mental ill health.

STHFT - Sheffield Teaching Hospitals Foundation Trust – provider of secondary medical services from the following hospitals: Royal Hallamshire Hospital, Weston Park Hospital, Northern General Hospital, Jessop Wing and Charles Clifford.

As a result of the Transforming Health Care legislation the Community services have now merged with the Trust to deliver quality health services within the community.

SYFR - South Yorkshire Fire and Rescue.

SYP - South Yorkshire Police.

YAS - Yorkshire Ambulance Service.

Alert - concern raised by any person about the safety of a vulnerable adult.

Referral - Concern passed to Communities or Sheffield Health and Social Care NHS Foundation Trust for a decision for admission into safeguarding processes.

Case conference - meeting to discuss the findings of the investigation and reach a “balance of probabilities” decision as to whether or not abuse has occurred and create a protection plan if required.

VAP - Vulnerable Adults Panel – a strategic meeting responding to the high risk cases involving vulnerable adults who misuse services attended by senior managers.

VARMM - vulnerable adults risk management model – used when people have capacity and their choices are leaving them at risk of significant injury/death.

DOLS

Annual statement and statistics for the Deprivation of Liberty Safeguards (DOLS) for 2011/12

Activity

Table 1- New assessments in care homes

Year	Number of new assessments	Number authorised	Number not authorised
2009/10	49	25	24
2010/11	57	34	22
2011/12	58	28	30

Table 2 - New assessments in Health settings

Year	Number of new assessments	Number authorised	Number not authorised
2009/10	26	17	9
2010/11	46	34	12
2011/12	61	35	26

Reassessments and Part 8 reviews

Table 3 - Care Homes: 2011/12

Reassessments in care homes	57
Part 8 reviews in care homes	16

Table 4 - Hospitals: 2011/12

Reassessments in hospitals	3
Part 8 reviews in hospitals	40

Table 5 - Total Activity: 2011/12

Care homes	131
Hospitals	104
Total combined work (assessments and reviews)	235

Previous year total activity was 175.
This is a 25% increase in activity based on the previous year.

Key trends in care homes

Number of new assessment requests has remained the same - however less where authorised: 28 in 2011/12 compared with 34 the previous year (see table 1).

Key trends in hospitals

Significant increase in the number of applications in hospitals. For the fist time exceeding new requests from care homes.

The number of requests increased from the previous year from 46 to 61 however the actual number authorised only increased by 1. Consequently the number of requests not granted more than doubled from 12 to 26. (see table 3)

Total assessments undertaken overall has increased by 25%. (See table 5) This is largely due to an increase in hospital applications and an increase in reassessment of existing DOLS authorisations - from 33 to 60 the vast majority of reassessment 57 took place in care homes. Hospital applications are usually short term and end with a part 8 review and are extensions to DOLS authorisations are rare (see table 3 and 5).

Whilst hospital applications continue to increase 17 from March to 15th May 2012 in the same period there were only 7 new care home applications (less than for the whole of December).

Given that the majority of care home applications are from recent admissions it is difficult to explain fluctuations. Work continues to promote the Deprivation of liberty safeguards and educate care homes in the process understanding the complexities of the DOLS process.

Safeguarding

Requests for Case Advice

During 2011/12 we received 397 formal requests for case advice compared with 538 in 2010/11, this is not a true reflection of the volume of case advice given as an increasing number of health and social care colleagues email individual managers in the team to request help and support which makes formal recording more difficult. This will need to be addressed to accurately record the support offered by the safeguarding adults' office.

We have increased the number of professionals who are now acting as referrers and providing support to colleagues within the full range of agencies in the city.

Alerts/Referrals

Table 6 - Alerts received

Alerts/Referrals	2010/11	2011/12
Alerts received	1586	2069
Alerts accepted into Safeguarding	428	709

The numbers of alerts received has increased, this is comparable with other cities and we are in line with the number of cases accepted into safeguarding (approximately 33%). Some notable exceptions exist to this trend Kirklees received 2625 alerts and screened 365 into safeguarding (20%) and Bradford received 2050 alerts and screened 1790 into safeguarding. Leeds received 3450 referrals however screened approximately a third into safeguarding at 985. It would be helpful to analyse the consistency of decision making in the city as practice appears to differ by team/service that does not appear to wholly relate to the number of alerts received by each service area. This is being addressed within the Local Authority and Sheffield Health and Social Care NHS Foundation Trust by reaching agreement to complete audits and report to the Safeguarding Adults Best Practice Group.

Cases by service area

Table 7 - Number of cases by service area (Screened into Safeguarding)

Service area	2010/11	2011/12
Physical disability and sensory impairment	49	80
Older adults	254	412
Learning disabilities	62	137
Mental health	60	52
Substance misuse	3	19
Other vulnerable adults	-	9

Source of referrals

Table 8 - Source of referrals into Safeguarding

Referrals source	2011/12	Referrals source	2011/12
Family and Friends	52	Housing	17
Primary care	72	SDS	0
Secondary care	41	Day care	7
Communities	50	Education settings	2
Domiciliary care	60	Mental health	22
Police	62	Other	162
Other social care	43	CQC	5
Residential and nursing care	107	Self referral	7

The number of referrals from Primary Care settings which is really encouraging and a reflection of the work undertaken with nursing teams and GP practices, combined with additional information hosted on the NHS Sheffield's web site.

The increase in referrals from residential and nursing care suggests that they do not view safeguarding as a punitive process that always results in negative consequences. A joint piece of work completed with Sheffield City Council's training and development unit has delivered a bespoke training for trainers course into the Independent, Private and Voluntary sectors to equip them to deliver safeguarding training in house using materials and methods validated by the Education and Development sub group.

We should be particularly encouraged by the, still small, number of self referrals as these have been absent in previous years. The very public advertising on public transport, DeCaux boards and the revised leaflets for service users appear to have increased confidence to make referrals. It will be interesting to note, following the launch of the "tear and share" leaflet the impact on the number of self referrals at the end of 2013.

Table 9 - Types of abuse reported

Type	2010/11	2011/12
Physical	140	226
Sexual	28	55
Psychological	110	134
Financial	206	221
Neglect	144	239
Discriminatory	1	4
Institutional	26	51
Total	655	930
Of which multiple abuses	129	179

The increase in multiple abuses is a worrying trend, as most of these cases relate to individuals in care settings, a smaller number of individuals who are subject to multiple abuses by family members.

We are really encouraged to see the significant rise in the number of cases were discriminatory abuse has been identified, indicating that the messages given to service users and workers that discriminatory behaviour is not acceptable is starting to become embedded in practice. We are confident that these figures will grow as the work with the service user forum expands and the close working relationships with Hate Crime and Anti-social behaviour becomes embedded.

Less positive is the rise in the number of cases of neglect, many of these relate to adults in twenty four hour care settings, some of these are units who have been found responsible for neglect of a number of adults and for a smaller number repeatedly responsible for institutional abuse.

We continue to work closely with colleagues in Health and Contracts to implement sustainable improvements and where necessary take actions to remove or restrict numbers of residents in these "struggling" private sector care providers.

Sheffield is broadly comparable with most of its colleagues in the region for physical, sexual, discriminatory and institutional abuse. Sheffield has higher rates of financial abuse ranking fourth in the region; third in the region for neglect and second for multiple abuses. Without greater analysis it is difficult to determine if this is related to increased awareness and reporting or a higher incidence in Sheffield. The comparator data which suggests that Sheffield is directly comparable for four of the categories of abuse does suggest that we may have a higher incidence?

Table 10 - Location of abuse

Location	2010/11	2011/12
Own Home	180	307
Care Home - Permanent	65	130
Care Home with Nursing - Permanent	53	73
Care Home - Temporary	10	23
Care Home with Nursing – Temporary	15	9
Mental health inpatient setting	1	4
Alleged Perpetrators Home	37	45
Acute Hospital	3	16
Community Hospital	2	3
Other Health Setting	3	1
Supported Accommodation	20	32
Day Centre/Service	5	13
Other	10	22
Not known	23	17
Public place	12	12

The significant increase in the numbers of cases in the following settings will require review in the coming year.

The 50% rise in the number of cases of abuse in care settings compared with the previous year, suggests that we may need to review if adults needs are best met in these settings? A number of the local cases involved care providers who were repeatedly involved in both individual and institutional abuse of service users. As a direct response to this the Safeguarding Board has endorsed the creation of the Quality in Care Homes Executive to address strategic issues around care provision and quality in the city and receives regular reports from them.

The rise in cases in acute hospitals, which indicates a confidence to refer issues into safeguarding for an independent scrutiny by an external process; the number of cases that are proven to be abusive, remains low. The low numbers of cases from health is consistent with both regional and national trends, this appears to be linked to use of more established mechanisms such as complaints, serious untoward incidents, patient safety etc. This is an area of work the Safeguarding Board have identified to examine through an audit of alerts and referrals and will shape training and policy development in the coming year.

Table 11 - Relationship with the alleged perpetrator

Relationship	2010/11	2011/12
Partner/spouse	37	47
Other family member	74	123
Neighbour /friend	47	66
Health worker	13	14
Volunteer	0	2
Social care staff	129	93
Other vulnerable adult	23	34
Stranger	10	6
Not known	55	256
Other	34	57
Other professional	6	4

In 123 cases the alleged perpetrator lived with the vulnerable adult and in 72 cases the alleged perpetrator was the main carer. As many cases are screened out of safeguarding when carer stress is identified and support offered. This raises questions about the motivation of family who are identified as the alleged perpetrators and indicates we need to try and provide additional support for isolated vulnerable adults who are reliant on family for support and care and who may be denied access to alternative care options. Work with the service user forum may assist us access vulnerable adults more directly to voice concerns about the quality of care/life they receive from family members.

Table 12 - Ethnicity of the alleged victim

Ethnicity of the alleged victim	Alerts 2011/12	Referrals 2011/12
Asian or Asian Indian	54	18
Black	46	11
Mixed	12	8
Other ethnicity	19	8
White	1866	650
Not stated (including refused)	72	14

These figures indicate a significant improvement on the previous year with over 50% more cases involving mixed and other ethnicity groups. Whilst this is encouraging further work will need to be completed to reflect the ethnic demographics of Sheffield. The production of safeguarding adults' information in all the main community languages in audio form which will form part of the revised web page in the future will support individuals whose first language is not English to access help and support.

Case Conference Activity and Outcomes

Ninety initial case conferences were held in 2011/12 in addition 45 virtual case conferences were held. The criteria for virtual case conferences are:

- The case has been subject to a process of equal or higher burden of proof, this could include disciplinary action, criminal outcomes etc.
- No ongoing risk remains for the vulnerable adult.
- The alleged victim or perpetrator does not wish to attend a meeting and support a conclusion virtually.

These cases avoid the need to bring professionals together to discuss a case that will not require a protection plan and are a very resource effective mechanism for concluding safeguarding concerns.

6 number of RCC were held, which indicates that very few case conferences resulted in protection plans requiring review.

Table 13 – Safeguarding outcomes for victim (all referrals)

Outcome for victim	2010/11	2011/12
Increased monitoring	104	115
Vulnerable adult moved from property or service	3	9
Community care assessment	39	38
Civil action	0	1
Application to Court of Protection	1	1
Application to change appointee ship	6	2
Referral to advocacy scheme	2	6
Referral to counselling/training	2	1
Moved to increased/different care	27	25
Management of access to finances	15	14
Guardianship/use of Mental Health Act	1	0
Review of Self Directed Support (individual budgets)	2	13
Restriction of access to alleged perpetrator	14	7
Referral to MARAC	1	3
Other	39	35
No further action	203	337

The increase in the review of Self Directed support packages will continue to grow in line with the change in policy in relation to accessing social care support. This is supported by the creation of Risk Enablement Panels to review packages that have significant risks associated with them to support a **transparent assessment of the risk with the service user and/or their family.**

Sheffield remains high in the region for cases with no further action and this has increased again from 48.8% in 2010/11 to 58.3% in 2011/12. This could be an indication of effective earlier protection planning but will require a level of scrutiny which will be gained by use of the independent case conference chairs who will report back to the Safeguarding Adults Office.

Table 14 – Safeguarding outcomes for perpetrator (all referrals)

Outcome for perpetrator	2010/11	2011/12
Criminal prosecution/caution	8	10
Police action	9	27
Removal from property or service	5	7
Management of access to vulnerable adult	14	9
Referral to POVA/ISA	4	15
Referral to registration body	1	2
Disciplinary action	37	28
Action by CQC	1	0
Continued monitoring	76	111
Counselling/treatment/training	22	17
Action by contract compliance	3	6
Exoneration	15	7
No further action	202	257
Not known	30	92
Community Care assessment	12	11

Multiple entries are allowed in this chart so many of the case involving disciplinary action will have included referral to ISA and/or registration body and a number of nurses in private care settings were subject to this outcome. The low numbers of exonerations indicates that we have very few malicious allegations made into safeguarding as this would not include individuals who were not found responsible in a criminal court but were found "on the balance of probabilities" to have abused a vulnerable adult.

The significant increase in both the number of cases involving the police and/or courts is encouraging and indicates the close working relationship with the Public Protection Unit locally. To retain this upward trend work will need to be completed with the police to embed their knowledge and use of the Mental Capacity Act to support people to access the criminal justice system; this work is planned for 2012.

The high numbers of no further action places us third in the region, though the picture indicates that either other Local Authorities have comparably high rates or have very small numbers. A discussion at regional level to analyse this may be helpful in the next year.

Vulnerable Adults Risk Management Model (VARMM)

Practitioners continue to report that this model of working with adults with capacity who chose to decline services or actively self neglect is an effective tool in facilitating multi-agency response to:

- Accurately assess the risks.
- Provide creative and flexible solutions.
- Support active monitoring.
- Enable senior managers to be notified of high risk situations.

On average seven cases per quarter are reported to the safeguarding adults office, this may be an under-reporting as unlike safeguarding no specific recording tools exist on care first and it relies on the team sending the data via email to the office. We hope to agree that the paperwork will become part of the new IT solution “Wisdom” and create a more robust reporting framework in the next year.

