Public Document Pack

Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee

Wednesday 15 January 2014 at 10.00 am

To be held at St Luke's Hospice, Little Common Lane, Sheffield, S11 9NE

The Press and Public are Welcome to Attend

Membership

Councillor Mick Rooney (Chair), Sue Alston, Janet Bragg, John Campbell, Katie Condliffe, Roger Davison (Deputy Chair), Tony Downing, Adam Hurst, Martin Lawton, Jackie Satur, Diana Stimely, Garry Weatherall and Joyce Wright

Healthwatch Sheffield
Anne Ashby, Helen Rowe, Alice Riddell and Mike Smith (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 and recording is allowed under the direction of the Chair. Please see the website or contact Democratic Services for further information regarding public questions and petitions and details of the Council's protocol on audio/visual recording and photography at council meetings.

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 Matthew Borland, Policy and Improvement Officer on 0114 27 35065 or email matthew.borland@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
15 JANUARY 2014

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 (Pages 1 - 4)
Members to declare any interests they have in the business to be considered at the meeting

5. Minutes of Previous Meetings (Pages 5 - 24)
To approve the minutes of (a) the special meeting of the Committee held on 5th November, 2013 and (b) the meeting of the Committee held on 20th November, 2013, and to note the Actions List

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

7. Sheffield Adult Safeguarding Partnership - Annual Report 2012/13 (Pages 25 - 72)
Report of the Director of Business Strategy, Communities Portfolio

8. An Introduction to St Luke's Hospice
A member of St Luke’s Executive Management Team to report

9. Hospice Care in Sheffield (Pages 73 - 76)
Report of the Chief Executive, St Luke’s Hospice

10. Adult Social Care Performance Update - Quarter 2 2013/14 (Pages 77 - 82)
Report of the Director of Care and Support, Communities Portfolio

11. Work Programme (Pages 83 - 86)
Report of the Policy and Improvement Officer

12. Date of Next Meeting

The next meeting of the Committee will be held on Wednesday, 19th March, 2014, at 10.00 am, in the Town Hall

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.

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 (selflessness; integrity; objectivity; accountability; openness; honesty; and leadership).

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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S H E F F I E L D   C I T Y   C O U N C I L

Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee

Special Meeting held 5 November 2013

PRESENT: Councillors Mick Rooney (Chair), Sue Alston, Janet Bragg, John Campbell, Katie Condliffe, Roger Davison (Deputy Chair), Tony Downing, Adam Hurst, Martin Lawton, Jackie Satur, Diana Stimely, Garry Weatherall and Joyce Wright

Non-Council Members (Healthwatch Sheffield):-

Helen Rowe (Healthwatch Sheffield)

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1. APOLOGIES FOR ABSENCE

1.1 Apologies for absence were received from Anne Ashby and Alice Riddell (Healthwatch Sheffield).

2. EXCLUSION OF PUBLIC AND PRESS

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

3. DECLARATIONS OF INTEREST

3.1 Councillor Martin Lawton declared a personal interest in agenda item 6 – Call-in of Cabinet Decision on Developing the Social Model of Public Health, as a Member of the Task and Finish Group on Public Health, which had developed the Social Model of Public Health within the City, which had been considered by the Cabinet at its meeting on 16th October 2013.

4. PUBLIC QUESTIONS AND PETITIONS

4.1 There were no public questions or petitions.

5. CALL-IN OF CABINET DECISION ON DEVELOPING THE SOCIAL MODEL OF PUBLIC HEALTH

5.1 The lead signatory to the call-in was Councillor Ian Auckland and the co-signatories were Councillors Roger Davison, Shaffaq Mohammed, Andrew Sangar and Diana Stimely.

5.2 The Committee scrutinized the decision of the Cabinet at its meeting held on 16th October 2013, approving the adoption of the Social Model of Public Health as an addition to the policy statement set out in the vision for Public Health, agreed at the Cabinet meeting held on 25th January 2012, and considered a joint report of the

Executive Director, Communities and Director of Public Health submitted to the meeting on 16th October 2013. Attending the meeting for this item were Councillor Mary Lea, Cabinet Member for Health, Care and Independent Living, Chris Shaw, Director of Health Improvement and Jeremy Wight, Director of Public Health.

5.3 Councillor Ian Auckland outlined the reasons for the call-in, indicating that there was a distinct lack of detail and clarity in the report, specifically regarding the proposed re-allocation of funding. He referred to the improvement in health outcomes under the present Healthy Communities Programme, questioning the need for change, and expressing concern at the potential risks of removing funding from other areas of health work.

5.4 Chris Shaw reported on the reasons behind the report, indicating that, following the transfer of the Public Health function from the Primary Care Trust to the City Council, Members had expressed a wish to see how the function should be implemented from a Local Authority point of view. He stated that the report now submitted set out details of the work undertaken by the Members' Task and Finish Group on Public Health, to develop the Social Model of Public Health within the City, together with details of the outcome of the first area of Public Health investment which had been reviewed within the context of the Social Model – the Healthy Communities Programme.

5.4 The Task and Finish Group had been established in 2012, chaired by Councillor Mary Lea, Cabinet Member for Health, Care and Independent Living, and Phase 1 of the review, included outlining Members' thinking, but did not detail any specific conclusions as they had not been reached at that point. The second phase of the work had four objectives, one of which was to develop a Social Model of Public Health and Wellbeing to inform thinking and activity across the City Council, including the Council's contributions to outcomes in the Health and Wellbeing Strategy. As part of this work, interviews had been held with a number of groups and individuals, which resulted in a draft model being produced, as well as providing Members with some information on a number of existing Public Health programmes already in operation.

5.5 Mr Shaw indicated that the main reason for the review of the Healthy Communities Programme was that Members considered that some of the work being undertaken to tackle health inequalities was not as effective as it could be and that in order to address this issue, a shift in investment in some areas was needed. It had been considered that the proposed shift in investment would better reflect the emerging social model and result in an increase in the number of people who would be able to make changes to their behaviour and lifestyles. The aim was to change the existing Healthy Communities Programme to one that operated within the context of the proposed Social Model, particularly focusing on the underlying root causes of ill health, such as poverty, unemployment and poor housing. A potential to enhance social, capital and community development was also identified. In response to comments made by Councillor Auckland regarding potential risks, Mr Shaw stated that whilst it was not possible to give any assurances in terms of potential risks involved, Members were confident that any changes made to the existing Healthy Communities Programme would be made to the benefit of

Sheffield residents. He reported that work would commence shortly on producing a number of measurable indicators for the new proposals.

5.6 Members of the Committee raised questions and the following responses were provided:-

- Whilst there was no detail available at the present time, officers were in the process of working through the outcome profile, with a view to providing a new profile sometime in 2014.

- There were no details available at the present time regarding which services/programmes would be reduced/stopped following the proposed shift in investment.

- There would be an emphasis, as part of the new Healthy Communities Programme, on targeting the psycho-social pillar of the model, including loneliness and social isolation. There was evidence to suggest that breaking down these barriers, rather than targeting specific health improvement programmes, resulted in an improvement of people's wellbeing and health.

- In terms of screening appointments for both men and women over the age of 60, reminder letters were sent to those people who did not attend their initial appointment. It was accepted that there would always be a number of people who would not attend such appointments, but every effort was made to highlight the importance of attending.

- The level of funding as part of the review equated to £1.8 million, which was not considered a significant amount in terms of overall Government spending on health. The proposals were to re-invest the funding specifically to address the objectives in the proposed Social Model, particularly focussing on the underlying root causes of ill health and poverty and the potential to enhance social, capital and community development. Following the review, the Healthy Communities Programme would continue to target those residents within the most deprived third of the City.

- As part of the review, Members did not see any evidence to show that any of the existing work under the Healthy Communities Programmes would stop, although there was a possibility that funding in some areas of work could be reduced as a result of the shift in investment. Members were clear that they did not wish to lose the excellent work undertaken under the current Healthy Communities Programme, but considered that the shift in investment in certain areas of work could improve the work even more. One of the recommendations of the Cabinet at the meeting on 16th October 2013, was to request the Director of Public Health and the Executive Director, Communities, in consultation with the Cabinet Member for Health, Care and Independent Living and the Executive Director, Resources, to take forward proposed changes to the Healthy Communities Programme and as part of this work, every effort would be made to ensure that the good work undertaken under the Programme would continue.

- The proposed shift of emphasis in terms of investment, from lifestyles and physiological conditions, to social and psycho-social conditions, had been proposed on the basis that some people faced significant barriers in terms of changing their behaviour, and therefore needed targeting before they could go on to make the relevant lifestyle changes. It was considered that the proposed shift in investment would go a long way to helping people overcome some of these barriers.

- The work undertaken as part of the current Healthy Communities Programme had contributed to an increase in life expectancy rates across the City, although levels of health inequality had remained broadly the same.

- Whilst there was evidence to show that health inequalities broadly followed deprivation in the City, examples of inequality could be found, in pockets, in all areas of the City.

- As part of the review, officers had discussed the issues relating to barriers faced by some individuals in terms of access to employment opportunities. Although communication between the Department of Health and Department for Work and Pensions could be improved, efforts were being made to provide improved links between the two areas of work within the City as people in work or those who had better employment opportunities often experienced better health.

- In terms of timescales, due to the level of work required, it was planned that the majority of the work in connection with the proposed changes to the Healthy Communities Programme would be undertaken during spring/summer 2014, with a latest possible implementation date of 1st April 2015.

- It was likely that the £290,000 funding in respect of Social Capital would potentially be commissioned through the existing local Voluntary, Community and Faith (VCF) organisations, but it would be through an open process. The Council would shortly be commencing discussions with the existing VCF providers, then would commence discussions with all potential providers with the aim of implementing such programmes over the next six months.

- Arrangements would be made for all the background papers and information produced as part of the review undertaken by the Members' Task and Finish Group on Public Health to be circulated to Members of the Committee.

5.7 RESOLVED: That the Committee:

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

(b) agrees (i) to take no action in relation to the called-in decision and (ii) that, as part of its Work Programme, it monitors the progress of this work, over its

18 month delivery period, including the receipt of a monitoring report from the Director of Health Improvement at its meeting to be held in March 2014, outlining the implementation plan, targets, how outcomes would be measured and progress on commissioning.

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S H E F F I E L D   C I T Y   C O U N C I L

Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee

Meeting held 20 November 2013

PRESENT: Councillors Mick Rooney (Chair), Sue Alston, Janet Bragg, John Campbell, Katie Condliffe, Tony Downing, Adam Hurst, Martin Lawton, Jackie Satur, Diana Stimely, Garry Weatherall and Joyce Wright

Non-Council Members (Healthwatch Sheffield):-

Anne Ashby and Helen Rowe

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1. APOLOGIES FOR ABSENCE

1.1 An apology for absence was received from Councillor Roger Davison.

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 personal interest in Agenda Item 9 (Memory Management Services) as a Non-Executive Member of the Sheffield Health and Social Care NHS Foundation Trust.

3.2 Councillor Sue Alston declared a personal interest in Agenda Item 10 (Nutrition and Hydration Working Group) as an employee of the Sheffield Teaching Hospitals NHS Foundation Trust.

3.3 Councillor John Campbell declared a personal interest in Agenda Item 10 (Nutrition and Hydration Working Group) as an employee of the Sheffield Teaching Hospitals NHS Foundation Trust.

4. MINUTES OF PREVIOUS MEETING

4.1 The minutes of the meeting of the Committee held on 18th September 2013, were approved as a correct record and, arising therefrom, it was reported that:-

(a) a response had been received from St Luke's Hospice, indicating that they would be happy to host the Committee's meeting in January 2014, at which the Chief Executive and Deputy Chief Executive of the Hospice would give a short presentation and arrangements would also be made for a tour of the Hospice. "The Nature of Funding for Hospice Care in Sheffield" had

previously been identified as a topic for the Committee's Work Programme 2012/13, and Members therefore agreed that they would like to request that the Chief Executive of the Hospice produces a report on this subject for discussion at the meeting; Members welcomed the invite and requested the Policy and Improvement Officer to contact the Hospice to make the necessary arrangements;

(b) Members would be welcome to attend one of two Open Day sessions on Friday, 22nd and Tuesday, 26th November 2013, from 12 noon to 2.00 pm, regarding the Home from Home Scheme; the Policy and Improvement Officer would circulate full details of the sessions to Members of the Committee;

(c) a response had still not been received to the letter sent to the Secretary of State for Health, expressing the Committee's concerns regarding the lack of a national framework and regulation for male circumcisions, and the Chair agreed that he would send one more letter on this issue, which would be sent to the six Sheffield MPs, and would request that this issue be raised as a question in Parliament;

(d) arrangements had been made for Councillor John Illingworth, Chair of the Yorkshire and Humber Joint Health Overview and Scrutiny Committee, and Steven Courtney, Principal Scrutiny Adviser Officer, Leeds City Council, to give a presentation to all Members of the Council on the review of adult congenital heart disease services on 30th January 2014, at the Town Hall, Sheffield.

(e) the Policy and Improvement Officer had forwarded a paper provided by Ken Lawrie, Director of Commercial Relations, Sheffield Health and Social Care NHS Foundation Trust, containing information relating to the contracts that had been let to voluntary and faith sector organisations around offering help and advice to patients with mental health, drug and alcohol problems;

(f) the Policy and Improvement Officer had circulated the current draft of the Sheffield Clinical Commissioning Group's (CCG) Engagement Plan on 5th November 2013; Members were asked to forward any comments to the Policy and Improvement Officer, who would collate and submit them to the CCG; and

(g) the suggested changes raised by the Committee in respect of the contents and layout of the Adult Social Care Local Account 2012/13, had been forwarded to Ben Arnold, Development Officer, Business Strategy, Communities, and a response had been received from Mr Arnold, which had been circulated to Members of the Committee.

5. PUBLIC QUESTIONS AND PETITIONS

5.1 Sylvia Parry, representing Stocksbridge and Upper Don 50+ Group and Stocksbridge Community Health Forum, raised questions and responses were

provided as follows:-

(a) Has the City Council responded as part of the consultation on the Government's 'Caring for Our Future' plans and if so, could a copy of the response be made available?

The Chair stated that he was not sure if the Council had responded as part of the consultation, but would check with Councillor Mary Lea, Cabinet Member for Health, Care and Independent Living.

(b) Members of the above groups were very concerned that the Council's Adult Care budget had been cut, and were querying how best they could help to support people who may now receive less care at home.

The Chair confirmed that the budget had been cut, but stated that if people were struggling to fund the care they received in their homes, they could request a review of their care package. In addition to this, the Council provide advice on how people could maximise their income in terms of benefit entitlement.

(c) When do you think that the Council's Social Care and Health Service Care will be joined up to provide the best care for those who need it?

The Chair stated that it has always been the aim of both the Health and Social Care elements of the Health sector to work together in order to provide the best care for those who need it. He added that if there were continuing problems, the Committee would request a report on why progress was not being made to improve the links between the two elements, and highlighting any problem areas.

(d) Will the new area structure be able to report to this Committee on how care and health issues for older people were being dealt with as the Community Assemblies previously did?

The Chair stated that as the Local Area Partnerships were in their infancy, he was not in a position to respond, but would refer the question to Councillor Mazher Iqbal, Cabinet Member for Communities and Inclusion.

6. RIGHT FIRST TIME PROGRAMME - UPDATE

6.1 The Committee received a report on the progress of work undertaken in connection with Phase 2 of the Right First Time Programme.

6.2 In attendance for this item were Kevan Taylor, Chief Executive, Sheffield Health and Social Care NHS Foundation Trust and Right First Time Programme Director, and Zak McMurray, Joint Clinical Director, NHS Sheffield Clinical Commissioning Group.

6.3 Kevan Taylor reported on the aims of the Right First Time Programme, referring specifically to the agreed priorities in respect of Phase 2 of the Programme. The main priority was to develop effective and timely discharges from and through the

acute hospitals and intermediate care provision across the City, with the aim of reducing the average length of stay in hospital and/or intermediate care, and to maximise individuals potential to return home and live as independently, and as long, as possible. Mr Taylor reported on the work being undertaken under the Programme to achieve this aim. He made specific reference to Project 4 under Phase 2, which involved focussing on patients with serious mental illness and their physical health needs as such people could be particularly vulnerable to becoming seriously ill with physical health conditions, such as heart disease or diabetes, and the aim of Project 4 was to make sure all organisations and service users work together to change this. Zak McMurray added that there was a need to identify high risk patients as there were high numbers of people in hospital, who did not necessarily need to be there.

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

- One of the main aims of the Programme was, by using patients' profiles, to try and target emergent risk patients, investing resources in the community and drafting a care plan and an escalation plan. The Virtual Ward model was able to target those patients who were not known to mainstream services and/or who would be best supported by an intensive co-ordinated approach from the ICT. Whilst this model was being tested at two GP practices, it was likely that it would be rolled out to other practices. Efforts were being made to ensure that GP practices were more assertive and targeted such people.

- In the light of the increased risk of potential death and a reduced life expectancy of 16 years for women and 20 years for men for people suffering from a serious mental illness, special efforts were being made to look at ways of making it easier for such people to access health services. A high number of people having a serious mental illness smoked and the drugs a number of such people took had an adverse impact on their physical wellbeing, such as making them hungry, which often led to weight problems.

- In terms of the involvement of the voluntary sector under the Programme, some Support Workers were employed by voluntary sector organisations.

- There were no plans at the present time to appoint any Admiral Nurses, who worked with family carers and people with dementia, in the community and other settings, but significant developments in dementia services have been made in the community, such as rapid response teams.

- Sheffield will follow the guidance on each "at risk" patient, having a named practitioner, as recently announced by the Government. In Sheffield, all patients in primary care have had their degree of risk "stratified". The NHS Trust was rolling out a programme where GPs and their teams identify those people at emergent risk, and develop a care plan to help such people to stay well and healthy at home.

- Although quarterly figures regarding emergency admissions and length of stay in hospitals could not be produced at this meeting, such information could be provided.

- The request relating to whether the work of the 50+ Group to reach missing voices could be passed to the Community Support Workers as another method of getting people some involvement would be forwarded to the relevant Service in the City Council responsible for the Workers.

- The additional investment identified to expand the Community Nursing Service would be provided by the CCG.

- The suggestion of having one name for intermediate care services – such as the Re-enablement Service – would be reconsidered in the light of potential confusion.

- There were still some outstanding areas regarding the age range of people seen by the Child and Adolescent Mental Health Service (CAHMS) and the Adult Service that needed to be resolved, and these would be reported back to the Committee when agreement had been reached.

- In terms of sharing the work undertaken under the Programme, there was a national pilot under the auspices of the NHS Improving Quality. This would involve networking and sharing learning. Although Sheffield was more advanced than other areas on risk stratification and primary care, lessons could, and would, be learnt from work being undertaken under the Programme in other areas.

6.5 RESOLVED: That the Committee:-

(a) notes the information contained in the report now submitted, the information reported as part of the presentation and the responses to the questions raised; and

(b) (i) thanks Kevan Taylor and Zak McMurray for attending the meeting and responding to the questions raised and (ii) requests that they attend a future meeting to report on the progress in respect of Phase 3 of the Right First Time Programme, including data/statistics on the impact of the Programme to date.

7. SHEFFIELD DEMENTIA STRATEGY AND COMMISSIONING PLAN

7.1 The Committee received a report on the Sheffield Dementia Strategy and Commissioning Plan, which outlined the approach to dementia care across the City, including Continuing Healthcare funding criteria and the role of bed-based facilities in the Strategy. The report also attached, at Appendix ‘A’, a copy of the Plan, together with the 2013/14 Work Plan and the NICE Guidance ‘Support for Commissioning Dementia Care’.

7.2 In attendance for this item were Sarah Burt, Senior Commissioning Manager, NHS Sheffield Clinical Commissioning Group (CCG), Eamon Harrigan, Head of Clinical Services, Sheffield Clinical Commissioning Group (CCG), and Steve Jakeman, Commissioning Officer, Communities.

7.3 Sarah Burt reported that good progress had been made in terms of the key objectives of the Sheffield Dementia Strategy and Commissioning Plan, building on the long history of the collaborative approach to the commissioning of dementia services in the City. Health and Social Care Commissioners in the City were continuing to work hard in order to ensure that people with dementia and their carers were able to live well with the condition, and since the National Dementia Strategy was published in 2009, Sheffield had made significant progress in all key objectives. In terms of benchmarking against key outcome indicators, Sheffield was presently ranked second in England and Wales for its diagnosis rate. Ms Burt stated that she had recently met with Alistair Burns, National Clinical Director for Dementia, to discuss dementia commissioning in the City, and he had indicated that Sheffield was progressing well in terms of its dementia strategy and plans.

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

- Particular efforts were being made, as detailed under the heading ‘Early Diagnosis and Intervention’ in the 2013/14 Work Plan, appended to the report, with regard to making people aware of the signs of dementia at an early stage so they can access health services and receive the care and support they need. The CCG was working with Public Health in terms of raising public awareness of early signs of dementia and the Alzheimer’s Society had also undertaken considerable work on this issue. In addition to the work already undertaken, a national campaign in terms of raising awareness of dementia was planned for early 2014.

- In terms of public involvement, there had been a number of involvement exercises and consultations with people with dementia, their carers and the public on dementia and dementia services. Since the Local Dementia Alliance had been created, the structure of the City’s Dementia Board was being reviewed to ensure service user views were integral to the planning process.

- The CCG was considering whether to change its arrangements for procuring nursing home care for people with challenging behaviour. The CCG purchased most nursing home care using the NHS national contract and a defined specification. Nursing home care for people with dementia and challenging behaviour was usually provided by two local homes, who were also contracted to the CCG. However, a small number of patients with challenging behaviour had nursing home care spot-purchased and the CCG was considering how to introduce specifications for their services so that quality could be better assured.

- The eligibility criteria for continuing healthcare is set out in the National Framework for Continuing Healthcare, published by the Department of Health. Eligibility was determined by assessing the individual's needs and whether they had a 'primary health need'. This assessment was carried out by looking at all of their care needs and relating them to four key indicators – nature, complexity, intensity and unpredictability.

- Trends in terms of people suffering from dementia were taken into consideration as part of the long-term planning process. There was a need to ensure that the system was sustainable in the light of the predicted longer life-expectancy and projected increase in population.

- Care planning was currently being tested in primary care, and for people with dementia, and should focus on living well, promoting independence, understanding the disease and managing other co-morbidities.

- Advanced care planning was on the agenda, and whilst there was significant work to do, there had been some good progress made.

- The issues regarding personalised care and how this would be included in the Commissioning Plan, would be discussed at a future meeting.

- The question of whether there were any plans to increase the number of carer breaks should be directed to the relevant Council officer.

- In response to what people with dementia have told the CCG, and through a planned joint commissioning project in 2014/15, all dementia sufferers would receive the offer of an annual review.

7.5 RESOLVED: That the Committee:-

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

(b) (i) thanks Sarah Burt, Eamon Harrigan and Steve Jakeman for attending the meeting and responding to the questions raised and (ii) requests (A) the Director of Business, Planning and Partnerships, Sheffield Clinical Commissioning Group, to submit a report to a future meeting of the Committee, containing details of the progress made in terms of the Sheffield Dementia Strategy and Commissioning Plan, with an emphasis on the Action Plan, financial details and work undertaken in terms of public engagement, together with details of an explanation as to how the service was integrated, and (B) the Executive Director, Communities, to attend the same meeting to explain how the Council and Health were responding to the requirement for integrated service provision.