Reports from our partner agencies

Customer Advisory Forum

The Safeguarding Adults Customer Advisory Forum was formed in June 2011. The main aim was for service users and family to be actively involved in the work that the Sheffield Safeguarding Adults Office does around policy and procedure and training. Sheffield City Council Staff supporting and encouraging the group are:

- Dawn Shearwood - Safeguarding Adults Office
- Gillian Hallas – safeguarding Adults Office
- Christina Shipley - Quality and Development Team
- Ed Sexton- Partnership Support Manager

The group have had four meetings to date, during which they have negotiated between themselves a Terms of Reference and Code of Conduct. They have also planned the dates of the meetings for 2012, and these dates will allow the group members to provide information and feedback to the Policy, Practise and Review Group, the Training and Development Group and the Operational Board.

The dates are:

Date	Location	Time
Tuesday 6 March 2012	Town Hall G42	1.30- 4pm (1pm for coffee/tea)
Wednesday 6 June 2012	Howden House R1050	1.30 – 4pm (1pm for coffee/tea)
Friday 31 August 2012	Howden House R1050	1.30 – 4pm (1pm for coffee/tea)
Tuesday 6 November 2012	Town Hall G42	1.30 – 4pm (1pm for coffee/tea)

The group have now elected a Chair person and Vice Chair and secretary.

The Chair Person will be in office for 12 months and all officials will receive training and support to help them in their posts. The group members will also receive training about safeguarding adults to help them understand the policies and procedures and processes. It is hoped that in the future customer forum members will be involved in the delivery of training sessions.

Adam Butcher
Chairman, Customer Service Forum

Communities (Sheffield City Council)

Achievements in the year

Creation of the Vulnerable Adults Panel. Co-chaired by Community Safety and Safeguarding Adults Heads of Service, this forum provides a strategic response to high risk cases, defined as:

- High risk of harm to the individual or people involved with them.
- High cost due to inappropriate use of services.
- High risk to organisation's reputation.

The panel has membership from all key agencies in the city including police, health, ambulance service, probation, mental health services, social care etc and has created some creative and positive solutions for a number of individuals referred to the panel.

An audit is planned to analyse the cost savings to agencies as a result of the panel and to identify changes that may reduce the number of cases that need to be referred. Referrals are made via the safeguarding adults' office and screened by the joint chairs in advance of the meetings

Creation and consultation on a Hate Crime action plan. The hate crime plan will be signed off in 2012 and will lead to a city wide strategic and operational board being established to implement the plan and report back to the Community Safety and Safeguarding Adults Board. Safeguarding Adults is a key attendee and vulnerable adults and safeguarding are key themes within the action plan. Implementing a third party reporting of Hate Crime has been adopted by Community Safety who are working to establish a city wide model in the coming year.

Close working links with Domestic Abuse Partnership. A number of training sessions have been provided for staff working on the helpline to assist them to identify vulnerable adults and make referrals into safeguarding processes. Joint meetings are held with the service manager of DAP and Safeguarding to support effective working on joint issues such as forced marriage etc.

Creation of the Quality in Care Homes Executive. As a direct response to the identification of repeat concerns in a small number of care providers, combined with the desire to create a cohesive strategy to support the deliver of high quality care led to the creation of this group. Chaired by the Head of Service for Commissioning and attended by counterparts from health, social care and safeguarding it has developed a number of work streams and progress is reported to the Safeguarding Adults Board. It is anticipated that this approach will support:

- Attracting new providers to the city.
- Combining agenda's to support more effective implementation and monitoring.
- Identify sources of support and development for existing care providers.
- Engage service users and their families in shaping existing and new care provision for the city.

Progress will be reported to the Board and a full summary will be included in the next annual report

Establishing a safe in Sheffield Scheme. Funding has been agreed to establish a safe in Sheffield scheme which will initially focus on adults with learning disabilities but will extend to cover older adults with cognitive issues, adults with brain injuries and adults with mental health issues.

A steering group has been established to lead the work which has been contracted to Heeley City Farm who will centrally involve service users in the design, delivery and evaluation of the project.

Performance Monitoring. In collaboration with colleagues within Business Strategy weekly updates are provided to Assessment and Care Management about their compliance with safeguarding. Advice and support is available from the safeguarding adults office to assist them to resolve issues with progression of cases through the process.

Targets for the coming year

Community Safety staff undertake safeguarding training and identify 'Safeguarding Champions'.

ASB Champions network to be established by October 2012, with safeguarding incorporated in their expertise.

Introduction of the Partnership Resource Allocation Meeting (PRAM) which will bring police and partner ASB data and intelligence together for the first time and improve our ability to identify vulnerable people suffering from ASB, respond to issues of vulnerability, and signpost to agencies to ensure that they are receiving the appropriate level of support and interventions. PRAM will not replace pre-existing structures or procedures, but will instead provide an early warning system forging strong links with MARAC and Adult Safeguarding.

Reviewing the internal Best Practice group membership and terms of reference to assist the dissemination and embedding of safeguarding best practice within the portfolio.

Sheffield Health and Social Care NHS Foundation Trust (SHSC)

Achievements

- SHSC has made significant progress against its strategy for Safeguarding Adults and has detailed this progress in its Annual report to the Board and Quality Assurance Committee.

- SHSC has continued to work in partnership with the Local Authority and NHS Sheffield to deliver best practice in Safeguarding throughout the organisation and to protect those vulnerable to abuse who use our services.

- The Community Mental Health Teams have also worked closely with private organisations in developing their safeguarding standards for protecting vulnerable working age adults.

- The SHSC Safeguarding office has begun a programme of work with the new services joining the organisation, in order to ensure they have systems and policies that are commensurate with Trust's high standards in Safeguarding Adults.

- Throughout the year the SHSC Safeguarding office has endeavoured to integrate newly reviewed Safeguarding documentation onto its electronic data system (Insight), in order to simplify the alerting process for staff and to make data extraction easier and even more robust. This work will be fully completed in January 2013.

- The SHSC Safeguarding office is also planning to simplify the process for receiving alerts into the organisation via dedicated secure e-mail addresses in each of its Community Mental Health Teams. This work will be completed in December 2012.

- SHSC has continued to monitor and respond to National changes in Safeguarding via its internal governance processes and via attendance at all external partnership meetings held in the city.

- SHSC has also attended all regional Safeguarding meetings and conferences in order to forge new and maintain old, links with other NHS organisations.

- The SHSC Safeguarding office has intentionally focused on whole team training that is directly relevant to the work of these individual teams, as well as offering internal generic1 day awareness training to all staff within the Trust. SHSC delivered 12 internal awareness courses during this period, all

of which were well received and evaluated to an exceptionally high standard by staff.

- SHSC has maintained robust governance standards by providing the Local Authority with AVA data, producing quarterly and annual Board reports and completing internal practice audits.

- SHSC has been represented on all relevant city-wide Serious Case Reviews and is currently producing a report in regard to a recent Domestic Homicide.

- SHSC Safeguarding processes are over-seen by the SHSC Safeguarding Steering Group and they maintain an updated and contemporary action plan throughout the year.

- The Safeguarding Steering group has also focused its attention on the implementation and monitoring of the Mental Capacity Act and Deprivation of Liberty Safeguards and has a Trust wide lead for these areas of work as well as a Local Authority expert within the group.

- Following this year's internal audit inspection recommendations SHSC has developed specific intranet pages for Safeguarding Adults that are aimed at providing a range of relevant guidance and support to all staff. These pages include information on Domestic Abuse, the Vulnerable Adults Risk Management Model (VARMM) and details of all other relevant agencies.

- SHSC has a named doctor, a named nurse and named executive and non-executive Directors in relation to Safeguarding Adults.

Looking Ahead

- High on the Safeguarding offices agenda for 2013 is the development of embedded processes to ensure we routinely gather feedback from vulnerable adults who experience safeguarding processes.

- SHSC will continue to focus on the integration of Safeguarding procedures into its risk management strategy and electronic assessment pathways, with the ultimate aim of making the process of alerting as simple and streamlined as possible for all staff and clients.

- Internal training will be fully reviewed in January 2013 to ensure that the training being delivered meets practice requirements for the forthcoming year.

- The Safeguarding office will re-write its policy and procedures in-line with the review of the South Yorkshire procedures.

Sheffield South Yorkshire Police

Achievements in the year

Because of the units' previous mentioned co-location to Sing Hill, Sheffield multi agency working continues to be an important and developing facet of work. There is a continued commitment to immediate working between the Police and differing agencies, which is supported by the close proximity of Sheffield Domestic Abuse partnership.

The PPU investigation team continue to provide a robust response to those matters, which require a joint approach. Dedicated staff have responsibility and a growing expertise in the investigation of such matters utilising specialist skill such as advocates where necessary to enhance these processes.

Throughout the last year, there was a need to bolster the police response to the non-investigation matters that are reported by either the Police to social care or the other way around. Historically one person acted as the liaison officer to Adult services. This may have assisted communication with agencies however highlighted the lack of resilience built into the process when that person was not available. As such, the eight Domestic Violence officers now rotate responsibility for addressing Adult protection matters building resilience into the process and providing a cohesive response to matters reported.

Looking Ahead

Work is ongoing to integrate Sheffield Adult Protection Staff into the day to day work of the PPU by having a member of staff collocated on a daily basis within the unit. This would further enhance multi agency working by providing a joined up response to reports of elder abuse.

Opportunities will be sought to ensure that training remains an instrumental part of Police Officers 'Street Skills' and all avenues are explored to further develop officers in this field of work.

NHS Sheffield

NHS Sheffield remains committed to keeping vulnerable adults safe while they are in NHS care in Sheffield. To achieve this Safeguarding and Adult Protection is at the heart of all our planning and decision making.

We have continued to work hand in hand with our partners to do this and make sure that everyone in the city's NHS understands their role in the health and wellbeing of vulnerable adults.

Safeguarding vulnerable adults remains integral to commissioning, primary care services, contracts with providers and clinical governance. We strive for good practice in everything we do, learn from safeguarding incidents, both those which became serious case reviews and those which did not and ensure that changes are put in place quickly across the local health system. We also ensure that all health professionals in the city working with vulnerable adults understand their role in safeguarding and how to report concerns and act to safeguard vulnerable adults.

Partnership Working

NHS Sheffield has continued to be an active member of the safeguarding adult's partnership. We have maintained our financial commitment to the partnership on behalf of all the health agencies within Sheffield and contributed to the successful achievement of the actions within the 2011/2012 SASP Development and Improvement Plan.

Specifically in respect of action 5 we have ensured our Associate Director with the lead for Safeguarding is a member of the emerging Clinical Commissioning Group (CCG). Along with one our Clinical Directors this provides a Safeguarding Champion at a senior level to ensure the CCG understands and meets its Safeguarding responsibilities. Our Associate Director with the lead for Safeguarding remains a member of the SASP Executive Board thereby ensuring the link between this and the Sheffield CCG. We have planned for September 2012 a development session for the CCG re their safeguarding responsibilities. This will be led by SASPs Independent Chair.

Re action 6, we have secured three GPs to undertake Independent Management Reviews (IMRs) to contribute to Serious Case Reviews. One of these is also undertaking other duties of the named GP role and is supporting us in developing a business case for a substantive named GP.

As well as our membership of the SASP Executive Board we continue to play an active role within SASPs subgroups, chairing the Policy, Practice and Review (PPR) subgroup and attending the Health Reference Group.

Internal safeguarding structures/accountability

We have made significant progress against our objectives from our Safeguarding Adults strategy and further detail re this work is contained within NHS Sheffield's Safeguarding Adults Annual Report.

Our internal 'Commissioning Safeguarding Adults Group' has continued and provides assurance to our Board in respect of Safeguarding Adults work undertaken within the organisation.

Transition

We have undertaken significant work in the last year to ensure the Safeguarding Adults agenda remains firmly at the heart of the emerging CCG. As above, we have ensured Safeguarding Adults leadership continues

The CCG structure has identified staff to ensure it meets it safeguarding responsibilities and transition work is a priority for 2012/2013.

Commissioning and Provider Assurance

We continue to actively performance manage our health providers around both Safeguarding Adults and MCA/DoLS and through evidence gained, including SASP assurance processes undertaken with organisations, we assure our Board of our providers safeguarding activity.

We have developed a safeguarding commissioning policy which details standards our providers must meet. Our providers have agreed these and adherence to the policy will form part of our contracts with them.

Strengthening Safeguarding Adults work with GPs

We held our first Safeguarding Adults Protected Learning Initiative (PLI) this year. 250 GPs attended and the event covered recognising and reporting abuse, Domestic Abuse, Hate Crime, recognising abuse in care homes and assessing Mental Capacity. The event evaluated extremely well, some comments being: *'I feel more confident', 'I now have relevant contacts for advice', 'have more knowledge about pathways', 'I will do further e-learning'* and *'I now know the relevant high risk circumstances to look out for'*.

We undertook a baseline audit to better understand GPs level of knowledge and confidence in Safeguarding Adults and will use the results to inform further training.

Mental Capacity Act (MCA) and Deprivation of Liberty Standards (DoLS) activity

This year has seen the sign off of a section 75 agreement between us and Sheffield City Council (SCC). This allows both organisations to enter into a range of shared operational and administrative arrangements to most effectively carry out our respective MCA/DoLS functions. Operating jointly has removed the need for separate systems and processes and separate cover arrangements.

The agreement also prepares both organisations for the transfer of DoLS responsibilities to SCC from April 2013.

As the CCG becomes a legal body, it will retain the responsibility for ensuring its providers are compliant with their MCA responsibilities. Ensuring this work takes place is one of our objectives for the coming year.

For NHS Sheffield DoLS activity please see the MCA/DoLS section of this report.

Objectives for 2012/2013

We will continue to achieve the objectives set out in our Safeguarding Adults Strategy for 2011/2013. Priorities also include:

- Ensuring a smooth transition of Safeguarding and MCA/DoLS responsibilities from NHS Sheffield to Sheffield CCG and Sheffield City Council.
- Further work with GPs to ensure they meet their safeguarding responsibilities.
- Embedding the Safeguarding commissioning standards with our providers and being assured by them.