8. MEMORY MANAGEMENT SERVICES - DEVELOPMENT OPTIONS

8.1 The Committee received a report outlining the plans being explored by the

Sheffield Clinical Commissioning Group (SCCG) and Sheffield Health and Social Care NHS Foundation Trust (SHSC) to improve access to memory services for the people of Sheffield. The report summarised the current position and outlined the areas being explored to inform future service development planning within the City. The development was being progressed jointly by the SCCG and SHSC and together, both organisations had delivered a range of improvements over previous years, and remained committed to ensuring future improvement remained a priority, and were delivered upon.

8.2 In attendance for this item were Jason Rowlands, Director of Planning, Performance and Governance and Michelle Fearon, Service Director, Sheffield Health and Social Care NHS Foundation Trust, and Sarah Burt, Senior Commissioning Manager, Sheffield Clinical Commissioning Group.

8.3 Jason Rowlands stated that the purpose of the report was to provide the Committee with an update on the progress made in terms of the steps taken to further reduce waiting times for memory management services, as requested by the Committee at its last meeting. Mr Rowlands reported that over the last three-year period, the number of people assessed, and who had received diagnosis support, had increased by 22.5%, and that Sheffield had estimated to have had 63.6% of people diagnosed with dementia, which had resulted in the City being ranked second in England and Wales in terms of diagnosis rates in 2012. Whilst the waiting time from referral to assessment had been reduced from 40 weeks to between 16 and 18 weeks, this was still not considered reasonable. He referred to the work undertaken, as well as the planned work, in order to help reduce such waiting times, which included, by way of shifting resources, to build capacity in the community with regard to primary care.

8.4 Members of the Committee raised questions and the following responses were provided:-

- The resource implications of the proposed model were still being considered and evaluated. The work undertaken as part of the proposed model would be funded through a shift in resources and a key area of focus had been how to improve capacity within primary care services to enable them to provide ongoing re-assessment support. Achieving this was expected to deliver the benefits of care closer to home and free up resources within the City-wide specialist services for them to see more people, and to see them within more acceptable timescales. The preferred approach to achieving this was based upon a ‘hub and spoke’ model of care, which would comprise initial assessment through a City-wide specialist service, and ongoing support and monitoring of progress being provided in primary care.

- The expected increased numbers of people with dementia in the future was mainly due to the increased number of elderly people and the fact that medical staff were getting better at recognising and diagnosing those who already have dementia.

- Whilst dementia was predominantly age-related, and that the National Model

was based mainly on an age-profile, there were a number of other factors taken into consideration.

- There has been a major shift in the views of GPs in terms of dementia.

- Efforts were being made to look at how and where the process could be speeded up in terms of contacting patients, following their first assessment appointments. In connection with this, it had been identified that there was a need to look at producing an information pack for patients and their families in terms of action they could be taking whilst waiting for treatment.

- It was accepted that the current waiting times were unreasonable.

- By continuing to work together on a number of tasks required to reduce waiting times in terms of referral to assessment, it was deemed possible that the current waiting time of between 18 and 22 weeks could be reduced to between six and eight weeks within a period of 12 to 24 months. The feasibility of this was the focus of the final stages of the current development work.

- There would be problems in terms of capacity, but efforts would be made to look at how resources could be re-directed to address this issue. It was accepted that the current waiting times were unreasonable. The main challenge with regard to reducing the timescales for delivery down to 12 months would be capacity, and so efforts would need to be made to look at how resources could be redirected to address this.

- If possible, Michelle Fearon would provide a link to the modelling system used to compile the data in the report, which could then be shared with Councillor Lawton.

8.5 RESOLVED: That the Committee:-

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

(b) thanks Jason Rowlands, Michelle Fearon and Sarah Burt for attending the meeting and responding to the questions raised; and

(c) requests that:-

(i) further consideration be given to the information/resources available to people whilst they are on the waiting list for the service, such as what is available through the Voluntary and Community Sector;

(ii) Sarah Burt, as lead for Early Diagnosis and Intervention, ensures that information on memory management services is displayed in GP surgeries; and

(iii) with regard to the proposed reduction in waiting times, to around six to eight weeks, the Chair writes to Ian Atkinson, Chief Officer of the Clinical Commissioning Group, requesting that consideration be given to whether the planned improvements can be introduced within 12 months, as opposed to the current 12-24 month timescale.

9. NUTRITION AND HYDRATION WORKING GROUP

9.1 The Committee received a report on the work of the Nutrition and Hydration in Hospitals Working Group, which had been established by this Committee, in November 2012, to look at the quality of food in the City's hospitals, as well as the support that people got to eat and drink whilst they were in hospital. Attached at Appendix A, was the final draft report of the Working Group, containing its draft findings and recommendations following the work it had undertaken.

9.2 Councillor Garry Weatherall, Chair of the Working Group, reported briefly on the work undertaken, and expressed his thanks and appreciation to those members of staff of the Sheffield Teaching Hospitals NHS Foundation Trust who had reported to the Working Group, and the staff and management of the Services and Wards at the Northern General Hospital for accommodating the Working Group on its visits. Councillor Weatherall confirmed that 77 volunteers, across eight Wards, who had been recruited to assist with mealtimes, had been in place since February 2013.

9.3 RESOLVED: That the Committee:-

(a) notes and welcomes the report now submitted, together with the draft findings and recommendations of the Nutrition and Hydration in Hospitals Working Group;

(b) requests that its thanks be conveyed to members of staff of the Sheffield Teaching Hospitals NHS Foundation Trust who had reported to the Working Group, and the staff and management of the Services and Wards at the Northern General Hospital, for accommodating the Working Group on its visits; and

(c) approves the recommendations set out in Section 4 of the report now submitted.

10. DATE OF NEXT MEETING

10.1 It was noted that the next meeting of the Committee would be held on Wednesday, 15th January 2014, at 10.00 am, at St Luke's Hospice, Little Common Lane, Sheffield, S11 9NE.

Healthier Communities & Adult Social Care Scrutiny Committee
Actions update for meeting on 15th January 2014

Action	Minutes	Update	RAG
Minutes of previous meeting 4.1 (a) a response had been received from St Luke's Hospice, indicating that they would be happy to host the Committee's meeting in January 2014, at which the Chief Executive and Deputy Chief Executive of the Hospice would give a short presentation and arrangements would also be made for a tour of the Hospice. "The Nature of Funding for Hospice Care in Sheffield" had previously been identified as a topic for the Committee's Work Programme 2012/13, and Members therefore agreed that they would like to request that the Chief Executive of the Hospice produces a report on this subject for discussion at the meeting; Members welcomed the invite and requested the Policy and Improvement Officer to contact the Hospice to make the necessary arrangements	20th Nov 2013	**Complete** – the Meeting on 15th January will take place at St Luke's Hospice and will include a tour of the facility (for members of the Committee). The meeting will also include a report on "Hospice Care in Sheffield" which will be presented by the Chief Executive of St Luke's Hospice.	
4.1 (b) Members would be welcome to attend one of two Open Day sessions on Friday, 22nd and Tuesday, 26th November 2013, from 12 noon to 2.00 pm, regarding the Home from Home Scheme; the Policy and Improvement Officer would circulate full details of the sessions to Members of the Committee	20th Nov 2013	**Complete** – dates for the open days have been circulated.	
4.1(c) a response had still not been received to the letter sent to the Secretary of State for Health, expressing the Committee's concerns regarding the lack of a national framework and regulation for male circumcisions, and the Chair agreed that he would send one more letter on this issue, which would be sent to the six Sheffield MPs, and would request that this issue be raised as a question in Parliament	20th Nov 2013	Letters have been sent to the 6 Sheffield MP's.	

4.1(d) arrangements had been made for Councillor John Illingworth, Chair of the Yorkshire and Humber Joint Health Overview and Scrutiny Committee, and Steven Courtney, Principal Scrutiny Adviser Officer, Leeds City Council, to give a presentation to all Members of the Council on the review of adult congenital heart disease services on 30th January 2014, at the Town Hall, Sheffield.	20th Nov 2013	**Complete** – This session will take place on Thursday 30th January 10.30-12noon, Reception Room A, Town Hall.	
4.1 (e) the Policy and Improvement Officer had forwarded a paper provided by Ken Lawrie, Director of Commercial Relations, Sheffield Health and Social Care NHS Foundation Trust, containing information relating to the contracts that had been let to voluntary and faith sector organisations around offering help and advice to patients with mental health, drug and alcohol problems	20th Nov 2013	**Complete**	
4.1 (f) the Policy and Improvement Officer had circulated the current draft of the Sheffield Clinical Commissioning Group's (CCG) Engagement Plan on 5th November 2013; Members were asked to forward any comments to the Policy and Improvement Officer, who would collate and submit them to the CCG	20th Nov 2013	**Complete**	
4.1 (g) the suggested changes raised by the Committee in respect of the contents and layout of the Adult Social Care Local Account 2012/13, had been forwarded to Ben Arnold, Development Officer, Business Strategy, Communities, and a response had been received from Mr Arnold, which had been circulated to Members of the Committee	20th Nov 2013	**Complete**	
Memory management Services – Development Options 8.5 (c) (i). further consideration be given to the information / resources available to people whilst they are on the waiting list for the service, such as what is available through the Voluntary and Community Sector (ii) Sarah Burt, as lead for Early Diagnosis and Intervention, ensures that information on memory management services is displayed in GP surgeries; and	20th Nov 2013	**Complete** - A response has been received from Tim Turner, Assistant Service Director, Sheffield Health & Social Care NHS Foundation Trust; this has been circulated to members of the Committee.	

8.5 (c) (iii.) with regard to the proposed reduction in waiting times, to around six to eight weeks, the Chair writes to Ian Atkinson, Chief Officer of the Clinical Commissioning Group, requesting that consideration be given to whether the planned improvements can be introduced within 12 months, as opposed to the current 12-24 month timescale	20th Nov 2013	A letter has been sent to Ian Atkinson, Chief Officer of the Clinical Commissioning Group	
Nutrition & Hydration Working Group 9.3 (b) requests that its thanks be conveyed to members of staff of the Sheffield Teaching Hospitals NHS Foundation Trust who had reported to the Working Group, and the staff and management of the Services and Wards at the Northern General Hospital, for accommodating the Working Group on its visits;	20th Nov 2013	**Complete**	

Briefing papers / items for information

Care & Support Performance Update Briefing paper - Following an update at the Scrutiny Committee meeting in January 2013- the Committee requested: “the Head of Adult Services, Care and Support to submit a progress report on the new performance measures to this Committee in 12 months’ time” (Jan 16th 2013)

A briefing paper from Robert Broadhead, Director of Care & Support has been circulated.

Items for information

CCG Governing Body Minutes – a link to papers for the meeting on 9th January 2014 has been circulated.

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Report to Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee 15th January 2014

Report of: Director of Business Strategy Communities Portfolio

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Subject: Safeguarding Adults Annual Report 2012/2013

Author of Report: Head of Quality and Adult Safeguarding

Summary:

The Annual Report provides an overview of Adult Safeguarding activity and information on the contribution individual partners have made towards Adult Safeguarding in Sheffield. On its production each Annual Reports is considered annually by Scrutiny.

Safeguarding Adults directly contributes to 2 Council outcomes
- Better Health and Wellbeing
- Safe and Secure communities

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 Annual Report and provide comments and reflections on the work related to Safeguarding Adults.