Sheffield Homes

In April 2011 Sheffield Homes re-organised its management structure with corporate responsibility for both adult and child safeguarding being allocated to one senior manager with the Tenancy Management and Enforcement Team overseeing the day to day development of safeguarding systems.

Sheffield Homes manage approximately 42000 council properties for Sheffield Homes and work is continuing to develop systems which will ensure that vulnerable and potentially vulnerable customers are identified at the earliest opportunity, receive appropriate advice and support and have access to external partners and organisations that can assist in meeting their individual needs.

Since 2010, 80 staff have been trained to assist them to identify and report cases involving vulnerable adults and safeguarding, with an additional 192 staff being trained to act as referrers. As of the 1 July 2012 there are only seven members of staff waiting for safeguarding training. However, during 2012/13 additional training is planned for 234 staff on domestic abuse and MARAC. This continual development programme ensures that Sheffield Homes Staff are provided with the best training and guidance to meet the needs of its most vulnerable customers. Sheffield Homes have agreed to engage with Professional Boundaries training to assist them to deal with tenants more effectively.

During 2011/12 work continued in ensuring that the equalities data was collected for as many customers as possible with Sheffield Homes holding data on all of the equality strands for 83.3% of its customers but more specifically:

- Ethnicity – 97.3%
- Disability – 92.4%
- Date of Birth – 99.9%
- Language need – 91.6%
- Religion – 90.4%
- Sexuality – 85.9%

This data is used to ensure services are personalised to an individual's needs. During 2012/13 Sheffield Homes will be reviewing how it allocates vulnerability codes to customers and how we should support and respond to the needs of different client groups. This will form a big part of any review into delivering preventative strategies for vulnerable groups to prevent cases escalating to safeguarding levels.

Sheffield Homes public access points have all of the up to date literature on Safeguarding, ASB, domestic abuse and hate crime and will be working in 2012/13 to ensure all information and links are available electronically and online for maximum exposure and access.

Sheffield Homes are also members of the Stay Safe in Sheffield initiative with all relevant staff to be trained on responding to specific requests within this initiative.

Sheffield Homes will also be developing a Quality Assurance Framework for safeguarding and vulnerability to ensure that the organisation can ensure that systems are in place to deliver best practice in all cases. This work will be completed in 2013/14.

Sheffield Teaching Hospitals NHS Foundation Trust (STHFT)

Partner Agencies Achievements and Internal Governance Arrangements

Following the successful integration of Adult Community Services from NHS Sheffield, the Trust has an integrated adult safeguarding team which covers both adult community and hospital services.

The adult safeguarding team has continued to embed the safeguarding and Mental Capacity Act (MCA)/Deprivation of Liberty Standards (DOLS) awareness across the organisation, advising and supporting staff to make timely and appropriate safeguarding referrals and best interest decisions.

The safeguarding adults' governance and performance framework ensures accountability and reporting through timely submission of performance and governance data both internally and to the SASP.

Achievements

- The safeguarding adults' policies from the former acute and community services have been amalgamated into a joint policy to ensure a consistent and standardised approach to adult safeguarding across STHFT.
- Links between the Sheffield Adult Safeguarding Office and other health partners have been strengthened by participation in the quarterly Health Partnerships meetings and by the attendance of the individual safeguarding team members at supervision sessions with the local authority Sheffield Safeguarding Adults team.
- A '4 Steps to raising a safeguarding alert' flowchart has been developed for community staff to complement the existing flowchart for staff working in the acute setting.
- A database of safeguarding adults' referrals has been established to enable monitoring of sources of referrals, identify any gaps and facilitate a future audit of the appropriateness of referrals.
- Work has been undertaken with the Patient Partnership Department to establish a process for escalation of potential safeguarding concerns identified from complaints received by the Trust.

- An audit of compliance with Mental Capacity Assessments and best interest decision making was undertaken in September 2011 which highlighted some examples of good practice, but also some gaps in knowledge and variations in practice. An action plan to address the gaps in knowledge is in place.

- A service evaluation of the in house safeguarding basic awareness training was undertaken from September to December 2011. An audit of safeguarding awareness was undertaken in the Community Care Group in October 2011

- Both the audit and the service evaluation demonstrated a variation in staff recollection of how to recognise and report abuse. The safeguarding adults' basic awareness training materials have been updated to reflect the findings from these evaluations.

- 100% attendance from STHFT at the Multi Agency Risk Assessment Conference (MARAC)

- Completion of two Internal Management Reviews (IMRs) in response to a Case Review and a Serious Case Review (SCR) held in Sheffield.

- Completion of an IMR in response to a Serious Case Review held in Nottinghamshire, where the individual at the centre of the SCR had received care within STHFT. STHFT has been commended by the Nottinghamshire SCR Panel for the high standard of the IMR submitted.

- Completion of an IMR in response to a Domestic Homicide Review held in Sheffield.

- Updated the Nursing Care Guidelines for Domestic Abuse as part of the action plan following the Domestic Homicide Review.

- Participation in a multi agency 'Lessons Learned' review in response to a death in the community which did not meet the criteria for a Domestic Homicide Review.

- A guidance document for provision of safeguarding adults' supervision to staff working with complex and challenging individuals has been developed and is available on the STHFT Safeguarding Adults intranet site.

- A model of reflection has been used to develop a tool to enable staff to reflect on significant events. This model has been trialled by the Named Nurse following a specific incident and early indications are that this is a useful tool to identify lessons learned and inform future practice.

Partner Agency Involvement in Safeguarding Adults Education

STHFT reviewed and updated its training needs analysis relating to safeguarding adults to reflect the requirements of the Bournemouth competencies for safeguarding adults.

The STHFT safeguarding team has updated the in house training materials to reflect developments in safeguarding adults. Referrer training is now offered in house.

The STHFT safeguarding team has provided a rolling programme of Safeguarding Adults Basic Awareness training, as well as bespoke training sessions to specific staff groups in both the acute and community settings in line with the training needs analysis and as requested.

MCA/DOLS awareness is delivered as part of the newly qualified staff nurse induction programme.

A rolling programme of Dementia Awareness training has been commissioned and is facilitated by the Sheffield Hallam University.

In addition to these sessions staff can access e-learning and where appropriate, multi –agency training in subjects relating to safeguarding adults.

The Lead Nurse for Adult Safeguarding and the Named Nurse for Adult Safeguarding are members of the multi-agency training pool.

The Lead Nurse for Adult Safeguarding and the Named Nurse for Adult Safeguarding undertook the training for trainers' course for the Prevent anti-terrorism strategy and now provide in house Prevent training.

The Named Nurse attends the Sheffield Adult Safeguarding Educational Development group (SASED)

The Lead Nurse for Adult Safeguarding attends the Yorkshire and Humber regional safeguarding training sub-group meetings.

Looking Ahead – Partner Agencies

The Action Plan for the year ahead includes:

- To provide referrer training to heads of therapy and other allied health services and to senior staff within the community care group.
- To provide awareness of the Government's Prevention strategy.
- To provide training on Vulnerable Adults Risk Management Model (VARMM).

- To provide further training and support in embedding the MCA/DOLS/best interest principles into practice.
- To undertake an audit of complaints to identify whether safeguarding concerns are being correctly recognised via the complaints review and risk grading process.
- To develop an appropriate audit tool and undertake a re-audit of safeguarding awareness across both community and acute staff.
- To maintain an excellent attendance record at the delegated safeguarding meetings and sub groups.
- To work with Human Resources to develop guidance for line managers to support staff who may be victims of domestic abuse or forced marriage.
- To develop a system of identification of vulnerable adults accessing services at STHFT who may need referral into the vulnerable adults' panel.
- To develop a robust system for implementing recommendations and actions from the vulnerable adults panel, MARAC, SCRs and DHRs, reporting progress to the associated operational Boards as required.
- To identify key individuals from within the trust who have the skills to lead on safeguarding investigations.
- To provide specialist training for key staff in undertaking IMRs.

South Yorkshire Fire and Rescue

South Yorkshire Fire and Rescue continue to employ a designated lead Safeguarding Officer for safeguarding children, young people and vulnerable adults. Key responsibilities include the development of policy, guidance & procedures, implementation and delivery of training and specialist advice and reporting internally and externally. Group Managers are identified to deputise out of hours and in the absence of the Safeguarding Officer.

Safeguarding Alerts & Referrals

- All Safeguarding Alerts are triaged through Safeguarding Officer or via Control and Group Managers.
- A central database collates all alerts and referrals from a Single Point of Contact.
- 51 Alerts triggered April 2011 – March 2012 throughout South Yorkshire, the majority are linked to Fire Safety and are linked into appropriate Adult Services, 5 Referred into Safeguarding and 1 into VARRM.

Policy

Safeguarding policy, guidance and procedures were initially approved in 2010 and an annual review and update together with an Equality Impact Assessment has recently been completed and communicated across the organisation.

A Safeguarding page on the SYFR Intranet is being developed and information will be made available on the external website directing the public to information on child and adult protection

Training

All Community Safety staff, Human Resources, Equality & Diversity Team, Technical Fire Safety and 85% of Operational Fire Fighters have received Basic Awareness Training.

Vulnerable Persons Advocates are in the process of attending multi agency training courses across their given districts.

An internal electronic Refresher programme is to be developed for 2013.

Board Membership

The Safeguarding Officer/Group Manager or Community Partnership Officer represents SYFR at the SAPB meetings across South Yorkshire.

SYFR is also now represented on both Safeguarding adult and children boards in each district.

Priorities

Key priorities for South Yorkshire Fire & Rescue are:

- reducing deaths and injuries as a result of fire or road traffic collisions;
- safeguarding property and reducing the impact of fire;
- reducing arson;
- educating communities; and
- protecting the environment.

In addition to the Operational Fire & Rescue emergency response Prevention and Protection initiatives are key drivers for an extensive range of Community Safety activities which include:

- Home Safety Checks – fire risk assessment, advice, plan and fitting of smoke alarms.
- Vulnerable Persons Advocates and Fire Community Support Officers provide additional risk assessments and advice to vulnerable people in their homes and to families and carers.
- Multiagency Partnerships providing targeted services and training to specific staff and care groups.

Contribution to Case Reviews and Serious Case Reviews

SYFR would contribute to any review commissioned by the Board, especially if this involved fire safety.

Report from the Safeguarding Adults Partnership Board

Significant progress has been achieved by the Board against it s Development and Improvement plan.

Key Targets

Establish a policy and process to safeguard vulnerable adults who do not traditionally fit safeguarding.

- VARMM training has been established for partner agencies and cases of self neglect are being managed by social care, health and housing to produce a multi agency response to reduce risks.
- Vulnerable Adults Panel established to respond to very high risk VARMM cases, adults who inappropriately use services of a frequent basis etc. Early evaluation suggests that this is an effective model, a more formal evaluation, including cost analysis will be completed in 2012/13.
- A South Yorkshire agreement has been reached to include VARMM and self neglect within the new Safeguarding procedures.

All partner organisations to develop quality standards for service users to assure the board of safeguarding best practice.

- Progress has been made on this area, especially by Communities who have established a service user forum to shape the work of the board and a system for seeking feedback from service users and their families about their satisfaction with the safeguarding process. This is an area of work that will require further action in 2012/13.
- Create a governance document for one good learning system to include realistic models that are audit compliant and risk management compliant.
- SASED (education and training sub group) have agreed a competency model for safeguarding adults and work has progressed in all agencies to agree its adoption and associated training needs analysis. Once this has been completed this will assist the board set realistic priorities for education in the coming years.

- A review of all E learning packages has been completed by the Safeguarding Adults Office at the request of SASED and improvements made. A more robust mechanism for recording the numbers of staff accessing and completing these has been established and this data is shared with SASED on a regular basis.

Consider the benefits of share/pooled services and co-location for safeguarding generally.

- Outline agreement between South Yorkshire Police and Sheffield City Council to progress a partial co-location within the Public Protection unit as been reached. All staff vetted to support this move. A date to be agreed to commence pilot.
- Begin formal approaches to GP Consortia to engage them in Safeguarding and seek to appoint a GP champion to join the Executive Board. Create a business case for a named GP.
- Lead GP identified and with support from him and NHS Sheffield a protected learning event will be held in 2012 to provide GPs with information about safeguarding, VARMM and MCA/DOLS.
- Strong links with CCG established via NHS Sheffield and safeguarding adults is regularly discussed at CCG meetings.
- Strong links have been established with the Local Medical Council and a number of practice agreements have been reached as a result of these meetings.
- This work will continue into 2012/13 as the transition from NHS Sheffield to Clinical Commissioning Groups (CCGs) is completed.
- Develop a business case for a named GP to undertake serious case reviews and independent management reviews (IMRs).
- A GP has been identified as the lead for Safeguarding Adults and contributes to the NHS Sheffield Safeguarding Adults Steering group. A number of zero hours GPs have been identified to complete individual management reviews for case reviews and serious case reviews. These appointments will create a valuable link with the emerging CCGs.

Develop relationships with HealthWatch.

- The Safeguarding adults' office has contributed to the design of the service specification for the new service and has strong relationships with LINK. Further work will continue in 2012/3.
- Re-write South Yorkshire procedures to include VARMM and communities of interest/diversity.

- Broad agreement to include these has been reached with South Yorkshire colleagues. The tender process has not yet been established but will be completed in 2012/13.

Consider the impact of the Domestic Homicide Reviews (DHR) on SASP Board activity and capacity

- Evaluation of the DHRs completed by the Domestic Abuse Partnership indicate that they will have significant resource impact for safeguarding and this will need to be considered in future financial planning

Summary of partner's progress against key themes

Theme 1 – managing and recording alerts and referrals. Significant progress has been made by all agencies to create a system to log all safeguarding concerns with no agency unable to complete this, the wider challenge of being able to report centrally is still be addressed by a small number of SASP partners. A city wide register of all safeguarding data has been explored but would be financially and resource intensive and will have to be evaluated as to the benefits of its implementation in 2012/13

Theme 2 - Involving service users and other relevant participants. Partners have a number of internal and external forums to share best practice and learning and this provides SASP with evidence of coordinated and consistent working to key objectives. Feedback from service users and their families needs to be improved across the partnership to demonstrate our success against this criterion. The creation of the service user forum group will generate evidence in the coming year

Theme 3 – People know how to get help. Joint work with a range of service user groups and partners have resulted in all of the safeguarding leaflets being re-written and circulated to all partner agencies to distribute. A publicity campaign using DeCaux board and buses and trams has provided information to all service users to their families in a non targeted way, evaluation on the number of self referrals made in the coming year.

Report from the Safeguarding Adults Office

Work with partner agencies

The office supports the internal safeguarding adults and MCA groups in all partner agencies and facilitates a safeguarding health partnership meeting to create opportunities for sharing of best practice and joint working. Evaluation of the latter indicates that health colleagues have found this very beneficial.

The office meets regularly with South Yorkshire Police, locally and regionally to address any practice concerns and create multi agency learning opportunities.

Health colleagues are provided professional development opportunities on a regular basis by shadowing "duty" cover dealing with all aspects of safeguarding and mental capacity/deprivation of liberty.

The office supports the following:

- Hate crime strategy and executive meetings
- Vulnerable adults' panel
- Monitoring of all VARMM cases
- Management of all SASP meetings
- Service user forum meetings

Regular meetings and information sharing take place between the office and:

- Safeguarding Children's Services
- Domestic Abuse Partnership

Quality assurance Audit and monitoring

A wide range of monitoring is undertaken on behalf of the board and partner agencies, in 2011/12 these included:

- All Deprivation of Liberty safeguards application body for both the Local Authority and NHS Sheffield under the Section 75 agreement.
- Review of all completed safeguarding adults investigations in advance of conference.
- In collaboration with colleagues from business strategy monitor the performance of the Board against agreed target.
- Monitor VARMM and Safeguarding compliance and update partners when areas of concern or non compliance are identified.

- Monitor the budget and provide recommendations for spending.
- Complete service user satisfaction surveys via a range of mechanisms.
- Complete, support and monitor case reviews and serious case reviews as required.
- Supervise and provide development opportunities for the Best Interest assessors, mental health assessors and independent case conference chairs.
- Coordinate and chair MCA/DOLS governance meetings.
- Advise agencies on internal safeguarding and MCA policies.
- Provide reports to partner agencies on areas of concern.
- Complete audits and support audits within agencies covering safeguarding and mental capacity.
- Support elected members via scrutiny and other mechanisms.
- Case advise to all agencies.
- Monitor performance detailed in action plans linked to case reviews and serious case reviews.
- Contract monitoring of the IMCA and Paid Representative services linked to DoLS.

Education/Training/professional development

The office has a pool of accredited trainers who work with the office, free of cost, to deliver a full range of education and training opportunities – see next section. In addition the office provides:

- Bespoke events on safeguarding, MCA and DOLS for partner agencies.
- Advise on the quality of internal training programmes and provide updates on local and national developments.
- Produce a bi-monthly newsletter.
- Act as a moderator for accredited education programmes in collaboration with further education partners.
- Contribute to the design and delivery of regional and sub regional events.
- Design and delivery quarterly development events for Best Interest Assessors, Mental Health Assessors and Independent Case Conference Chairs.

Project management

- Oversee the management of the Safe in Sheffield Project on behalf of the board.
- Transitions project across adult and children's social care to improve quality of safeguarding and MCA/DOLS.
- Other short term projects – eg Changes to CareFirst etc.

View from the Chair of SASED

The Sheffield Adults Safeguarding Education and Development Group met quarterly throughout 2011/12. The group comprises of representatives from across partner organisations and meets to oversee the development and implementation of adult safeguarding education both through multi-agency and in-house activities.

Throughout 2011/12 SASED has been supported by the temporary Development and Training Manager within the SAO who has now moved into the post on a permanent basis from June 2012.

Achievement 2011/12

Progress across all areas of the Training Strategy for 2011/12 has been good, key achievements across a broad range of targets include:

Multi Agency Training Safeguarding Adults/Safeguarding Children. This initiative started as a pilot in March 2011 to provide information and guidance regarding safeguarding children and adults and to raise awareness of issues in multi generation families and communities. Following positive feedback four further workshops have been delivered to March 2012. It is anticipated that further workshops will be organised and advertised in 2012/13.

Community Partnership Multi Agency Training. A new multi agency workshop was run in September 2011 with over 50 delegates from the Police, Social Care, Health, Housing, Environmental Services and Fire service. The aim of the workshop was to promote the need for closer multi agency and partnership working in the community and included 'hate crime' issues. The feedback was excellent, however funding and organisational changes have delayed development and running of further workshops for the present. Although the programme has been adapted and run very successfully with Sheffield Homes.

Specialist Workshops. 14 Specialist Courses have been run in 2011/12 as an extension to the core programme. These have proved very popular and have evaluated extremely well. They will continue to for a key part of the training programme for 2012/13 with 38 planned for this year.

E learning Programme. This has been fully updated and re-launched this year. The Safeguarding Operational Board endorsed SASED request that organisations commit to using this e-learning programme to support basic awareness training across organisations and where organisations used other e-programmes that the Safeguarding Office quality assure these.

Training For Trainers Courses. In 2011 we ran one 8 day training for trainers' course, as a result the multi-agency training pool membership swelling to a very healthy 45 active trainers. We also ran a 5 day train the trainers aimed specifically at the independent care sector. This resulted in 8 staff from the sector being trained and now able to deliver safeguarding awareness training to their own and other independent sector organisations. This new 'IPV' pool is being supported by SCC's workforce development unit at Brockwood.

Cert Ed/PGCE achievements. Members of the multi-agency training pool have successfully undertaken an abridged Cert Ed/PGCE course through Sheffield Hallam University.

Training Pool Delivery. The trainers in the multi-agency training pool have increased the range of programmes they can deliver on this year. The training pool continues to show great commitment to supporting the delivery of the multi-agency programme. Their dedication is reflected in the number, range and quality of programmes being delivered and SASED wishes to formally thank each of them and their organisations for their contribution, it is an essential and highly valued part of the multi-agency training delivery.

Service User Engagement. Forum in place and involved in advising and developing training materials for multi-agency programmes.

Engagement with GP Consortium. Inclusion of Safeguarding at GP Consortium Meetings has been well received resulting in plans to roll out training to all GP Consortium in 2012/13.

Hate Crime Materials. Hate crime training materials have been developed and incorporated into multi-agency training programmes and included in in-house safeguarding awareness programmes.

Working Relationship with Colleges and Universities. Safeguarding is now included as a module in Sheffield Colleges Health and Social Care programme for 16-17 year olds.

- **Developing a Safeguarding Competency Framework linked to roles and training.** Good progress has been made to map the national Learn to Care Adult Safeguarding Competency framework against the multi-agency training programmes and types of roles within health and social care organisations. The Operational Board has endorsed SASED's proposal that in 2012/13 all organisations will be required to map all their organisational job roles against both the competency framework and the related multi-agency training, and subsequently complete a full training needs analysis of their organisations safeguarding training requirements based on this framework.

Benefits and Challenges

- **Key benefits to organisations being part of SASED are opportunities to share development needs and opportunities with partner organisations and share best practice.**
- **Be able to raise practice issues and respond through agreed and standardised multi-agency training**
- **Be supported to benchmark organisation requirements against national competencies and standards.**
- **Develop skilled Safeguarding trainers who can deliver both into the multi-agency pool, but also directly back into own organisations.**
- **Challenges facing organisations and SASED members are maintaining member engagement and contribution to the multi-agency work of SASED.**

Looking Ahead 2012/13

- SASED priorities continue to include ensuring committed partner representation and engagement in Safeguarding Training and Development through attendance at SASED meetings.
- An increase in service user involvement in the safeguarding training we develop.
- Ensuring that the organisational mapping of roles and training requirements is completed by all partner organisations to enable a competency based education training model can be rolled out by 2013.

Sarah Pack
Chair of SASED

Report from the Development & Training Manager: Education & Training

The Safeguarding Adults Office Development and Training section continue to offer a core multi agency training programme across the city. These courses are constantly being reviewed, monitored and updated in line with changes in policy and procedure, legislation and feedback from students and trainers. We review current trends, media coverage and information and ensure that our courses fully support staff to safeguarding adults at risk of harm or abuse.

To maintain our high standards we routinely offer high quality training; the Safeguarding Adults Development and Training section has rolled out the following development options in 2011/12:

- New partnerships with local Colleges and Universities.
- Development and Training of GPs and GP surgery staff.
- South Yorkshire Training Group.
- Competency Framework.
- New initiatives and development events.
- Sheffield Trainers Group.

The core programme and many of the additional development training and initiatives are delivered by members of the Sheffield Trainers group, who are qualified, competent and dedicated trainers, who volunteer their time with the support of their host organisations. Without their commitment we would not be able to offer the vast range of training and development opportunities on offer in the city.

Development and Training Manager

This post has been covered on a secondment basis until May 2012, when a permanent post was agreed. This is a positive step forward for the Safeguarding Adults Office. It means that initiatives and training events can be planned and rolled out across the city with the security that they can be sustained. Discussions about training and development needs can take place with partners and other providers to identify training needs and plan for their scheduling.

Amalgamation with Mental Capacity and Deprivation of Liberty (MCA)

In early 2011 the Safeguarding Adults office joined forces with the MCA office and as a result the training programme now includes MCA training inclusion in core programmes and specialist MCA development events to increase practitioners' confidence in practice. We have introduced workshops, master classes and also invested in a new e learning programme.

New Partnerships with Colleges and Universities

One of the initiatives identified in last years report was in relation to developing and maintaining working partnerships with further education and higher education providers in Sheffield and these exciting new partnerships with were established in late 2011. This included:

- Delivering a Safeguarding Adults session on the Health and Social Care course at a range of Sheffield College sites; these sessions enabled us to raise awareness around adults at risk, to young people who were considering health and social care as a profession.
- Delivering a safeguarding awareness session to psychology students.
- Contributing to a trial careers day at Peaks College for health and social care students, the careers day was very well received and there are plans to organise a second one in 2012 and extend it to all students from all four college sites.

Sheffield University in 2011 also invited us to provide regular inputs on the Social Work degree courses and the Clinical Psychologist courses which have been well received and the feedback has been very positive. In 2012 the Sheffield Training Group gained two new members, who are lecturers at Sheffield Hallam University and along with an exiting member, they will continue to deliver safeguarding sessions at Sheffield Hallam and be champions within their own organisation.

Development and Training of GPs and GP surgery staff

In early 2011, there was a great deal of national debate in relation to 'GP Consortiums' and the way forward. We wanted to try and be pro active and deliver training and awareness sessions before the consortiums were formed to raise the profile of safeguarding and agree its inclusion as a key target In f 2011 we began delivering mini workshops at GPs surgeries on both safeguarding and MCA. We are working with Sheffield PCT to deliver a specialist PLI event for GPs in the near future.

South Yorkshire Training Group

The South Yorkshire Training Group consists of representatives from the four South Yorkshire local authorities and South Yorkshire Police and all members have a key role in their organisations in relation to training and development. The group meet on a regular basis and one of their main aims is to ensure there is good practice across the county. Over the past few years the group have worked closely on designing and sharing delivery of a two day "Working Together" course which is attended be staff from health, social care and the police with the primary goal of supporting effective information sharing. In light of positive evaluation and a commitment to continuing professional development (CPD) the following courses have been added to the regional programme:

- Three, two day 'Working Together' courses.
- Two development workshops (hate incidents and interpreting care plans etc).
- Two master classes (Sexual Trauma Syndrome and second to be confirmed).

These will be actively evaluated to determine if they will remain priorities in 2012/13.

Competency Framework

In November 2012, Bournemouth University published a set of competencies for staff and volunteers working vulnerable adults. The document outlined a number of competencies and performance indicators for staff. In collaboration with our South Yorkshire colleagues have developed a framework which has been circulated to all partner agencies for discussion and will result in a the creation of a formal assessment tool to map competence in 2012/13.

Safeguarding Advisory Forum

This was one of the key targets for 2011/12 was a more formal engagement of service users within Safeguarding adults, the enthusiasm the service users has shown has been very positive and we would like to thank colleagues in business strategy for their support and assistance with this work. The group held its first formal meeting and has since agreed Terms of Reference and contributed to the review of education and training materials. We are confident that this positive relationship will bring greater benefits in the coming year.

New Initiatives and Development

- Eight day, accredited trainers course.
- Two day investigating skills course for safeguarding investigators.
- Two day Safeguarding Managers Course.

- Five day, non accredited trainers course for Independent, Private and Voluntary Sector staff.
- Vulnerable Adult Risk Management Model (VARMM).
- Mental Capacity Act Master Classes.
- Assessing Mental Capacity throughout the Safeguarding process.
- Implementation of the Mental Capacity Act in Care Home Settings.
- Implementation of the Mental Capacity Act in Health Settings.
- Managing Safeguarding Alerts.
- Running Effective Strategy Meetings.
- Conducting Effective Investigations.
- Interview Skills/Interview Recording Skills.
- Quality Assurance of the Investigation Process and Preparing for Case Conference.

These courses are well attended and receive excellent feedback. The dates are planned for 2012 and hopefully the programme will be sustainable throughout 2013.

Sheffield Trainer's Group

A huge thank you is extended to all the trainers who form part of the Sheffield Trainers Group. The member's commitment to safeguarding adults at risk and ensuring staff receive quality training is exemplary.

The training group in Sheffield is a key factor in all of the information provided for this report, as many of the session would not be possible without the commitment of the trainers on the pool. We continue to invest in the group membership by not only training new trainers, but also ensuring we offer development workshops and training sessions to maintain their own CPD around training methodology, materials and course content but also around changes in safeguarding policy and practices. The members are also actively engaged in the design and development of new material and courses, sharing their wealth of experience and knowledge.

The past eighteen months has seen many organisations undergo cuts in budget and staffing levels. Many members of the group have seen an increase in their own work load and responsibilities. However they have continued to engage with the programme and deliver quality, effective sessions to over 2741 attendees. Their knowledge, willingness and professional and personal commitment are a credit to Sheffield.