Background Papers:
Safeguarding Adult Safeguarding Partnership Annual Report 2012-2013

Category of Report: OPEN/~~CLOSED~~ (please specify)

Report of the Director of Business Strategy in Communities Portfolio

Title of report – Safeguarding Adults Annual Report 2012-2013

1. Introduction/Context

Safeguarding Adults is a national requirement. It comprises a series of measures and processes designed to protect people at risk of abuse and or neglect. Across Sheffield Safeguarding is the responsibility of the Safeguarding Adults Partnership. Sheffield City Council is responsible for the effectiveness of Safeguarding. To achieve this the Council works in conjunction with partners including health services, the criminal justice system and housing providers. Safeguarding applies across all sectors and care settings, including independent care providers and in people's homes. Safeguarding Adults directly contributes to 2 council outcomes

- Better Health and Wellbeing
- Safe and Secure communities

The Annual Report provides an overview of Adult Safeguarding activity across the city. It contains information on the contribution individual partners have made towards Safeguarding in Sheffield.

2. Commentary and Issues

2.1 Commentary

2.1.1 Alerts of concern have increased from 2069 to 2633, an increase of 27%. We attribute this to increased awareness across the Partnership. This heightened awareness means more potential instances of abuse or neglect are identified and reported. A mapping exercise to demonstrate the incidence of abuse across the city has been agreed and will support more targeted interventions in future years.

2.1.2 Of those able to express a view 92% of those helped through safeguarding felt safer as a result whilst 85% were satisfied with the process itself.

2.1.3 There is a suggestion that a national increase in awareness of abuse and neglect as an issue is being driven partially by high profile cases including Winterbourne View and Mid Staffordshire Hospitals.

2.1.4 Referrals into Safeguarding continue to be drawn from a wide variety of sources including residential care, primary and secondary health care, and family and friends. Self-referrals continue to increase but still remain at a low level, continued work with the Customer Forum will help engagement with families, carers and people who are in receipt of services to make their own alerts. Most statutory partners have shown an increase in the number of referrals demonstrating a growing knowledge and confidence in Safeguarding processes and the relationship with the Safeguarding Sheffield Adult Safeguarding Partnership. Targeted work in primary care has resulted in GP

referrals continuing to increase and they are now the second largest referral source.

2.1.5 Decreases in Mental Health referrals into Safeguarding are potentially linked to the use of alternative ways of managing risks specifically the 'Care Programme Approach'. We are currently reviewing the position with mental health service providers to ensure that, where appropriate, referrals are made into the Safeguarding process. An improved performance management system will assist in this. We are also working with domiciliary care providers to ensure they are fully aware of Safeguarding and the requirements to consider Safeguarding where possible abuse or neglect may have occurred.

2.1.6 In terms of types of abuse Financial [248 instances] and Physical [235 instances] are the 2 largest single categories of abuse. Both have increased marginally during the year. Financial abuse continues to be perpetrated in the main by family or friends. Instances of neglect have risen from 239 to 292 compared with 2010/2011.

2.1.7 Psychological abuse [157 instances] has also increased, although only in proportion to the overall increase. Sexual abuse accounts for less than 5% of abuse cases. Institutional abuse has increase to 78 instances. This could be as readily attributable to increased awareness and self-disclosure as to an overall deterioration in practice. Comparisons with regional Safeguarding Partnerships indicate that the pattern and numbers of alerts and referrals for Safeguarding in Sheffield are broadly in line with activity levels elsewhere.

2.1.8 There is a significant gender differential with more women [61%] than men [39%] being considered under Safeguarding, explained by longer lifespan of women compared to men and the reluctance of a lot of men to accept services.

2.1.9 We continue to see trend of increasing use of Safeguarding for people from Black and Minority Ethnic backgrounds with a 50% increase in alerts to 146. Further work is in progress to promote awareness of Safeguarding across diverse communities

2.1.10 Age continues to be a significant factor characterising those people at risk with 1464 of alerts being identified as older adults aged over 65. 592 of these people were over 85 years old. These are often the most vulnerable adults in the City.

2.1.11 Other significant categories of people at risk in include Learning Disabilities [519], Mental Health [318] Physical Disabilities/Sensory Impairment [256] and Substance Misuse [55]

.

2.1.12 The Safe Places scheme is jointly funded by Safeguarding Adults Partnership and Safer and Sustainable Communities; the funding employs a part time coordinator based at Heeley City Farm who works with a dedicated group of service users to advertise and embed the scheme. Seventy 'Safe Places' now exist in all areas of the city and staff and volunteers have been given education and support to provide vulnerable adults with the confidence to engage with the local and wider communities. The safe places provide a "refuge" to vulnerable people who are feeling afraid or are lost or unwell. Over 600 people have enrolled on the scheme, the safe places report that they feel

more confident to respond to the needs of all of Sheffield's citizens and have been able to report both safeguarding and hate incidents/crimes as a direct result of this initiative. The scheme hopes to expand to offer adults with dementia and other cognitive impairments and adults with mental health issues.

2.1.13 Although instances of abuse in Supported Accommodation have increased this is proportionate to the increase of this type of housing within the city.

2.1.14 For perpetrators outcomes there has been a drop off in convictions following significant changes to the Sheffield's Polices' Public Protection Unit. Improved training and support provided through the Police is resulting in an increase in capacity to utilise the Criminal Justice system to full effect. Disciplinary action taken by employers continues to be a positive outcome as it can take less time than other outcome routes.

2.2 Summary of Issues

2.2.1 As yet we do not have a complete sense of the extent to which abuse and neglect are prevalent across the city. A priority in 2013/14 is to establish the potential extent of abuse and neglect by starting to map this across the city. Useful primarily as a mechanism for identifying circumstances in which potential abuse / neglect may occur enabling us to have a stronger focus on prevention.

2.2.2 Inconsistencies as to what constitutes an alert and a referral remain an issue. We continue to address this through a comprehensive accessible training programme. 2314 frontline staff across partner agencies were trained in the 12 months. An improved performance management and best practice framework will be operational from April 2014 supplementing existing and quality assurance audits, our case advice line and targeted surgeries across agencies.

2.2.3 The Safeguarding Adults Partnership continues to oversee multi-agency work to help people at risk. Throughout 2013 the Vulnerable Adults Risk Management Model [VARMM] and Vulnerable Adults Panel [VAP] have continued to protect those most at risk. The former is a multi - agency shared approach to identifying and managing risk with people who self- abuse or put themselves at risk through their behaviour and lifestyle. The Vulnerable Adults Panel brings together senior representatives from a range of agencies to jointly manage risks for those individuals who have complex issues. The behaviour of these people towards specific services requires wider engagement and co-ordination of interventions to manage risks of harm.

2.2.4 Although there has been an increase in the number Discriminatory Abuse cases this is again from a low level. Further intensive targeted work is being undertaken with the Police and other agencies with a public safety / law enforcement remit to make sure all instances of potentially Discriminatory Abuse and Hate Crime is being recorded and appropriately actioned.

2.2.5 Patterns of multiple abuse are emerging where neglect and financial abuse combine often when people are supported by family or friends in the community. There is the potential for this to increase and become a major

priority. Further work is needed with carers, who are often under acute pressure themselves, where there is a risk of this pattern occurring.

2.2.6 The vast majority of abuse takes place in an individual's own home often with family and friends, as perpetrators. Often this is the main carer, a trend that is increasing. A person's home is inevitably the least regulated environment. There has also been an increase in the number of social care staff identified as perpetrators. This is attributable to increased monitoring resulting in more alerts, possible financial pressures on poorly paid care staff, identification of cases where numbers of staff have been implicated in poor institutional practices or behaviour and deficiencies in staff training programmes.

2.2.7 The recording of outcomes for Safeguarding cases is being overhauled as some of the data is incomplete with cases being incorrectly classified as not requiring further action. We estimate no further action was an outcome in only 85 cases for the victim compared to the figure recorded

3 What does this mean for the people of Sheffield?

3.1 Safeguarding Adults directly contributes to the achievement of 2 council outcomes.

- Better Health and Wellbeing
- Safe and secure communities

How effectively the Safeguarding Partnership manages Adult Safeguarding is a reflection of how we deal with abuse and neglect across the city as a whole.

3.2 Safeguarding Adults is a partnership bringing together key agencies including primary and secondary health care providers and commissioners, social care providers across sectors, criminal justice agencies and housing providers as well as Sheffield city council. Effective cross agency working means delivery of better outcomes and value for the people of the city.

3.3 Safeguarding is about protecting those most at risk and dealing with those who harm them. Given the potential number of people at risk across the city Safeguarding has a significant direct role in protection and the reduction of avoidable harm. Achieving these aims is a major challenge.

3.4 Focusing on Safeguarding raises general awareness amongst people across the city of the risks of abuse and the circumstances that can give rise to it. Safeguarding provides a way for people to raise concerns, and assurance that those reports are taken seriously and acted upon.

3.5 Safeguarding is a mechanism for driving up standards and monitoring quality of care across sectors. As well as being a means to hold providers to account through a focus on identifying and promoting best practice it can deliver support and encourage self-awareness and improvement amongst providers.

3.6 Through our Customer Forum service users are able to represent and articulate the views of those Safeguarding is designed to help. The customer

Forum and other service user groups and the feedback from individuals supported by Safeguarding have all had opportunity to directly influence the way in which Safeguarding operates. Consultation with service user groups will be completed in advance of the introduction of revised Safeguarding procedures planned for April 2014.

4. Recommendation

The Committee is asked to review the annual report and provide comments and reflections on the work related to safeguarding Adults described in the Annual Report

Simon Richards
Head of Adult Safeguarding
03/01/14

Appendix 1

The 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
    - Relevant 'Council officer with Social Services responsibilities'
    - 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, on the balance of probability, as to whether abuse had taken place. Also a Protection Plan is confirmed.

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

Appendix 2

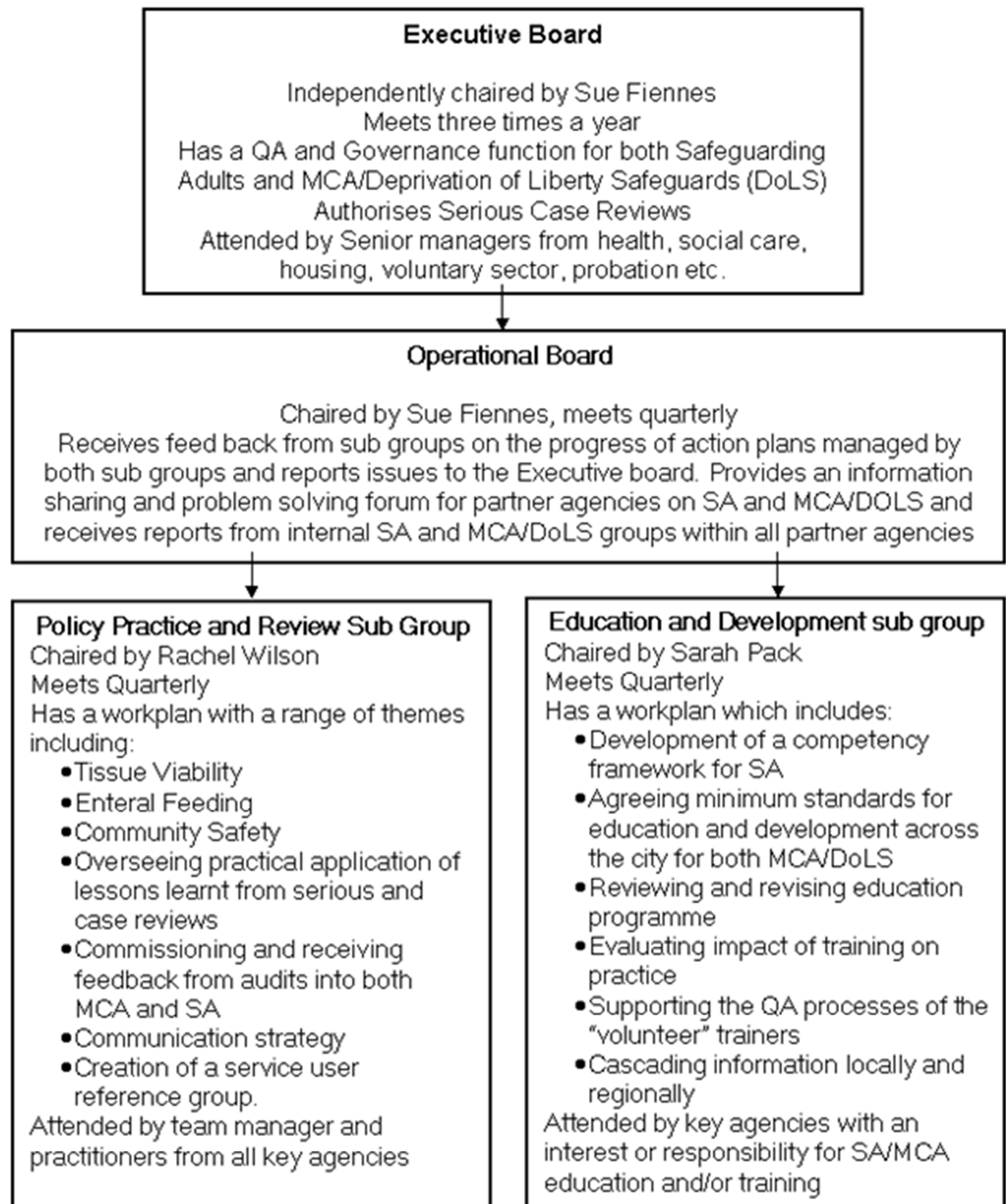
Mental Capacity Act and Deprivation of Liberty Standards Process

The European Court of Human Rights (ECoHR) 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 the responsible body (Supervisory Body) for assessments in Care Homes and Hospitals.

Appendix 3

Safeguarding Adults Governance



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Sheffield Adult Safeguarding Partnership

Annual Report 2012 - 2013

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Introduction by the Independent Chair

Glossary

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Independent Chair commentary

Sue Fiennes Independent Chair

Sheffield Adult Safeguarding Partnership

Dear Colleagues

This annual report comes at a time of very stretched finances even so, partners have been determined to continue to support the Safeguarding Adults Partnership at the same level which has enabled developments to continue.

The safeguarding pathway has become more robust and alerts have increased from ethnic minorities. This shows both more confidence to raise concerns and improved data quality.

The Safe in Sheffield scheme has been very successful and plans for the scheme to cover South Yorkshire are being discussed.

The Partnership has a Customer Forum which is increasingly involved in assisting with data on how safe people feel.

The voice of the Forum is valued and supported.

This year has also seen the Safeguarding Adults Board reviewing the governance of the safeguarding arrangements to ensure they are fit for purpose going forward. This review is now complete and the results will be shared early in 2014.

As part of this review an additional post has been supported to enable the Board to be assured on the health/NHS perspective in both the safeguarding pathway and the development of quality practice in this area of work.

It must be said that the quality of practice in safeguarding adults is going to be an important priority for the Board.

It is worthy of note that the practice in relation to self-neglect in Sheffield is well regarded nationally and soon research will be published in which will show the Sheffield contribution.

I would wish to thank all practitioners and partners for their commitments over 2011/12.

Sue Fiennes

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
- **CCG** -Clinical Commissioning Group – Commissioner of health services in Sheffield, manages GP contracts, oversees quality of health providers.
- **SHSCFT** – Sheffield Health and Social Care Foundation Trust - provides a wide range of services across the city across all age ranges for Mental well-being, Learning disabilities, and neurological assessment and rehabilitation. SHSC 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 and adults with substance misuse issues.
- **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 for a decision for admission into safeguarding processes
- **Protection Plan** - plan agreed to maximise the safety and well-being of an adult who is named as the alleged victim in a safeguarding cases
- **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

Safeguarding people of Sheffield – what have we been doing?

Case Advice

The Safeguarding Adults office provides case advice on:

- Safeguarding Adults processes
- Mental Capacity and Deprivation of Liberty
- VARMM
- Vulnerable Adult Panel
- Local and Regional links for safeguarding and MCA

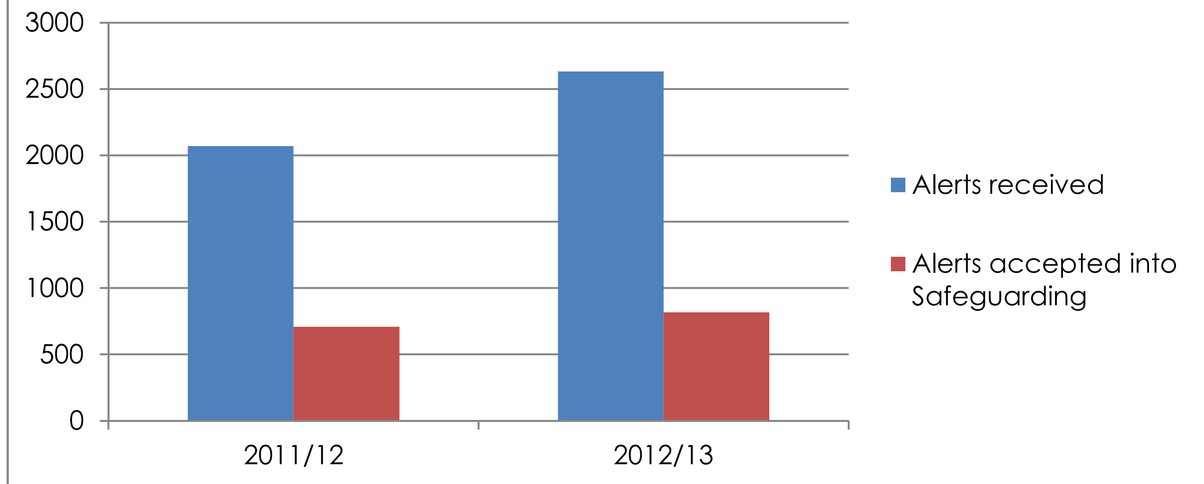
The office has a service standard of responding to case advice within three hours, in the year this was achieved in **98.5%** of requests.
General Practitioners contact with the office doubled in the year as a direct result of delivering a Protected Learning Initiative (specialist training session) jointly with the CCG.
Safeguarding Leads within health provide a useful alternative for health staff to discuss safeguarding concerns and is highly valued.

Alerts and Referrals by Service Area

Alerts

This is the stage at which concerns are raised about the safety of an adult, believed to be vulnerable; alerts can be raised by anyone and are received by the following individuals/organisations:

- Adults Access (24 hour phone line)
- Named worker – health, social care, mental health etc.
- CQC – regulator of health and social care
- Complaints departments - who transfer to safeguarding, as appropriate.



The increase in numbers of alerts is comparable with the rest of the Yorkshire and Humber region.

1606 women were referred into safeguarding compared with 1027 men
The table below indicates the number of alerts/referrals by Ethnicity, progress continues to be made in supporting communities to refer into safeguarding but this requires additional work to reflect the demographics of Sheffield. (Further information on this work can be found in section Two).

Alerts and Referrals by Ethnicity (2011/12 data shown in brackets)

Ethnicity	Number of Alerts	Number of referrals
White British and White Irish	2297	733
Asian	60 (54)	21 (18)
Mixed race	23 (12)	11 (8)
Black	60 (46)	17 (11)
Chinese	3	1
Other	14 (8)	7 (8)
Refused or not obtained	146 (72)	12 (14)

Alerts/Referrals by Service Area and Age

Vulnerability	Age band	Number of alerts in 2012/13	Number accepted into safeguarding	
			2011/12	2012/13
Learning disabilities	18 - 64	519	137	248
Mental health	18 - 64	318	52	27
Physical disabilities (sensory impairment)	18 - 64	256	80	77
Substance misuse	18 - 64	55	19	5
Older adults	65 +	1464	124	453
Total		2612	**412**	453

The numbers of cases screened into safeguarding is comparable with other Local Authority areas (about 33%), however the number of cases screened into safeguarding processes by Mental Health and substance misuse does not follow the local/regional trends.

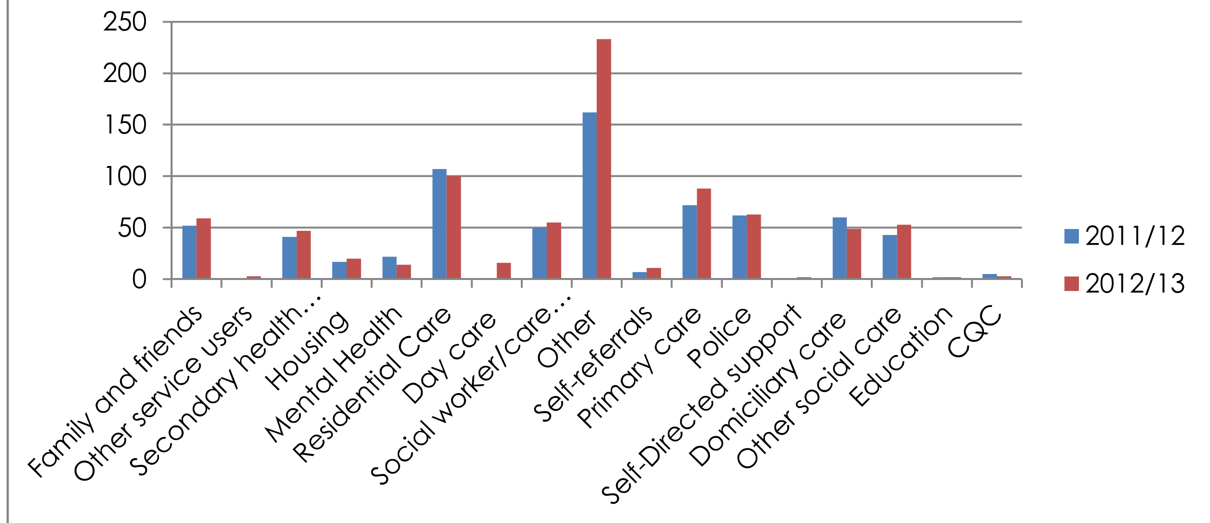
Mental Health receive a large number of alerts that relate to adults who are not eligible for safeguarding as there is no “alleged perpetrator” where concerns exist about their mental health and/or living circumstances. Nationally the numbers of individuals with mental ill health within safeguarding remain low which may be partly explained by use of the Care Programme Approach (CPA) instead of safeguarding. Work is underway to ensure that adults are being supported to stay safe through the use of the CPA processes.

The large increase in the number of cases screened into safeguarding by learning disabilities is related to the increase in the number of alerts suggesting the “risk appetite” has decreased in light of the national scrutiny on these services.

The following are considered by Safeguarding Managers within Sheffield City Council and Sheffield Health and Social Care Mental Health Services to determine if Safeguarding is appropriate:

- Vulnerability of the client
- Significance of the harm
- Risk to this adult
- Risk to other vulnerable adults
- Views of the adult and their ability/willingness to protect themselves
- Context of the concern/alert

Training is available to assist practitioners to improve the consistency of this screening process; however numbers of cases screened in by services remains inconsistent across the city. Inconsistencies continue to be addressed across the partnership.