Safeguarding Adults Education and Development Activity

A total of 2741 training places were delivered in 2011/12 compared with 2276 in the previous year. The increase is directly linked to the employment of a permanent Development and Training Manager, which has not only facilitated the running of the core training programme but also further development workshops, seminars and conferences. A total of 1399 training places were delivered "in house" by accredited trainers who form part of the Sheffield Safeguarding Adults Training Pool.

The tables below indicate the breakdown of courses and their attendance by organisation.

The half day and one day courses are still popular and continue to evaluate well and meet attendee's needs, assisting them to transfer knowledge into the workplace. This year we have piloted training for trainer's course for the Independent, Private and voluntary sector so that training can be delivered within those organisations. It is also hoped that our statutory partners will increase their ability and capacity to deliver this course in house in the coming year and there are plans to support this by running a similar training course, to equip staff to deliver safeguarding at ground level within their own work environments.

Half day Safeguarding awareness

Organisation	Number of delegates
Communities	22
Sheffield Teaching Hospitals NHS Foundation Trust	33
Sheffield Health and Social Care NHS Foundation Trust	34
Sheffield Homes/ Housing Associations	17
Sheffield Primary Care Trust	15
Nursing and Residential care	21
Home Care	4
Charity/Voluntary Sector	89
Other	6
Totals	**241**

Update course

Organisation	Number of delegates
Communities	5
Sheffield Teaching Hospitals NHS Foundation Trust	28
Sheffield Health and Social Care NHS Foundation Trust	80
Sheffield Homes/ Housing Associations	10
Sheffield Primary Care Trust	8
Nursing and Residential care	12
Home Care	4
Charity/Voluntary Sector	66
Other	1
Total	**214**

Uptake of this course remains constant, Sheffield Health and Social Care NHS Foundation Trust demonstrated a strong commitment to staff training this year, taking up large numbers of places on all courses and commencing the process of developing and enhancing their own internal group of accredited trainers.

Referrers course

Organisation	Number of delegates
Communities	14
Sheffield Teaching Hospitals NHS Foundation Trust	8
Sheffield Health and Social Care NHS Foundation Trust	14
Sheffield Homes/ Housing Associations	6
Sheffield Primary Care Trust	4
Nursing and Residential care	5
Home Care	12
Charity/Voluntary Sector	20
Other	6
Total	**101**

In the referrers course we begin the process of looking at specific roles and responsibilities within the safeguarding process and the continuous demand for this course reflects the desire of staff to have a clear picture of how they contribute to the safeguarding process and clarity about their roles.

Beyond Strategy Meeting course

Organisation	Number of delegates
Communities	17
Sheffield Teaching Hospitals NHS Foundation Trust	3
Sheffield Health and Social Care NHS Foundation Trust	2
Sheffield Homes/ Housing Associations	5
Sheffield Primary Care Trust	2
Nursing and Residential care	3
Home Care	8
Charity/Voluntary Sector	16
Other	5
Total	**51**

Managing Staff in the Safeguarding Process course

Organisation	Number of delegates
Communities	6
Sheffield Teaching Hospitals NHS Foundation Trust	3
Sheffield Health and Social Care NHS Foundation Trust	4
Sheffield Homes/ Housing Associations	6
Sheffield Primary Care Trust	2
Nursing and Residential care	14
Home Care	5
Charity/Voluntary Sector	28
Other	4
Total	**72**

The Beyond Strategy and Managing Staff in the Safeguarding Process were both re designed and piloted towards the end of 2011. Both now contain a structure and material which looks at the more complex issues of safeguarding and managing staff. However there have been a couple of these courses in the last eight months which have had little or no response and have had to be cancelled even though both courses have continued to have excellent feedback and evaluation regarding course content and relevance to role and safeguarding. This year we intend to re visit the material and look at how we can market the two courses to achieve an increase in attendees.

Training for Trainers - accredited 8 day course

Organisation	Number of delegates
Communities	2
Sheffield Teaching Hospitals NHS Foundation Trust	2
Sheffield Health and Social Care NHS Foundation Trust	1
Sheffield Homes/ Housing Associations	2
Sheffield Primary Care Trust	2
Nursing and Residential care	2
Home Care	1
Charity/Voluntary Sector	2
Other	1
Total	**15**

This course continues to be in great demand, as it represents the only accredited course in the Yorkshire and Humberside region. It enables us to provide quality training and assessment and quality assure the training which is delivered by the Safeguarding Adults Office in Sheffield. It also means that with the managed expansion of the training pool, the demands on pool members are reduced and we have some flexibility when trainers are no longer able to commit to its membership.

In addition to this course we have piloted a five day training course (non accredited) for people who will be responsible for delivering training, in house in the Independent, Private and Voluntary Sector. A similar course is planned for 2012 for Sheffield Health and Social Care NHS Foundation Trust staff.

Workshops

Title of Workshop	Total
Joint workshop with children's services	36
VARMM (Vulnerable Adult Risk Management Model)	119
Mental Capacity Act (MCA and Deprivation of Liberty (DOL)	79
Managing Safeguarding Alerts	67
Assessing Mental Capacity in the Safeguarding process	43
Exiting the Safeguarding Process	10
Quality Assurance of the Investigation Process	15
Running Effective Strategy Meetings	29
Total	**397**

With the establishment of a permanent Development and Training Manager we wanted to ensure that as a training establishment we are continuously reviewing the courses we offer and tailor them to meet the ever changing needs of health and social care and its staff. We wanted to offer additional workshops which would compliment and build on existing courses and enable attendees to pick and mix courses which best suited their roles and responsibilities. This year has seen the introduction of new, innovative workshops, many of which focus on specific areas of the safeguarding process and provide more in depth knowledge, comprehension and application. These courses have received very positive and encouraging feedback and further workshops have been added to the above list and will be reported on in next year's annual report.

Investigator Training

Organisation	Number of delegates
Communities	18
Sheffield Health and Social Care NHS Foundation Trust	11
Other	2
Total	**31**

There have only been two investigators course offered in 2011/2012 so less people have received the training then did last year. This is because although we wanted to provide training to new attendees on this course we also wanted to provide some development workshops and events for existing investigators and invest in their continuous development. Further developments being explored for 2012/2013 are the accreditation of the investigators course and other courses. If successful these will quality assure the course and attendees and also provide evidence and supports the fact that we are committed to valuing are attendees and the work they do.

Safeguarding Manager

Organisation	Number of delegates
Communities	12
Sheffield Health and Social Care NHS Foundation Trust	3
Total	**15**

Evidence for last years report indicated that although this was an excellent course, Safeguarding Managers, Senior Practitioners and other Managers indicated that they would benefit from other specific workshops. These were instigated and as shown above as a pilot scheme, were well attended. These workshops are part of the programme for 2012/2013 and will become part of the core programme in January 2013. This is another course which we are seeking to be accredited and recognised as a quality course which meets national qualifying standards.

Working Together to Safeguard Adults course

Organisation	Total
Communities	5
Sheffield Health and Social Care NHS Foundation Trust	2
Police	
Other	8
Total	**15**

The South Yorkshire Training Group is made up of representatives from the four South Yorkshire local authorities and South Yorkshire Police. All members have a key role in Safeguarding Adults within their organisation and services. In essence the group is a support mechanism for members. It meets on a regular basis and allows for ideas and new initiatives to be shared between the members including good practice and developments in training. The group members are dedicated to ensuring that there is a multi agency, multi discipline approach to safeguarding and a corporate approach across the partnership areas. The two day Working Together programme will continue to run in 2012/2013. In past years there have been six, two day courses per year. This year we have decided to run three, two day courses and to use the other time and money to provide workshops and training sessions to people who have attended previous Working Together courses and require some networking or further development and training.

Education delivered within Partner Agencies (in house)

Organisation	Number of delegates
Communities	660
Sheffield Teaching Hospitals NHS Foundation Trust	40
Sheffield Health and Social Care NHS Foundation Trust	276
Sheffield Homes/ Housing Associations	212
Sheffield Primary Care Trust	19
Nursing and Residential care	51
Home Care	0
Charity/Voluntary Sector	17
Other	124
Total (2257 - 2009/10 total)	**1399**

This is an increase on last years figures, which were lower than previous years and we felt the following could be contributing factors:

- A number of partner agencies have already trained the majority of their staff.

- A lot of agencies are struggling to release staff for any education and training that is not classed as mandatory.

But the increase is very positive and reassuring that safeguarding training is still being delivered, despite the demands on agencies and we continue to offer our support and encouragement wherever possible.

Partner agencies uptake of Safeguarding Adults education and training - in house and multi agency

Organisation	Number of delegates
Communities	766
Sheffield Teaching Hospitals NHS Foundation Trust	161
Sheffield Health and Social Care NHS Foundation Trust	434
Sheffield Homes/ Housing Associations	231
Sheffield Primary Care Trust	68
Nursing and Residential care	122
Home Care	53
Charity/Voluntary Sector	304
Other	155
Total	**2341**

Trainers and their Host Organisation

Organisation	Number of trainers
Communities	10
Sheffield Teaching Hospitals NHS Foundation Trust	1
Sheffield Health and Social Care NHS Foundation Trust	6
Sheffield Homes/ Housing Associations	5
Sheffield Primary Care Trust	4
Private Sector	5
Charity/Voluntary Sector	6
Places	1
Private Training	2
South Yorkshire Fire Service	1
Sheffield Hallam University	3
Total	**43**

The training pool in Sheffield in unique in the region and is a key factor in the volume and quality of courses that Sheffield Safeguarding Adults Office is able to deliver. In the pool we have a committed group of qualified, competent and dedicated trainers, who have a huge amount of knowledge, experience, dedication and people who are passionate about safeguarding vulnerable adults.

A huge thank you is extended to the pool members as without those Sheffield Safeguarding Adults could not offer the comprehensive training opportunities that is currently offers.

Priorities for 2012/2013

The Board has agreed the following priorities:

- Continue our relationship building with GPs, including the lead Adult Safeguarding GP and shadow Clinical Commissioning Group.
- Develop the Safeguarding Adults Board Policy and Practice in relation to financial abuse.
- Develop a Quality Assurance Programme across SASP to include standards, dignity and harm reduction, and links to the Quality Care in Care Homes Board.
- Develop a personalised outcome based approach to Safeguarding, including obtaining views on whether risk has reduced, to be integrated into the safeguarding pathway.
- Consider the under reporting areas, including Police, Criminal Justice and diversity characteristics, and develop best practice responses to the gaps following an assessment.
- Continue the service improvement in relation to transitions (progressions) for young people and Safeguarding and MCA.

Report to Healthier Communities and Adult Social Care Scrutiny & Policy Development Committee
16th January 2013

Subject: Care and Support Update

Summary:
Following the discussion on Care and Support Performance at the October meeting of the Committee, an update was requested for January, including information on the Self Directed Support process and how it is presented to new service users.

The Committee will receive a presentation, and background information on the Self Directed Support process is attached to accompany it.

Type of item: The report author should tick the appropriate box

Reviewing of existing policy	
Informing the development of new policy	
Statutory consultation	
Performance / budget monitoring report	
Cabinet request for scrutiny	
Full Council request for scrutiny	
Community Assembly request for scrutiny	
Call-in of Cabinet decision	
Briefing paper for the Scrutiny Committee	**x**
Other	

The Scrutiny Committee is being asked to:
Note the attached information.

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Adult Social Care and Support:
What information is available to people new to the service?

We have a wide range of detailed resources that can provide people with everything they need to know when they first come into Adult Social Care.

However, in order not to overwhelm someone when a worker goes out to make the first visit, we have a number of documents that provide the person with the key information and a clear process for how they can find out more:

- **Self Directed Support Information Leaflet** – the 7 steps through Adult Social Care in Sheffield
- **Look Again Fact Sheet** – how to query any decisions that have been made by us about your support
- **Risk Enablement Panel Fact Sheet** – positive risk taking and challenging decisions about risk
- **Guide to choosing how to plan your support**

It is part of the worker's role to know what information is available and tailor it to the individual, providing it in the best, most accessible format for that person and at the most appropriate time along the way.

The person should then have the key information that they need but also be supported to find out more on what they need or want to know. They are signposted to our website where we have a wide range of information, guides and factsheets. We would provide support where necessary to enable the person to access this information in whatever format works best for them.

Below are some of the resources people can access following their first visit with the worker. By providing as much information as possible we aim to make the process transparent, fair and equitable:

- **Care and Support for Older People and Disabled Adults Booklet**
- **Guide to Self Directed Support and Personal Budgets**
- **Assessment Questionnaire for a Personal Budget**
- **Guide to Support Planning** – including tools to help plan your own support, example plans and other example documents used in the planning process
- **Stories and example support plans**
- **Support planner and Broker quality standards**

At the appropriate points along the self directed support process a person will also be provided with information on their financial assessment, ways of managing their money and Direct Payments. All of this is also available on the Adult Social Care website.

If you are interested in reading more about what information is available it can all be accessed and viewed on the Adult Social Care website:

www.sheffield.gov.uk/asc

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You can choose your own support and we can help.

Adult Social Care in Sheffield is changing to put you in control - it is your life, your choice and your support.

What is my life going to be like?

You can choose the support that you want to suit your needs.

You can self-direct your support. You are at the centre of the decisions which affect your life.

Support is not about someone else doing something for you. It's about working together to decide what's best for you.

Your support

- will be delivered in a personal and flexible way
- can give you freedom and independence to live your life
- can help you to meet new people and make new friends
- can give you the confidence to do the things that you have always wanted to.

How can I get this?

This will be the way that everyone will receive support. If you are currently receiving support from adult social care, this will be the process that will be in place for your review.

If you are over 18 and are not already receiving support, but you think that you may need some, you can contact our Adult Access Team on **0114 273 4908**. The team will advise you on whether you can receive support from adult social care.

How can I find out more?

For more information, you can visit our **website: www.sheffield.gov.uk/asc**

Or you can contact the Self Directed Support Team on:

Telephone: 0114 273 6837

Email:
selfdirectedsupport@sheffield.gov.uk

Address:
Redvers House
Floor 10
Union Street
Sheffield S1 2JQ

This document can be supplied in alternative formats, please contact 0114 273 6837

Sheffield City Council
Self Directed Support Team
www.sheffield.gov.uk/asc

DP12046

your life your choice your support

Personal budgets and Self Directed Support

Sheffield Health and Social Care NHS
NHS Foundation Trust

Customer Service Excellence

Sheffield City Council

How it works if we agree we can support you.