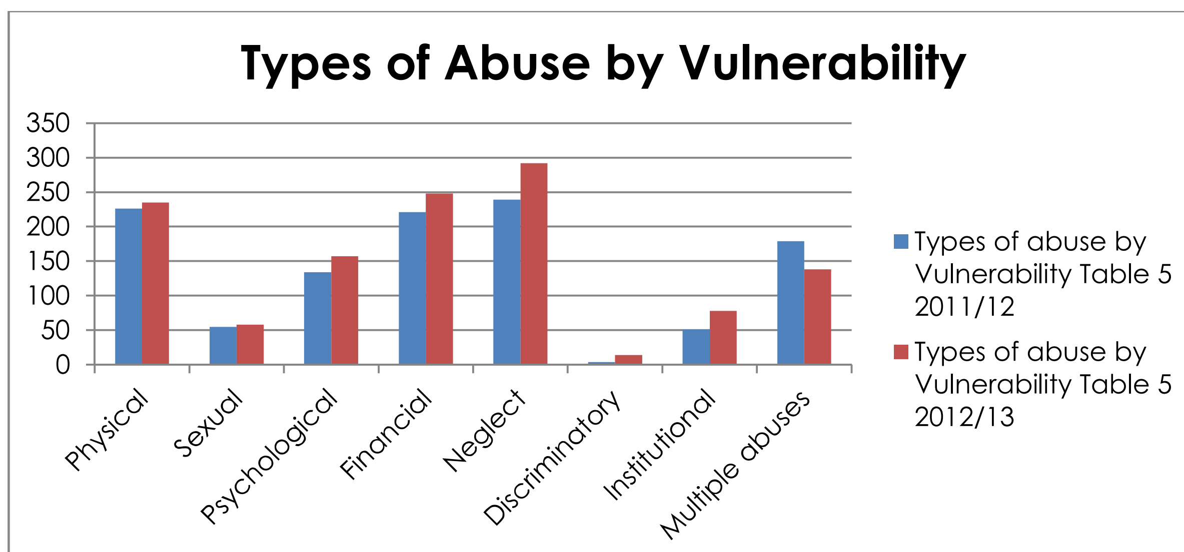


We are very encouraged by the continued increase in the number of referrals from family, friends, other service users and self-referrals. These numbers remain low but do suggest that the work with the customer forum and the Safe in Sheffield scheme is providing reassurance to these groups to access safeguarding.

The continued year on year growth from primary care is encouraging and indicates that the joint work with NHS Sheffield/CCG to engage GP practices in Safeguarding and VARMM by delivering specific training events is delivering positive results.

It is unclear why the number of referrals from Day Care has increased, this is not linked to specific training or learning from case reviews/serious case reviews however it is a positive change and one that we will monitor in future years.

The decrease in referrals from mental health may be linked to the use of alternative processes. The decrease in the number of referrals from domiciliary care may indicate that they are more confident in not making alerts when concerns are unlikely to meet the safeguarding threshold. This links directly to an increase in representatives from these sectors attending the Referrers' Training provided by the Safeguarding Adults Office. Alternatively it may be an indication that some providers are not raising alerts. Concerns are being addressed as safeguarding and contracts work closely together. The remainder of the referral rates have remained consistent and are reviewed annually.



Analysis of this data illustrates the majority of the physical abuse in the under 65 category is experienced by adults with learning disabilities (80 cases); adults over 85 accounted for 45 of the 111 reported cases.

Adults with learning disabilities are the most likely to be involved in sexual abuse (39 of the 50 cases) in the 18 – 64 age category. Six adults over 85 are included in the eight cases in the over 65 age category.

Psychological abuse was experienced by 50 adults with learning disabilities, under 65 years of age, and of the 73 cases involving adults over 65, fifty two cases involved adults over aged over 75. A number of these cases are linked to health and social care settings.

Financial abuse continues to escalate, in line with national trends, in the majority of cases the alleged perpetrator is a family member or friend. Some significant examples involving workers have been highlighted but are relatively rare. In line with the other abuse types; adults with learning disabilities (under 65) are most likely to experience this abuse (53 of the 97 reported cases). Adults with mental health issues are also significantly represented in this category with 10 adults aged under 65 affected. The majority of the cases involve older adults, of which the majority were adults over the age of 85 (61 cases). This raises challenges in ensuring that if adults are deemed to lack mental capacity to manage their finances that adequate risk assessments and monitoring are completed to avoid giving control to families who may not manage the money in their best interests.

Neglect cases numbers continue to rise, in line with the region, this is partly due to the level of scrutiny residential and nursing providers experience and the sharing of intelligence and data across both health and social care. Adults with Learning Disabilities are often in receipt of services compared with adults with physical disabilities etc.; which reflects in the 83 cases reported. Adults aged over 75 are more likely to be in receipt of services and this reflects in the 164 cases investigated under safeguarding. Similar factors impact on the number of institutional cases, particularly in social care, a small number of cases have been proven in Health settings but these remain low, in line with regional data.

It is encouraging to see the steady increase in the number of cases of Discriminatory abuse. Adults with learning disabilities account for 8 of the 14 cases. Many of these additional reports are directly linked to the Safe in Sheffield scheme, which has also reflected in a sharp increase in the number of reports of hate incidents and hate crimes involving vulnerable adults.

Adults who are in receipt of services are more likely to experience multiple abuse. A pattern of multiple abuses (financial and neglect) is starting to emerge for adults who are supported by family and friends in the community. Additional work will be required to support families to provide high quality care to vulnerable adults to minimise the risk of continued escalation of this trend.

The majority of abuse continues to be experienced in an adults' own home, often perpetrated by family members and friends as this is likely to be the least regulated and monitored environment. Sadly, for many adults who require care and support to maintain their independence, the one environment it would be reasonable to expect to be safe, is often the most likely to result in abuse.

Location of Abuse by Age and Comparison with 2011/12 (ages shown for 12/13 only)

Location	2011/12	2012/13	*Under 65*	*65 - 74*	*74 - 84*	*85 plus*
Own home	307	361	*166*	*49*	*71*	*75*
Permanent care home	130	130	*34*	*12*	*27*	*57*
Permanent nursing care	73	85	*16*	*7*	*19*	*43*
Temporary care home	9	22	*2*	*3*	*1*	*4*
Alleged perpetrators home	45	37	*22*	*5*	*4*	*6*
Mental health setting	4	3	*0*	*0*	*2*	*1*
Acute Hospital	16	20	*2*	*4*	*9*	*5*
Community hospital	3	0	*1*	*0*	*0*	*0*
Other health setting	1	5	*2*	*0*	*1*	*2*
Supported accommodation	32	44	*30*	*6*	*5*	*3*
Day centre/service	13	26	*24*	*0*	*2*	*0*
Public place	12	44	*36*	*3*	*4*	*1*
Other	22	36	*36*	*3*	*4*	*1*
Not known	17	21	*14*	*1*	*3*	*3*
Totals	684	850	387	96	156	211

The majority of abuse experienced by adults under 65 in their own home is directly linked to their relationship with the perpetrator, (shown in table below); for those adults whose home is a permanent care setting the majority of the adults under 65 have learning disabilities and in the over 65 age groups these adults are likely to have cognitive impairments linked to dementia etc.

The rise in the number of cases reported in supported accommodation is directly linked to the growth of supported accommodation provision in the City. The significant increase in the number of incidents in public places is a positive outcome of work with a range of agencies to provide “safe places”. This trend will require monitoring to ensure that this increase is linked to these agencies and not an increase in opportunistic attacks on vulnerable adults.

The table below outlines the relationship with the alleged perpetrator, the rise in number of social care staff identified as perpetrators is significant and is attributed to:

- Increased monitoring resulting in more alerts being raised
- Financial pressures faced by workers increasing the risk of financial abuse of adults, especially those with cognitive impairments
- A number of institutional cases identified individual workers responsible for abuse and neglect
- A trend to suggest that the quality of training may not be robust enough to promote safe practice (e.g. medication training) evidenced at case conferences and from case analysis

Relationship between Vulnerable Adult and Perpetrator (by age)

Relationship	***2011/12***	*2012/13*	*2012/13 (under 65)*	*2012/13 (over 65)*
Partner	*47*	*48*	*22*	*26*
Other family member	*123*	*120*	*43*	*77*
Other vulnerable adults	*34*	*33*	*17*	*16*
Neighbour /friend	*66*	*64*	*37*	*27*
Stranger	*6*	*9*	*7*	*2*
Volunteer	*2*	*1*	*1*	*0*
Health worker	*14*	*21*	*6*	*15*
Social care staff - breakdown shown in italics.	*93*	*228*	*88*	*140*
Domiciliary care staff		*70*	*31*	*39*
Residential and nursing care		*131*	*35*	*96*
Day care staff		*6*	*6*	*0*
Social worker/care manager		*0*	*0*	*0*
Self-directed care		*0*	*0*	*0*
Other		*21*	*16*	*5*
Not know	*256*	*239*	*103*	*136*
Other	*57*	*46*	*35*	*11*
The alleged perpetrator lives with the vulnerable adult	*123*	*125*	*65*	*60*
The alleged perpetrator is the main family carer	*72*	*89*	*39*	*50*

The increase in the number of cases involving the main carer as the perpetrator is a worrying trend. Closer scrutiny is required across all agencies as there is an increasing emphasis on families providing care in response to financial pressures. The numbers of "not known" cases relate to adults who have multiple people/agencies involved in their care and it is difficult to identify who might have been involved in the abuse concerns.

Outcomes for safeguarding activity (including case conferences)

The table below details the outcomes for the victim and perpetrator with comparator data for 2011/12; social care staff have been completing the no Further Action field based on the action at the point of exit. The DOH return guidance indicates it is a summary of action taken to protect the adult. An analysis of the data indicates the number of NFA cases is approximately 85 for the victim and 50 for the perpetrator. The Care First system is being amended to prevent recurrence.

Outcome for Victim

Outcome	2011/12	2012/13
Increased monitoring	*115*	117
Vulnerable adult moved from property/service	*9*	11
Community care assessment/service	*38*	59
Civil Action	*1*	0
Court of Protection	*1*	1
Appointee ship changed	*2*	6
Advocacy scheme	*6*	6
Counselling/training	*1*	4
Different or increased care	*2*	6
Management of finances	*14*	13
Guardianship or use of MH Act	*0*	0
Review of SDS	*13*	12
Restricted access to perpetrator	*7*	12
Referral to MARAC	*3*	0
Other	*35*	38
No Further action	*337*	498 (85- adjusted figure)

Outcomes for the victim of safeguarding

182 protection plans were agreed, of which 66 adults agreed with the plan, 115 adults were unable to give consent and a best interest decision was reached to implement the plan to reduce the risk of on-going harm and only 1 individual refused the plan but was subject to increase monitoring.

Of those adults able to express a view about whether or not they felt safer as a result of the safeguarding intervention overall 92% indicated they did feel safer, the level of satisfaction with the process was only 85%(based on a smaller cohort of individuals prepared to discuss with staff from the safeguarding office).

Outcomes for the alleged perpetrator

The decrease in the number of criminal cases is a reversal of previous trends and may have been affected by the significant changes experienced by our local Public Protection Unit. We anticipate that planned training and clarification of structures in 2013/14 will increase our ability to maximise use of the criminal justice system

The number of cases concluded by disciplinary is a positive outcome for both the victim and perpetrator as it reduces the number of interviews and in most cases reduces the time taken to conclude the safeguarding concern. For employers this reduces their overheads associated with paying a member of staff whilst suspended, often on full pay. The large number of NFA's are due to data collection issues as previously described.

Outcomes for the Alleged Perpetrator

Outcome	2011/12	2012/13
Criminal prosecution or caution	*10*	3
Police action	*27*	14
Community care assessment	*11*	11
Removal from property or service	*7*	12
Managed access to vulnerable adult	*9*	9
Referral to ISA/DBS	*2*	0
Referral to registration body	*2*	0
Disciplinary	*28*	45
Action by CQC	*0*	0
Continued monitoring	*111*	115
Counselling/training	*17*	17
Action by contracts	*6*	1
Exoneration	*7*	10
No Further Action	*257*	325 (50 - adjusted figure)

Case Conference Activity

113 initial case conferences and 127 virtual case conferences were administered by the Safeguarding adults' office during the year.