You are involved in the decision-making right from the start.

1 The first step is to fill out a questionnaire which will tell us about your needs. You will be supported by your social worker, care manager or care coordinator to do this. You can also choose to have your family, friends or an advocate there if you wish, but it will still be your questionnaire.

2 We can then use this information to work out how much money is available to help you plan your support to meet your needs. We will also work out how much you can afford to pay towards your support depending on how much money you have.

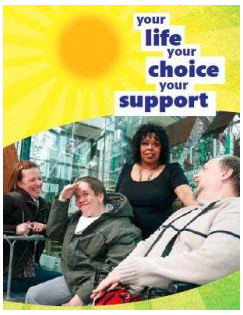
3 You can choose how you would like to spend this money, providing it meets your support needs, it is legal and it keeps you safe. This is called your support plan.

4 When writing your support plan, you can choose to manage the money and organise the support yourself. However, you can also ask for a family member, an agency or the council to do this for you.

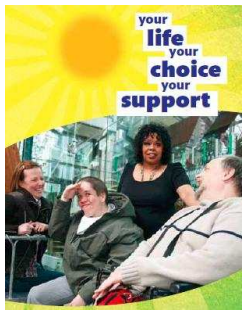
5 Your support plan will also help you plan for when things go wrong so that you know what will happen if there is an emergency.

6 Once your support plan has been agreed, the money will be released to organise your support. Then you can get on with living your life the way you want to.

7 We will review your support plan with you once a year or earlier if needed. This is to make sure that it is still meeting your needs and that you are happy with the support that you have chosen. We can also help you to make any changes that you might like.



Choosing how to plan your support



When it comes to writing your support plan it is really important that you know about all of the options available to you. There are many ways you can stay in control of planning and organising your support. This fact sheet can help you to decide how to do this.

There are three ways that you can choose to plan your support:

1. Planning myself, or with family and friends
2. Planning with a non-council Support Planner
3. Planning with a council Support Planner

You will also find it useful to know roughly how long it will take to plan your support. This will help you to understand roughly how much it might costs if you decide to pay for help. This information is available in section 4:

4. How long does support planning take?

If you would like more information or have any questions then you can talk to your social worker, care manager or care co-ordinator or visit our website www.sheffield.gov.uk/asc.

1. Planning myself, or with family and friends

What does this mean?
Lots of people often choose and enjoy writing their own support plan. Writing your own plan means you will need to spend time thinking about how you would like to be supported and plan how you will receive this support. Your social worker will then check your support plan when you have finished it and will help you to get it signed-off.

What are the advantages of planning by myself or with family and friends?

- By planning yourself you are completely in control of your support plan, including how it is put together and the amount of time you want to take working on it.
- It won't cost you anything to plan yourself.
- Even though they are not going to be planning with you, your social worker, care manager or care coordinator is still responsible for checking your plan and helping to get it agreed.

How do I contact people who can help?
You can choose who you want to help you write your support plan, including friends, family, your GP and other people who are important in your life. If you need help getting started your social worker can guide you and they will give you

their contact details when you do your assessment. You may also find that there are some free support planning services available in your community, which you will be able to find by searching the Sheffield Help Yourself database. You can do this yourself by visiting their website at www.sheffieldhelpyourself.org.uk or calling 0114 273 4763 and they will send you a list of the services you want. You can also choose to buy support from support planning professionals but you will need to pay for this using your personal budget. More information on this is below.

Where can I find resources to support me to plan?
There are lots of free resources that you can find online, especially at www.sheffield.gov.uk/asc-supportplan. If you do not have a computer you can use a computer at a library, ask a friend or family member to get information for you or you can call your social worker, who will send you the information you need.

How much will this cost?
Writing your own plan will not cost you anything. All of the resources are free. However, you may wish to thank the people or person who helped you with an appropriate gift. If so, then this can be paid for from your personal budget.

2. Planning with a non-council support planner

What does this mean?
In Sheffield, lots of people have been trained up to help people write their support plans. They work for a range of different organisations across the city including charities, providers, community centres and private businesses. These people provide support planning in the same way as any other service; you choose the person you want and they work for you, helping you to plan your support in the way that you want.

What are the advantages of planning with a non-council support planner?

- An independent support planner can often work with you very flexibly at times and in ways that make sense to you.
- Because you buying a service from this person, it gives you greater control over how information is presented to you, the work you can ask them to do and how quickly you can ask them to do it.
- You can choose from a range of people and plan with the person you most want to work with.
- You will benefit from the expertise of someone who has experience of support planning and knows about support and services available in the city – you can even choose someone with specific skills and experience of your circumstances, such as your culture or the area your live in.
- Your independent support planner will also be responsible for giving your social worker, care manager or care coordinator a copy of your plan so that they can get it agreed for you.
- Even though they are not going to be planning with you, your social worker, care manager or care coordinator is still responsible for checking your plan and helping to get it agreed.

How do I contact non-council support planners?
You will find a list of all support planners in Sheffield on the Sheffield Help Yourself database. You can search through this yourself by visiting their website at www.sheffieldhelpyourself.org.uk or call 0114 273 4763 and they will send you a list of the support planners in your area. You can also ask your social worker to do this for you.

How much will this cost?
Each different support planner will tell you their costs so that you can decide who you would like to pay. You can find out each support planner's costs by searching the Sheffield Help Yourself database, as explained above. You do not have to use your own money to pay for this help; you can use some of the money from your personal budget. Also, whilst you will have a financial assessment to see if you can afford to contribute towards some of your support, you will not have to make any contributions towards the cost of your support planning.

3. Planning with a council support planner

What does this mean?
All social workers, care co-ordinators and care managers are trained to assist people with writing support plans. Alongside their other duties they can help you to find the support that suits you and to put it in place.

What are the advantages of planning with a council support planner?

- You may prefer this option if you have known your social worker for long time and feel that you have a good relationship with them.
- They will have experience of support planning and knowledge of services and support available in the city.
- Your social worker, care manager or care coordinator will also be responsible for getting your plan agreed.

How do I contact council support planners?
In most cases your social worker will act as your council support planner, so you will already be in touch with them. In some cases your social worker will introduce you to another worker but either way this will be organised for you.

How much will this cost?
There is a cost when your social worker/ care manager/ care co-ordinator helps you to write your support plan, just as there is for an independent support planner. The standard cost for council support planning is £27.11 per hour. You do not have to use your own money to pay for this help; you can use some of the money from your personal budget. Also, whilst you will have a financial assessment to see if you can afford to contribute towards some of your support, you will not have to make any contributions towards the cost of your support planning.

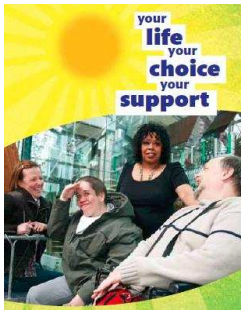
4. How long does support planning take?

The chart below gives you an idea of roughly the amount of time a support plan should take, depending on the person's level of need.

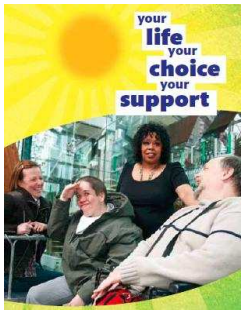
Level of need	**Hours spent planning**	**Reasons**
A straight-forward standard plan using a personal budget	10	This should be roughly: • 1 hour - initial introduction and thinking through some options • 2 or 3 hours - putting the body of the support plan together • 1 hour - office time for typing and phone calls etc • 2 or 3 hours - costing out and finalising all the options • 2 hours - any additional visits, activity or office-based work
A Support Plan using multiple funding streams (an individual budget) requiring meetings with other professionals	10 - 15	Because there are a number of funding streams, support planners may need to have meetings with a number of different professionals and agreement may be required from a number of different decision-makers. This is in addition to the work set out for a standard plan.
A Support Plan where the person has very complex needs, or where there are capacity or safeguarding issues and a multi-agency or best interest approach is needed	15 - 25	Needing to carefully plan and unpick issues as well as plan in a more multi-disciplinary way may mean that the planning needs a more step by step approach. More time needs to be available to enable the person to work through their options, try a range of activities or services and for any planning meetings to be held with the person involving lots of other people.

All of these figures are only estimates. Sometimes we find that a person with very complex needs and many professionals involved in their care can take a very short amount of time, whilst someone who is able to take more control over their plan may need lots of time to look at their options and have real choice.

Other individuals they may also want to take their time over planning. For example a young person moving from children's to adult's services who does not need their plan in place until July may be planning carefully for 3 or 4 months. However, they will still only pay for the hours spent actually planning, regardless of how much time passes between each planning session.



Look Again Process
Fact Sheet



What is it?

The Look Again process is a way for people accessing adult social care and their representatives, to request that decisions made about their needs and/or support is reconsidered.

The Look Again process enables you to ask us about the decisions we have made about your support.

Using the Look Again process does not stop you or your representative accessing the complaints procedure.

How to use the Look Again process

If you are unhappy with a decision that has been made then you should talk to your social worker, care manager or care coordinator and make them aware that you are unhappy.

They will record this and notify the Team Manager.

The Team Manager has five working days to get in touch with you to tell you what is going to happen next.

The options for what happens next are:

a. The manager arranges to meet with you to talk through the issues and try to resolve them
b. The manager agrees actions with your social worker / care manager / care coordinator to try and resolve the issue
c. The manager identifies a different worker to undertake actions and work with you to resolve the issue
d. Whichever way we agree to help resolve the issues, we will do this within 20 working days
e. If you are still not happy with the outcome of the Look Again process, you still may choose to access the Complaints Procedure.

When you can use the Look Again process and why

The Look Again process can start at any point in the self directed support process at which a decision has been made. This could be when you have an assessment, re-assessment, when your support is being singed off or at a review.

Assessment:

- You or your representative don't feel their needs have been fully considered
- Concerned about the way eligibility has been applied
- Someone else wants to make changes to your assessment and you disagree
- You feel that your views were not properly represented.

Support Plan:

- If it is not agreed either in full or partially, for example some or all of the things you wanted to do to meet your eligible needs have not been agreed
- If there is something in your support plan we feel is very risky and you disagree (Look Again seeks a second opinion).
- If we still cannot agree together then it can be referred to the Risk Enablement Panel
- If the decision maker suggests an alternative form of support and you are not happy with it.

Personal Budget Review:

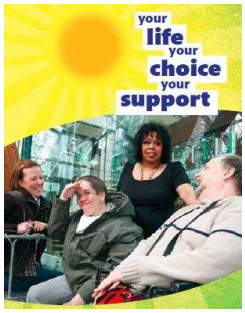
- If you are unhappy with what has been recorded in your personal budget review
- If you feel your views have not been properly represented
- Following your review, changes you want to make to your support haven't been agreed.

Reassessment:

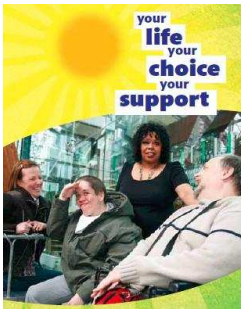
- You or your representative don't feel their needs have been fully considered
- Concerned about the way eligibility has been applied
- Someone else wants to make changes to your assessment and you disagree
- Your feel that your views are not properly represented.

Further Information

If you would like to discuss the Look Again process, please contact your social worker, care manager or care coordinator.



Risk Enablement Panel Fact Sheet



Why do we have Risk Enablement Panels?

We have to make sure that your support plan will help you to stay healthy, safe and well. This means that we have to consider any risks that might be part of the support you have chosen. For example, choosing to walk alone to catch a bus, rather than choosing a taxi to pick you up from your house.

When we decide whether to sign-off your support plan, we must consider these risks. Sometimes if we are worried about the risks in your plan we might choose not to agree your support plan.

If you don't agree with us, you can ask to challenge this decision and we will look at your support plan again. This may happen through a Risk Enablement Panel.

You can use the flowchart on page 3 to help you follow the process.

What is a Risk Enablement Panel?

This is a meeting where you and other people involved in signing off your support plan can discuss anything in your support plan that may pose a risk to your health or safety.

It gives everyone an opportunity to reach a shared decision to either:

- recommend that your support plan be agreed
- provide advice to help you think about the risks in your support plan.

Who is involved?

You will be invited to the Panel.

The other Panel members will be the people who make sense to discuss the specific issue in your support plan.

Your social worker, care manager or care coordinator is responsible for making sure the organiser of the Panel has all of the information they need about your support plan. The same person will be available to talk to you about the Panel if you have any questions.

The Panel will value every member's contributions and recognise individual skills and experience.

When will the panel meet?

The Panel will only meet if someone makes a request to look at risk within your support plan. Your meeting will take place within 20 days of the request. It will meet on a date and at a time convenient to you.

You should receive all relevant information two days before the meeting date. If not, then contact your social worker, care manager or care coordinator.

How does it work?

The Panel's main responsibility is to advise on whether or not they think your support plan should be signed-off and why.

To do this, it will take into account:

- Your choices as an individual
- Responsibilities that we share with you, your family and carers, and our partners including health and social care providers.

The Panel also offers advice, guidance and support to help all members consider all possible outcomes and reach an informed decision.