Section 2 – Sheffield Adult Safeguarding Partnership Activity

Pages	Content
15 - 17	Report on Business Plan and other activities
18 - 22	Report on the work of the Sub Boards of SASP
23	Priorities for 2013/14

Business plan

In addition to business as usual activity SASP set 6 key objectives for the year, summarised below:

Outcome	Achievements	Challenges
Build on SASP's relationship with GPs and the lead Safeguarding GP and Shadow Clinical Commissioning Group	• Well attended and evaluated protected learning event for over 250 GPs and practice staff. • Independent chair engaged with CCG and completed a 360 degree assessment related to safeguarding for adults and children • Chief nurse to sit on the SASP board • Increase in the number of requests for case advice from GPs	• Maintaining GP interest in the coming year.
Develop SASP policy and practice in relation to financial abuse	• Sheffield SCC completed an internal audit of SDS and financial abuse risks which reported to SASP • A joint workshop with Children and Young People's services was held to evaluate risks and opportunities associated with the Welfare Reforms • Links were made with the relationship managers from the DWP • DWP clarified their approach and involvement in safeguarding • Police to include safeguarding training in Street Skills, for all officers	• DWP response (nationally) is to discourage active involvement in Safeguarding and focus on direct management of benefits. This has resulted in some positive local relationships being revised.
Develop a quality assurance programme across SASP to include standards, dignity and harm reduction and establish links to the executive quality in care homes board	• Head of Quality and Safeguarding is represented at the Executive Care Homes Board • Updates are provided by Chair of the group to SASP at least annually • Robust frameworks for risk management and escalation implemented by SCC contracts have been shared and endorsed by SASP • VAP panel is jointly chaired by Head of Quality and Safeguarding and the police and an evaluation process to identify "savings" have been	None at this time

	implemented	
Outcome	**Achievements**	**Challenges**
Examine areas of under-reporting and develop best practice responses	• An equalities workshop was held to examine all protected characteristics and an action plan developed • Safe in Sheffield project has provided a springboard for the creation of third party reporting centres for hate incidents and hate crime which has increased in this year. • Head of Service and the Safeguarding office are actively involved in the hate crime forums and discussions across the city.	Resource to carry forward the action plan has been "frozen" as part of SCC budget savings
Continue service improvement around the transitions agenda for young people for both safeguarding and MCA/DOLS (deprivation of liberty safeguards)	• Joint action plan has been agreed by both Safeguarding boards and is being jointly monitored by the service managers from Children and Adults Safeguarding • Wider agenda around restructuring services for 14 to 25 year olds. (programme board)	Progressions Programme Board stalled due to changes in senior members of staff.

Serious Case Review - Adult B

SASP commissioned and signed off a SCR. An action plan was put in place response to the death of an older adult in a house fire. The adult was in receipt of both health and social care services, despite this and the treatment for burns linked to her smoking and limited mobility an adequate fire assessment had not been completed.

The learning from this case has been included in training provided by the Safeguarding Adults Office and has been written up in the bi- monthly newsletter

Serious Case Review - regional learning event

Sheffield and Doncaster Safeguarding collaborated to host joint learning events in Sheffield and Doncaster, focussing on the learning from a case involving an adult with learning disabilities and a self-neglect case that resulted in the death of a young woman with physical disabilities. The learning has been cascaded throughout health and social care organisations in the region, informing best practice.

Safe in Sheffield

SASP funded a project to establish a network of Safe Places across the City, initially focussed on adults with learning disabilities but with a longer term plan to extend to offer support to adults with cognitive impairments and mental ill health.

The scheme is project managed on behalf of SASP by the Safeguarding Adults Office, South Yorkshire Police, Safer and Sustainable communities, First Point and Heeley City Farm (who manage the part – time worker on a day to day basis).

Achievements in the first year include:

- Setting up over 60 safe spaces across the city, providing disability awareness training to staff and managers to assist them to respond to the needs of adults with learning disabilities
- Establishing and supporting a group of adults to deliver information sessions to organisations who may have clients who would benefit from the scheme
- Agreeing and distributing safe places cards to assist the adult and safe place venue to maximise the positive impact of the contact
- Sharing the learning regionally to cascade a best practice example
- Work with the police to explore the possibility of the Safe Spaces being used as third party hate crime reporting centres.

SASP has agreed a 50% funding of the scheme into 2013/201, the other 50% has been secured from Safer and Sustainable Communities.

Governance review

In 2013 SASP completed a governance review in response to significant changes across partner agencies. The review was led by the Executive Board and has focused on:

- A shared purpose for all partner agencies
- Developing the Executive role in leading the partnership
- More clarity on roles and responsibilities
- Stronger linkages and coherence across the partnership
- Building better working relationships.

Report from Sub Boards

SASED – Sheffield Adult Safeguarding Education and Training

Key Achievements

- ### Competency Framework

Building on the work completed by Bournemouth University on Safeguarding Competencies, Sheffield has been an active member of a regional group exploring the development and implementation of a competency framework for all workers. An on- line tool has been developed to record workers competencies and to support management scrutiny of individual and team progress. Further work is planned for 2013/14 to agree how the competencies will be rolled out.

- ### Street Skills

A regional venture, led by Sheffield has resulted in agreement that all South Yorkshire police will attend a safeguarding session during 2013/2014. The first session ran early in March 2013 and evaluated well. These sessions will be delivered by Barnsley, Doncaster and Sheffield.

- ### Re- accreditation of the Safeguarding Adults Training for Trainers course

Following restructure of education and changes in personnel the course, which is nationally recognised, needed to be re-accredited. This work was initially progressed with Rotherham and then Sheffield colleges and is due to be completed mid 2013.

- ### Consultation with the customer forum

Active engagement with the forum to evaluate the training materials to ensure that the messages delivered to practitioners were in line with the views of the customer forum, within the confines of the current procedures. Training has been provided to the training forum to support their role within the wider SASP.

- ### Supported the Protected Learning Initiative for GPs

SASED supported the involvement of the Safeguarding Office to deliver a number of workshops at this event, in collaboration with health partners. These included Safeguarding, Mental Capacity and Vulnerable Adults Risk Management Model.

- ### Maintenance and support of the Training Pool members

In the current climate many of the volunteer trainers have found it difficult to maintain their involvement in the training pool as their own employment has been under threat. Thanks to the on-going support from the Development and Training manager we continue to have a really committed group of individuals, to whom we owe a debt of gratitude. We hope that their commitment will be mirrored by support from their organisation to continue their involvement in delivering essential training in the coming year.

Challenges

Membership and strategic direction

The group has struggled to maintain effective membership to ensure that safeguarding is embedded within all agencies; the Independent Chair has been involved in reviewing membership. Without appropriate membership it is difficult to agree a strategic direction for safeguarding and MCA/DOLS training to provide the necessary assurance to SASP. This remains an on-going issue which will be resolved via the governance review work in 2013/14.

Policy and Practice Sub Board

Key Achievements

- Review of Enteral Feeding Pathway

A multi-agency task and finish group resulted in the creation of a paper circulated for adoption in all agencies. The main focus of the group was to examine compliance with the Mental Capacity Act and the Best Interest principles and practice.

- Evaluate the involvement/experience of the service user in the safeguarding process

Data from service users in relation to their experience of safeguarding and whether they felt safer as a result of safeguarding was reviewed and confirmed as valuable. Additional questions to be added to the main social care records to support future analysis. Initial meetings held with service users to establish a customer forum.

- Improve community safety by engaging community safety, trading standards and police

All agencies engaged in setting up the Safe in Sheffield Scheme and reviewed their internal responses to safeguarding in light of this. This has led to an increase in referrals from these sectors and an increase in the number of hate incidents and crimes being reported.

- Reviewed communications

A multi-agency group, including customers, reviewed and amended existing communications – leaflets, posters for both Safeguarding and Mental Capacity/Deprivation of Liberty Safeguards. Work to revise the web site was not progressed due to budget constraints. The poster campaign resulted in an increase in safeguarding alerts made by the public.

- Commissioned and received information from a series of audits

The group commissioned a series of audits in both health and social care to evaluate the quality of alerts, use of the Mental Capacity Act and a review of the forms. The data resulting from these was used to inform changes to forms, practice guides and practice development sessions.

- **Managed Case reviews**

The group managed the action plans for the case reviews. It was agreed later in the year that this work would be taken over by the operational board due to the volume of work on the sub board's action plan.

- **Use of advocates**

A mapping exercise was completed to explore the availability of advocates in the city; specific guidance was issued to practitioners to illustrate when an IMCA should be engaged.

- **Pressure relieving equipment responsibility pathway established**

Concerns about delays in essential equipment not following the individual in a timely manner as they move between services resulted in a multi-agency task group being established that resulted in a pathway being agreed between Sheffield City Council and Health partners.

- **Development of a root cause analysis into tissue viability concerns**

A number of alerts had been raised about tissue viability concerns that were not founded on investigation, a root cause analysis tool and pathway was agreed to support appropriate screening of these concerns to avoid unnecessary and time consuming investigations.

Challenges

Clarity about the relationship between the PPR and the wider SASP structures created some tensions about how work would be managed/commissioned; this was largely resolved by a review of the terms of reference. A future review of the group and its relationship with other city wide forums including medication management forums etc. will require future scrutiny.

Customer Forum

Key Achievements

- **Terms of reference agreed**

Terms of reference and membership of the group agreed and its relationship with the wider SASP structures explored, including joint meetings with the chair of the Policy and Practice Review and SASED sub boards.

- **Involvement in re-write of safeguarding leaflets and posters**

Members of the group contributed to the design and content of the leaflets and posters.

- **Established relationships with relevant forums**

The chair and vice chair established relationships with relevant city forums including the Learning Disability Parliament, Safe in Sheffield to promote effective communication and learning.

- **Reviewed and contributed to the Winterbourne learning**

The group actively reviewed the learning and documents from the Winterbourne review and sought assurances that appropriate preventative actions were in place in Sheffield.

- **Commissioned and supported members of the group to develop their knowledge of both Safeguarding and Mental Capacity.**

The chair commissioned the safeguarding adults office to deliver a series of learning events for members of the customer forum to increase their knowledge and confidence which is hoped will support them to be more active members.

Challenges

Maintaining effective communication between members of the group who are volunteers and supporting them to be active members. The group would like to acknowledge the support from the Safeguarding Adults office and Communities directorate in supporting them to develop into an effective forum

Decision making and delegated powers will require further scrutiny in the coming year.

Sheffield Adults Safeguarding Adults Partnership Priorities for 2013/2014

- Implement outcomes from the 2013 Safeguarding Adults Board (SAB) Governance Review
- Respond to improvement drivers (local and national) ensuring learning is embedded in practice, strengthening of risk mitigation and to ensure partnership working is effective
- Produce a Safeguarding Adults Performance Management Framework, focusing on delivering outcomes that make a positive difference to people at risk
- Strengthen relationships with stakeholders across Sheffield by developing linkages with relevant bodies and forums actively promoting a culture of candour combined with appropriate levels of professional challenge
- Establish a baseline understanding of the nature and extent of abuse and neglect across the city and use this information to inform strategic planning, priority setting and performance targets.