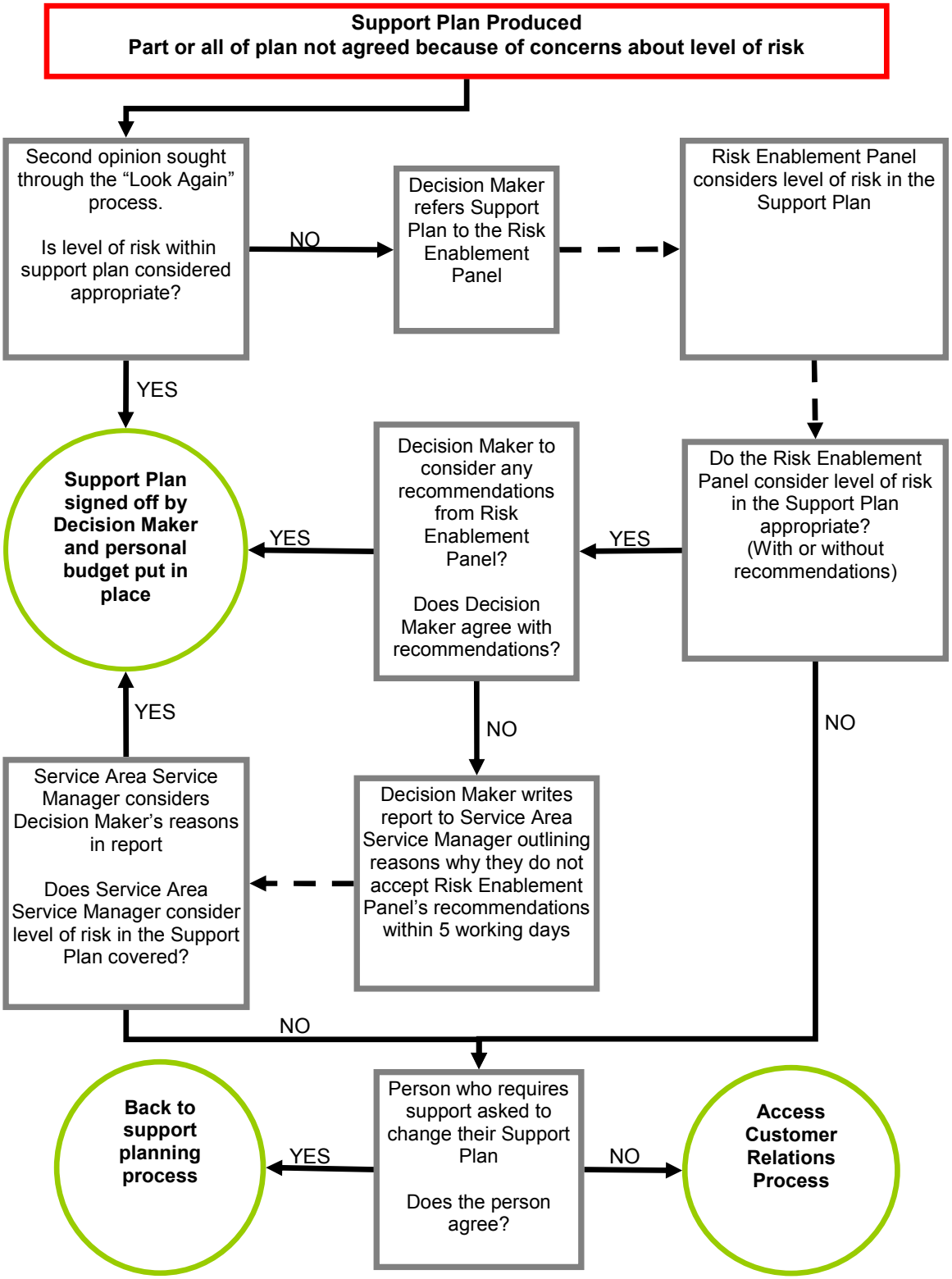
The Panel does not have the power to sign-off your support plan, but it does have the power to make recommendations about outcomes or courses of action.

The final recommendation will be based on the view of the majority of Panel members.

What are the next steps?

If you are not happy with the decision reached by the Panel then you can access the complaints process through customer relations.

Risk Enablement Panel Process Flowchart



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Report to the Healthier Communities & Adult Social Care Scrutiny and Policy Development Committee

16th January 2013

Report of: **Emily Standbrook-Shaw**
Policy Officer (Scrutiny)
emily.standbrook-shaw@sheffield .gov.uk; 0114 27 35065

Date: 16th January 2013

Subject: **Work Programme and Cabinet Forward Plan**

The Committee's draft work programme is attached for consideration.

The Committee is asked to identify any further issues for inclusion in the work programme as agenda items, or in depth task and finish reviews.

To ensure that information coming to the Committee meets requirements, Members are requested to identify any specific approaches, lines of enquiry, witnesses etc that would assist the scrutiny process for items on the work programme.

The latest version of the Cabinet Forward Plan is also attached. Consideration of issues at an early stage in the development process gives scrutiny an opportunity to make recommendations to decision makers and maximises scrutiny's influence. The Committee is therefore requested to identify any issues from the Forward Plan for inclusion on a future agenda.

Recommendations:

That the Committee:

- Considers the work programme and Cabinet Forward Plan
- Identifies further issues for inclusion on the work programme

Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee
Draft Work Programme
Last updated 13 November 2012

What	Why	How	When
Right First Time	*To consider the progress, future plans and outcomes from the Right First Time programme*	Report	16th January 2013
Non-clinical circumcisions	*NHS Sheffield CCG are seeking views on their proposals*	Report	16th January 2013
Adult Safeguarding	*To consider the annual safeguarding adults report and any issues arising from it.*	Report	16th January 2013
Experience of Care and Support – performance review	*To consider and comment on activity being undertaken to improve experience of care and support including how the process of assembling Self Directed Support (SDS) plans could be streamlined in order to improve waiting times; The revised performance indictors upon which the effectiveness of the SDS service can be measured; and role and performance of the Equipments and Adaptations service and Occupational Therapy within the SDS service*	Presentation – follow up from October meeting.	16th January 2013

Quality Accounts	*To consider and comment on the annual quality accounts of NHS providers in the City, as required by the Department of Health*	Discussions with Trusts	February 2013
Protocol for the Scrutiny of Health in Sheffield	*To refresh the protocol for the Scrutiny of health in Sheffield to reflect the changes to health and wellbeing structures in Sheffield brought about by the Health and Social Care Act 2012.*	Report	20th March 2013
Local Account	*Committee to have early input into the elements that make up the Local Account*	Report	Summer 2013
Self Directed Support	*To consider progress made in rolling out personalised budgets*	Report	TBD
Anti Social Behaviour Review	*With a particular focus on impact of anti social behaviour for people with learning disabilities.*	TBD	TBD
Sheffield Food Plan	*To scrutinise progress of the Sheffield Food Plan*	TBD	TBD
Child and Adolescent Mental Health Services	*To agree a terms of reference for a scrutiny task and finish exercise into waiting times for Tier 3 CAMHS*	Working Group	Ongoing
Nutrition and Hydration in Hospitals	*To consider support given to patients to eat and drink in hospitals, and to consider quality of food in hospitals*	Working Group	Ongoing

Paediatric Cardiac Surgery	*To scrutinise outcomes for children in Yorkshire and the Humber following the decision to reconfigure children's heart surgery centres.*	Through the Yorkshire and Humber Joint Scrutiny Committee.	Ongoing

CABINET DECISIONS AND KEY INDIVIDUAL CABINET MEMBERS AND EXECUTIVE DIRECTOR DECISIONS

Quarterly Forward Plan of Executive Decisions 3 January 2013 To 30 April 2013.

NOTE:

1. This schedule provides amongst other decisions, details of those Key Executive Decisions to be taken by the Cabinet , Individual Cabinet Members or Executive Directors in 28 days and beyond as required by Section 9 of The Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012.

2. The membership of decision makers are as follows:

   - **Cabinet** - Councillors Julie Dore (Chair), Harry Harpham (Deputy Chair), Isobel Bowler, Leigh Bramall, Jackie Drayton, Mazher Iqbal, Mary Lea, Bryan Lodge and Jack Scott)

   - Where **Individual Cabinet Members** or **Executive Directors** take Key Executive Decisions their names and designation will be shown in the Plan.

3. Access to Documents - Details of reports and any other documents will, subject to any prohibition or restriction, be available from the date upon which the agendas for the Cabinet and Cabinet Highways Committee and Individual Cabinet Member and Executive Director reports are published and accessible via the Council's web-site at www.sheffield.gov.uk. or can be collected at the Town Hall at the following address:-

   Democratic Services, Town Hall, Sheffield, S1 2HH

4. Where it is intended to hold a meeting, or part of a meeting, in private a notice will be published at least 28 days prior to the meeting in accordance with Regulation 5 of the Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012.

16 Jan 2013 Cabinet	Implementation of the Living Wage (K)	Cabinet Member for Finance and Resources (Councillor Bryan Lodge) Overview and Scrutiny Management Committee	Report of the Executive Director, Resources.	8/1/13	Resources Cheryl Blackett Tel: 0114 2734080 cheryl.blackett@sheffield.gov.uk

16 Jan 2013 Cabinet	Parkhill Redevelopment	Cabinet Member for Homes and Neighbourhoods (Councillor Harry Harpham) Safer and Stronger Communities Scrutiny Committee	Report of the Executive Director, Place.	8/1/13	Place Derek Martin Tel: 0114 2736639 derek.martin@sheffield.gov.uk
16 Jan 2013 Cabinet	The Successful Families Programme (K)	Cabinet Member for Children, Young People and Families (Councillor Jackie Drayton) Children, Young People and Family Support Scrutiny Committee	Report of the Executive Director, Children, Young People and Families.	8/1/13	Children, Young People and Families Sam Martin Tel: 0114 2296140 sam.martin@sheffield.gov.uk

16 Jan 2013 Cabinet	Redevelopment of the Fosters Phase 3	Cabinet Member for Homes and Neighbourhoods (Councillor Harry Harpham) Economic and Environmental Wellbeing Scrutiny Committee	Report of the Executive Director, Place.	8/1/13	Place Dave Mason Tel: 0114 2734617 dave.mason@sheffield.gov.uk
16 Jan 2013 Cabinet	School and College Attendance Strategy (K)	Cabinet Member for Children, Young People and Families (Councillor Jackie Drayton) Children, Young People and Family Support Scrutiny Committee	Report of the Executive Director, Children, Young People and Families.	8/1/13	Children, Young People and Families Diane Dewick Tel: 0114 2506865 diane.dewick@sheffield.gov.uk

16 Jan 2013 Cabinet	Revenue Budget and Capital Programme Monitoring 2012-13 (Month 7) (K)	Cabinet Member for Finance and Resources (Councillor Bryan Lodge) Overview and Scrutiny Management Committee	Report of the Executive Director, Resources.	8/1/13	Resources Allan Rainford Tel: 0114 2752596 allan.rainford@sheffield.gov uk
16 Jan 2013 Cabinet	Housing Revenue Account (HRA) Business Plan Update, HRA Budget and Rent Increase 2013/14 (K)	Cabinet Member for Homes and Neighbourhoods (Councillor Harry Harpham) Safer and Stronger Communities Scrutiny Committee	Report of the Executive Director, Communities.	8/1/13	Communities Liam Duggan Tel: 2930240 liam.duggan@sheffield.gov. uk

13 Feb 2013 Cabinet	Sheffield Regional City Region Regional Growth Fund Round 3 - Unlocking Business Investment (K)	Cabinet Member for Business, Skills and Development (Councillor Leigh Bramall) Economic and Environmental Wellbeing Scrutiny Committee	Report of the Executive Director, Place.	5/2/13	Resources Kevin Bennett Tel: 0114 2232416 kevin.bennett@sheffield.gov .uk
13 Feb 2013 Cabinet	Sheffield Development Framework:City Policies and Sites document and Proposals map - the Pre - submission version. (NOTE: This report will be submitted to the City Council on 3rd April, 2013) (K)	Cabinet Member for Business, Skills and Development (Councillor Leigh Bramall) Economic and Environmental Wellbeing Scrutiny Committee	Report of the Executive Director, Place and other appropriate documents	5/2/13	Place Peter Rainford Tel: 0114 2735897 peter.rainford@sheffield.gov

13 Feb 2013 Cabinet	Revenue Budget 2013-14 (K)	Cabinet Member for Finance and Resources (Councillor Bryan Lodge) Overview and Scrutiny Management Committee	Report of the Executive Director, Resources	5/2/13	Resources Allan Rainford Tel: 0114 2752596 allan.rainford@sheffield.gov uk
13 Feb 2013 Cabinet	Housing Strategy 2013 -23	Cabinet Member for Homes and Neighbourhoods (Councillor Harry Harpham) Safer and Stronger Communities Scrutiny Committee	Report of the Executive Director, Place.	5/2/13	Place Georgina Parkin Tel: 2736915 georgina.parkin@sheffield.g ov.uk

13 Feb 2013 Cabinet	Revenue Budget and Capital Programme Monitoring 2012/13 (Month 8) (K)	Cabinet Member for Finance and Resources (Councillor Bryan Lodge) Overview and Scrutiny Management Committee	Report of the Executive Director, Resources.	5/2/13	Resources Allan Rainford Tel: 0114 2752596 allan.rainford@sheffield.gov uk
27 Feb 2013 Cabinet	Vocational Skills Provision 2014 - 16 (K)	Cabinet Member for Children, Young People and Families (Councillor Jackie Drayton) Children, Young People and Family Support Scrutiny Committee	Report of the Executive Director, Children, Young People and Families	19/2/13	Children, Young People and Families Claire Slack Tel: 0114 2296140 claire.slack@sheffield.gov.u k

27 Feb 2013 Cabinet	Disposal of Land at Richmond Park Drive	Cabinet Member for Health, Care and Independent Living (Councillor Mary Lea) Safer and Stronger Communities Scrutiny Committee	Report of the Executive Director, Communities.	19/2/2013	Communities Dave Mason Tel: 0114 2734617 dave.mason@sheffield.gov.uk
27 Feb 2013 Cabinet	Disposal of Land at Sevenairs Road, Beighton	Cabinet Member for Health, Care and Independent Living (Councillor Mary Lea) Safer and Stronger Communities Scrutiny Committee	Report of the Executive Director, Communities.	19/2/13	Communities Dave Mason Tel: 0114 2734617 dave.mason@sheffield.gov.uk
27 Feb 2013 Cabinet	Modernisation of Planning and Highways Committees (Note: It is proposed that this item will be considered by the City Council meeting on 3rd April, 2013)	Cabinet Member for Business, Skills and Development (Councillor Leigh Bramall) Economic and Environmental Wellbeing Scrutiny Committee	Report of the Executive Director, Place	19/2/13	Place Graham Withers Tel: 0114 2037642 Graham.Withers@sheffield.gov.uk

27 Feb 2013 Cabinet	Voluntary Sector Grant Aid Investment in 2013/14 (K)	Cabinet Member for Communities & Inclusion (Councillor Mazher Iqbal) Safer and Stronger Communities Scrutiny Committee	Report of the Chief Executive.	19/2/13	Deputy Chief Executives Anne Giller Tel: 0114 2735126 anne.giller@sheffield.gov.uk
20 Mar 2013 Cabinet	The Future Delivery of Housing Repairs and Maintenance (K)	Cabinet Member for Homes and Neighbourhoods (Councillor Harry Harpham) Safer and Stronger Communities Scrutiny Committee	Report of the Executive Director, Communities.	12/3/13	Communities Jed Turner Tel: 27 34066 jed.turner@sheffield.gov.uk
20 Mar 2013 Cabinet	Procurement Contract for the Corporate Statutory Servicing and Repairs Contract (K)	Cabinet Member for Finance and Resources (Councillor Bryan Lodge) Overview and Scrutiny Management Committee	Report of the Executive Director, Resources.	12/3/2013	Resources Jed Turner Tel: 27 34066 jed.turner@sheffield.gov.uk

20 Mar 2013 Cabinet	Allocations Policy (K)	Cabinet Member for Homes and Neighbourhoods (Councillor Harry Harpham) Safer and Stronger Communities Scrutiny Committee	Report of the Executive Director, Communities.	12/3/13	Communities Sharon Schonborn Tel: 0114 2037613 sharon.schonborn@sheffield .gov.uk
20 Mar 2013 Cabinet	Revenue Budget and Capital Programme Monitoring 2012 -13 (Month 9) (K)	Cabinet Member for Finance and Resources (Councillor Bryan Lodge) Overview and Scrutiny Management Committee	Report of the Executive Director, Resources.	12/3/13	Resources Allan Rainford Tel: 0114 2752596 allan.rainford@sheffield.gov uk

10 Apr 2013 Cabinet	Revenue Budget and Capital Programme Monitoring 2012/13 (Month 10) (K)	Cabinet Member for Finance and Resources (Councillor Bryan Lodge) Overview and Scrutiny Management Committee	Report of the Executive Director, Resources.	2/4/13	Resources Allan Rainford Tel: 0114 2752596 allan.rainford@sheffield.gov.uk

A key decision* is one that is either part of the budgetary/policy framework, sets or shapes a major strategy, results in income or expenditure of £500,000+, is a matter of major public concern or controversial by reason of representations made or likely affects two or more wards. The full definition of a key decision can be found in Part 2, Article 14 of the Council's Constitution which can be viewed on the Council's Website www.sheffield.gov.uk. Requests for copies or extracts from any of the publicly available documents or other documents relevant to the key decisions, or for details of the consultation process and how to make representations, can be made by ringing the contact officer or via the Committee Secretariat, Legal and Governance, Town Hall, Sheffield S1 2HH email to: committee@sheffield.gov.uk

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Healthier Communities and Adult Social Care Scrutiny & Policy Development Committee

16th January 2013

Subject: Monitoring Advisory Board Minutes – For Information.

Summary:
It has been decided that the minutes of the Monitoring Advisory Board minutes should come to Scrutiny for information. The minutes of the October meeting are attached.

Type of item: The report author should tick the appropriate box

Reviewing of existing policy	
Informing the development of new policy	
Statutory consultation	
Performance / budget monitoring report	
Cabinet request for scrutiny	
Full Council request for scrutiny	
Community Assembly request for scrutiny	
Call-in of Cabinet decision	
Briefing paper for the Scrutiny Committee	**x**
Other	

The Scrutiny Committee is being asked to:
Note the minutes of the Monitoring Advisory Board

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Sheffield City Council

Contracts & Partnership Section

Meeting: Monitoring Advisory Board

Date: Wednesday 31st October 2012

Present:	Cllr Mary Lea (Chair; [ML])	Cabinet Member for Health, Care & Independent Living
	Andy Hare (AH)	Contracts Manager
	Nicola Afzal (NA)	Contracts Manager
	Brian Coddington (BC)	Senior Contracts Officer
	Louise Coombes	Contract Officer
	Joan Hubbard (JH)	Expert Elder
	Joan Memmott (JM)	Expert Elder
	Rachel Woollen (RW)	Programme Officer
	Deborah Willoughby (DW)	Programme Officer
	Cllr Peter Rippon (PR)	Labour Councillor and Chair of North & West Planning Board
	Lauren Bows (minutes)	Assistant Contracts Officer
Apologies:	Councillor Geoff Smith (GS)	Cabinet Advisor for Communities & Inclusion

		Action
1	**Welcome and Apologies** Introductions and apologies were noted.	
2	**Previous Minutes and Matters Arising** It was agreed that the previous minutes on the 25th July 2012 were an accurate record.	
3	**Home Support Update Report** BC summarised the distributed report, and informed the board that there are two providers in "amber" risk status (6 contact areas). The Contract & Partnership Team is monitoring the providers closely and will be assisting to support and improve performance. As of the 20th September, a decision was made to cease any new packages of care being sent to one of the providers, which affects three contract areas. Missed calls continue to be at minimal levels. The Contracts and Partnership Team are working with the two providers in "amber" to improve performance. Over Q3 all Cost and Volume Providers and the One Spot Provider that utilise the Electronic Call Monitoring System (ECM) will be visited by the Contract and Partnership Team and findings will be fed back into the KPI meeting. . A night care visiting service has been commissioned, using a contract variation to the Cost and Volume contract and Saga is now providing this service. At present no	

	decision has been made about the longer term future of this service. JM asked for clarification on the night care service as it sounded like this service has only just started. BC explained that the night care service was previously provided in-house but this service was now reduced and as an interim measure, Saga have been engaged to continue providing service where required. When the main contracts for Home Support expire, another solution will be required is the night service is still needed. Cllr PR asked why the provider with a hold on packages is not red on the status report. AH confirmed that the amber status was not increased to red due the provider showing willingness to change and capacity to improve. The risk status would change to red if the concerns about management capacity were greater, AH explained that the team did not feel the provider was at this stage. BC added that the status can also reflect something the provider may not have control over. i.e the new Tesco opening reduced staff in branch and therefore the capacity to deliver care. Cllr PR asked how often monitoring visits to this provider would be carried out. BC confirmed that providers in the amber status would receive at least fortnightly visits and regular formal meetings. Cllr PR asked if the visits are unannounced. BC confirmed that most of the visits are planned unless there is a great concern which would require an unannounced visit. AH explained that alternative care providers are contacted to pick up care packages if there is a stop on packages to a cost and volume provider as there is still a need for care in the three contact areas concerned. JH asked if more monitoring would pre-empt problems in the future. BC confirmed that a block contactor has to take the work under the contact. However, spot contactors can be used if necessary. BC confirmed that there are lots of spot contacts that have been able to pick up work if necessary.	
4	**Care Homes Update Report** LC summarised the Care Homes report. An update on monitoring visits was provided confirming that 74 homes out of 123 are fully compliant. Non-routine visits are also carried out if there are increased or significant concerns. One home has closed after increased concerns and 48 residents were moved to other care homes in the city. The residents have been monitored and appear to have settled well in their new homes. 10 homes currently have residents who are under safeguarding procedures and of these, 4 have suspensions on new admissions. The Contracts and Partnership Team have currently started to pilot the new Risk Assessment Tool which was brought to the last Board meeting, and most of the homes	

	are in the low risk area on the tool. AH mentioned that although we do not discuss providers' names in the meeting the home that LC was referring to is in the public domain JM commented that the care home closed very fast after it was discussed at the last meeting. JM also asked what will happen to this home in the future. AH confirmed that all the residents were offered a choice of accommodation and that we were very fortunate to have availability in other care homes, this enabled the team to provide everyone with the home of their choice and quickly. AH explained that the decision to close the home was made after a series of events within the home and a loss of confidence in the management. The decision was made with in a meeting of approx 20 professionals including NHS colleagues. The majority of the group made the decision. LC confirmed that we have no control over whether the home reopens. SSC and NHS made the decision to terminate the contract and move residents out but this does not mean the home is unable to reopen under an alternative provider. ML said that this decision will ensure that other care homes are aware that we do not accept poor service. BC confirmed that the building is not owned by the care company that has moved out. The building is still owned by the same landlord. LC confirmed that the building is a purpose built 60 bed care home. ML commented that this property could potentially reopen as a care home again. JH asked if any of the staff have been reemployed by other providers. BC confirmed that we are aware that some staff have found employment with other care homes in the city and redundancy notices were issued at the home. AH confirmed that some staff may be still working for Leyton Health Care. JH asked if any of the staff were responsible for poor care and should they be reemployed else where. BC advised that it is the new employer responsibility to request information on the past employment.	
5	**Recognised Provider List Update** RW confirmed that 17 applications were successful during the last RPL assessment process. RW explained that she has been looking at new ways to develop and improve the process for providers and staff involved in the assessments. The new process will be an open list for providers to apply but with two assessments per year. The first closing date will be the 30th November, and applicants will be informed of the decision by the 1st March. Second closing date for applicants is the 31st May, and a decision will be made by the 1st September, this will continue on a annual cycle.	

	ML and JM both requested some clarification on the Recognised Provider List as they are unsure about the level of knowledge the board had on this item. RW explained the purpose of the list and that this update was purely about the assessment process. RW confirmed that Providers are not put on the list until the assessments have been completed. **Action**: NA confirmed that she will circulate a paper on the process. RW confirmed that all successful providers will be monitored on a light touch basis as there is no contract in place for any of these providers. Monitoring forms will be sent to the provider to check the standard of care. Nicola confirmed that the RPL has been well received and the team has received positive feedback. JM commented that various service users are unsure where to look and this is a good system for the approval of providers.	**NA**
6	**Contracts Update** Recently awarded contracts – The Carers Contract (PIA) started on the 01/10/12. Contracts Officers are currently working closely with both successful organisations and holding regular KPI meetings. AH advised that the contract will be developed over a period of 3 years. Future Tenders – Support planning is being externalised and will now be provided by external organisations. Support Planning has a one off cost attached to it and will come out of the individual's budget. Commercial Services are now doing all the tenders for Adult Social Care and a timetable for the Support Planners tender will be available shortly. Dementia PIA – AH explained that we are working in partnership with the PCT and the Clinical Commissioning Group (from next year). This is a Dementia service that will offer support and advice. Home support – an enhanced specification for home support, which will focus on provision of a flexible service designed to promote independence, is being drafted and is like to be tendered for in 2013. This will largely meet the need of the people who are currently receiving ser vice through the cost and volume contracts. This is a significant piece of work with a deadline of March 2013. AH confirmed that he will continue to update the board. JH asked what customer involvement was involved in drawing this new contract up. AH confirmed that a questionnaire is going out imminently. The questionnaire includes questions such as 'what would you change about the service' and 'what do you want from a new modernised service'.	

	JM advised that there should be options rather than open questions as service users will not be aware of how it could be. This was confirmed by AH. Extra Care Housing - Roman Ridge and White Willows contract are due to expire soon and these are likely to be extended. A full review will take place by commissioning officers including Housing Independence. Budget - everyone will be aware of current budget pressures. The Contracts and Partnership Team are looking at ways to make savings. Fees and inflationary uplifts are being reviewed. NA confirmed that an updated will be available at the next meeting.	
7.	**Extra Care Housing** BC circulated a report for the four contracted Extra Care schemes and Brunswick Gardens. BC confirmed that if the Board is happy with this format he will continue to use for the next meeting. JM asked for clarification on the percentage information. JM was surprised with the information provided as this did not tally with informal information she had received. BC confirmed that the information on his report was accurate. Information had been received by JM that one of the extra care schemes was "becoming a care home by stealth" but the figures provided do not support this. BC confirmed that people's needs can change over time and more care and support is sometimes required. BC advised that providers are unable to leave flats empty to wait for a service user with the correct criteria. NA requested clarification, on the table and if it is just for people that are funded by us. LC confirmed that level one are people that are self funded. ML asked that BC & JM discuss this outside the meeting. BC confirmed this email address; brian.coddington@sheffield.gov.uk. JM asked how extra care schemes are monitored. BC confirmed that monitoring is the same as Home Support monitoring but includes some additional information. BC confirmed that this information will be reported at future meetings. ML confirmed that this will be a regular item on the agenda.	
8.	**Partnership Contracts Quarter 1** DW summarised the partnership contract reports. AH explained that these are old grants that have rolled up in to contracts. The reports are broken down in to 3 areas with spreadsheets behind to include the output/outcome figures that are received from the provider (e.g. referrals). The information has been summarised on the front page and a RAG rating provided. The	

	report will highlight performance rather than compliance. This report will be shared with the commissioners to highlight areas of concern and help make future decisions. DW informed the board that case studies have also been included in the report. JH asked how this info is obtained. DW explained that the provider has systems in place to collect feedback or relative have sometimes communicated via the provider. More case studies are also available on request. ML asked for clarification on Learning Disability Provider which is in "amber" The provider has commented that funding has been reduced The monitoring officer will investigate this when they received the information. This is a new process so may have been missed in this instance but further information will be obtained and fed back to future Board meetings. JM commented that providers are unfamiliar with the new process as they have been used to sending information in their own format. DW confirmed that there was some confusion at first but most the providers have been visited and hopefully the providers will feel confident when completing these in Q2. JH confirmed that monitoring should all be the same. DW confirmed that all monitoring within the contracts and partnership team is the same. However, the SE Community Assembly to send their own format and this can sometimes confuse the providers. JM explained that one of the older people's day care service is rated red in terms of attendance and it would be very surprising if there wasn't a need for this service. Ravenscroft and Newton Grange have recently closed; therefore the change in venue could have caused the low attendance. DW is meeting with commissioning officers to discuss further. DW suggested that this information is summarised. JM confirmed that the reports were useful and welcomed.	
9.	**AOB** AH asked that if there were any other areas that Board members would like to cover then other officers could be invited to present reports. Minutes go to Scrutiny.	

Time & Date of Next Meeting:

10:00 – 12:00

Wednesday 30th January 2013

Committee Room 5, Town Hall

Please send any apologies or agenda items to chris.boyle@sheffield.gov.uk