Section 3 – Partner Agency's Contributions to Safeguarding

South Yorkshire Probation Trust (Sheffield)

	How did you contribute to delivering the SASP 2012-13 Business Plan?
We participate and engage in operational and executive board business. Strong leadership within Sheffield Probation in terms of dissemination of key safeguarding messages and communication between operational delivery and strategic planning.	
	How did you perform over and above the SASP 2012-13 Business Plan within your organisation to make people feel safer, and describe evidence to support this
SYPT s central aim is to accurately assess and effectively manage on a continual basis the risks posed by offenders in order to reduce future harm. We proactively work and cooperate with other agencies to safeguard individuals and promote their well-being. The trusts supervision policy states that all team managers will review high risk cases on a 6 weekly basis - the high risk assessment includes risk of harm to self. Any training /development needs identified would be reflected in annual appraisal. Our " continuous improvement programme " reads random case files on a monthly basis and offers offender managers feedback which is followed up in supervision. Single point of contact (SPOC) who is a manager for staff to talk to about any concerns re adult safeguarding. SPOC will advise next steps.	
	We accept there is no single system that allows us to easily report and analyse concerns across the partnership that do not meet the Safeguarding threshold for referral into Social Care and consequently the outcomes and view of the service user. Reflecting back over the past 12 months, please share your local intelligence to describe activity, themes and trends relating to the concerns and alerts you received
Very few alerts over last 12 months – however, those cases that cause us most concern are mental health related and in terms of lack of support for individuals.	
	Looking ahead, please share your local intelligence to help predict emerging areas of risk and opportunity, relating to Safeguarding Adults, VARMM and MCA detailing any potential threats and opportunities

Our biggest gap in resources is mental health provision, closely followed by homelessness.
Training on MCA is an opportunity for staff to familiarise themselves with the pathway.
A threat over next 12 months is the "transforming rehabilitation programme "as we are not sure how the service to offenders is going to look after March 14.

South Yorkshire Police

How did you contribute to delivering the SASP 2012-13 Business Plan?

SYP have made strong progress in training and development, having continued to participate in the "Working Together" initiative and deploying training packages on Adult Safeguarding to all front-line Police officers through the Street Skills force-wide training programme.

SYP have also continued their involvement in Serious Case Reviews to maintain the momentum of organisational learning.

How did you perform over and above the SASP 2012-13 Business Plan within your organisation to make people feel safer, and describe evidence to support this

Initiatives in relation to criminality affecting vulnerable people, especially in their homes (such as distraction burglaries and rogue trader activity) were implemented across the city under the "Operation Liberal" protocols.

The experience of vulnerable people on the issue of Anti-Social Behaviour (ASB) continues to be monitored and local plans to support vulnerable ASB victims continue to be generated and deployed. The levels of reporting of ASB remain in line with previous trends.

We accept there is no single system that allows us to easily report and analyse concerns across the partnership that do not meet the Safeguarding threshold for referral into Social Care and consequently the outcomes and view of the service user.
Reflecting back over the past 12 months, please share your local intelligence to describe activity, themes and trends relating to the concerns and alerts you received

Themes and trends remain in line with previous years, increasing involvement in mental health crisis in homes and the community (as below).

Looking ahead, please share your local intelligence to help predict emerging areas of risk and opportunity, relating to Safeguarding Adults, VARMM and MCA detailing any potential threats and opportunities

The last 12 months has revealed an increasing trend in the involvement of police officers in dealing with mental health crisis in the home and within communities, often necessitating the use of police powers of detention in order to create a safe situation in which the needs of vulnerable people can be assessed and dealt with.

There is a growing recognition that more work is required across the partnership to ensure that staff with the most appropriate resources, skills and abilities are available for deployment to ensure that the most effective and least intrusive interventions are made in every case. Early work with partners suggests that good progress is possible and the trial of a mobile "Triage Team" to attend incidents and advise front-line staff on initial actions is being organised over coming months.

Furthermore general police training on issues around the MCA will be undertaken to continue to develop front-line staff.

Sheffield Health and Social Care Foundation Trust

How did you contribute to delivering the SASP 2012-13 Business Plan?

Sheffield Health and Social Care NHS Foundation Trust remain committed and involved in all of the Safeguarding Board meetings and sub groups and have been involved in the delivery of many of the objectives set within the business plan. Executive leadership has supported the delivery of the Trusts own work streams in support of the overarching business pan including the development of training, contribution to the establishment and development of the Vulnerable Adults Panel, commencement of the development of service user feedback within the Adult Mental Health service and contribution to the Equalities Workshop

How did you perform over and above the SASP 2012-13 Business Plan within your organisation to make people feel safer, and describe evidence to support this

- The implementation of electronic alerts being received by secure email and cascaded to appropriate teams within integrated mental health teams.
- Access to the Local Authority recording system to enable the Trust Safeguarding Team to complete timely multi record searches
- The development of the Trust's Safeguarding intranet site
- Development of a completely electronic safeguarding alert section within the Trust's Electronic Patient Record system (Insight).
- Internal Audit (undertaken by Independent auditors not employed by SHSC) which has demonstrated that the trust has a 'significant level' of assurance in relation to how it safeguards people.

We accept there is no single system that allows us to easily report and analyse concerns across the partnership that do not meet the Safeguarding threshold for referral into Social Care and consequently the outcomes and view of the service user. Reflecting back over the past 12 months, please share your local intelligence to describe activity, themes and trends relating to the concerns and alerts you received

The Trust has identified a concern around the threshold for entry into safeguarding and the question has been raised as to 'when does individual poor practice become institutional or organisation poor practice and failures to keep people safe.

In the last 12 months:

- Activity - has increased, including requests for advice, support and training.

- Themes - there appears to be an increase in multiple types of abuse.
- Trends - an increase in 'notifications of concern' from South Yorkshire Police which do not meet the threshold for Safeguarding Adults as there is no perpetrator.

Looking ahead, please share your local intelligence to help predict emerging areas of risk and opportunity, relating to Safeguarding Adults, VARMM and MCA detailing any potential threats and opportunities

Clarity is required about when and how to log and alert into safeguarding, concerns relating to patient to patient and patient to staff incidents of aggression or violence.
VARMM needs to be made explicit in that it is a process only for people with capacity who refuse to engage with protection services/plans and appropriate health and social care interventions and treatment.

South Yorkshire Fire and Rescue

Annual Policy & Procedure Review & Update Feb 2013

The document's now include more detailed information on the Mental Capacity Act, Serious Case Reviews and Domestic Homicide Reviews.

Number of Alerts & Referrals

The numbers for internal safeguarding alerts for adults have been increasing for SYFR across South Yorkshire. In 2010/11 there were 42, 2011/12 there were 49 and 2012/13 there were 54. The majority were related to fire risks linked to Self-Neglect and resulted in referral for services or management in VARMM (in Sheffield) rather than Safeguarding procedures.

Training Needs Review & Gap Analysis

Our (single agency) Introductory Basic Awareness programme (Stage 1) is now almost complete. Additional multi agency training for Advocates and an annual update for Group Managers is ongoing and a 3yrly Update & Refresh Programme is being developed. There will be an initial assessment using the online Common Induction Standards in Safeguarding Module (Stage 2) which will inform the 3rd stage which will be delivered through Case Study workshops to embed safeguarding into practice.

SYFR Information Sharing Protocol

A missed opportunity for SYFR to share information, where there are significant fire safety issues within a Care Home has been identified and arrangements have now been made to address this gap.

Technical Fire Safety when serving enforcement notices will also inform (from March 2013) the Local Authority Safeguarding/Contracts and CQC where, an Enforcement Notice is served, on a Care Home. A further alert will follow if the responsible owner/manager does not take action to comply with the corrective measures. SYFR will continue to pursue through the legislative process, but Safeguarding/Contracts are able to factor in any fire safety risks into their own audit and risk assessment process.

Home Safety Check Risk Assessments

In response to recommendations from an IMR conducted as part of a Serious Case Review, linked to a Fire Fatality and increasing complex risk factors, SYFR has developed a more detailed and effective risk assessment tool for Home Safety Checks. In line with this change the policy has been rewritten and all frontline staff received training. The changes are

focused on identifying specific vulnerabilities and related risks together with direction toward the most appropriate actions required to address the risks. A raft of observations and questions direct the assessor to identify those that are at increased risk of having a fire or unable to respond and evacuate in the event of a fire. From this referrals are made into the Community Safety Team who then liaise with the most appropriate agency.

Dementia Pledge

SYFR has signed up to both the National and the Yorkshire & Humberside Regional Dementia Pledge. One of the activities on the Action Plan is to raise awareness for frontline staff and training is to be piloted with our Community Safety teams this summer.

Sheffield Teaching Hospitals NHS Foundation Trust

How did you contribute to delivering the SASP 2012-13 Business Plan?

Key Outcome 1: Continue our relationship building with GPs, including the lead Adult Safeguarding GP and shadow Clinical Commissioning Group

STHFT Named Nurse contributed to Protected Learning Initiative by delivering workshops relating to the Vulnerable Adults Risk Management plan. In addition bespoke safeguarding adults training delivered to GP practices on request.

Key Outcome 3: Develop a Quality Assurance Programme across SASP to include standards, dignity and harm reduction, and links to the Quality Care in Care Homes Board

3.1 STHFT named Nurse attended Care Home KPI meetings to share appropriate information and to follow up any actions relating to STHFT staff working in Residential care homes.

How did you perform over and above the SASP 2012-13 Business Plan within your organisation to make people feel safer, and describe evidence to support this.

There has been significant further progress made during the year on embedding the safeguarding structure and awareness into the organisation, evidence that this is happening is shown by the year on year rise in referrals and alerts and contacts with the STHFT Adult Safeguarding Team for advice.

The full integration of the Primary and Community Care Directorate has increased the level of activity for the STHFT Adult Safeguarding Team both in providing support and advice to community staff in the recognition and reporting of safeguarding concerns and in the provision of safeguarding training. It has however also brought some valuable resource, knowledge and expertise into the Trust .

The addition of the MCA Practice Development Facilitator post has strengthened the team's skills and knowledge base with regard to MCA/ best interest and has provided much needed training in this area of practice.

However, the work of the STHFT Adult Safeguarding team continues to grow with significant work streams having been added in the last two years i.e. PREVENT and the

Domestic Homicide Review (DHR) /Serious Incident process.

Prevent is about protecting people and is therefore fundamental to our duty of care. The emphasis is on supporting vulnerable individuals whether patients or staff.

Health care staff are well placed to recognise those who may be vulnerable and therefore susceptible to radicalisation and recruitment into terrorist organisations with the process akin to the Safeguarding Model, which protects vulnerable adults.

The Lead Nurse for Older People/ Vulnerable Adults is the Prevent link for STHFT and represents the Trust at the city wide and regional Prevent meetings.

The Lead Nurse is also the only active accredited Prevent WRAP trainer for the Trust and delivers the Health WRAP training to targeted staff groups on a monthly basis.

STHFT Involvement in the DHR process

Since June 2011 STHFT has participated in three full DHRs and two SI Lessons Learned Reviews. Unfortunately there was a further domestic homicide in June 2013 for which the SSCP is currently commissioning a DHR in which STHFT will be required to participate.

STHFT is represented on the DHR or SI Review Panels by the Deputy Chief Nurse or Lead Nurse for Older People/Vulnerable Adults in his absence.

The Domestic Abuse Strategic Board has set up a Domestic Homicide and Serious Incident Review sub group to be responsible for overseeing the progress of Domestic Homicide Reviews and DA Serious Incident Reviews and the implementation of action plans on behalf of the Board. The Lead Nurse for Older People/Vulnerable Adults represents STHFT on this group.

Independent Management Reviews (IMRs) of the Trust's involvement in the provision of services to both the victims and the alleged perpetrators of all the DHRs and SIs have been undertaken by the Lead Nurse for Older People/Vulnerable Adults.

Services are provided in accordance with the Disability Act to meet the individual needs of patients that are cared for within the Trust. A range of services are provided to meet specific patient needs; for example there is access to interpreters 24 hours a day; availability of a range of written information in different languages and 'Easy Read' versions of information for anyone with a learning disability; there is provision of prayer facilities and specific dietary requirements are met. Specific actions are in place to meet the needs of patients with a learning disability; e.g. access to a communications booklet in all areas. There has been an increase of staff in Community Teams to meet the needs of older people.

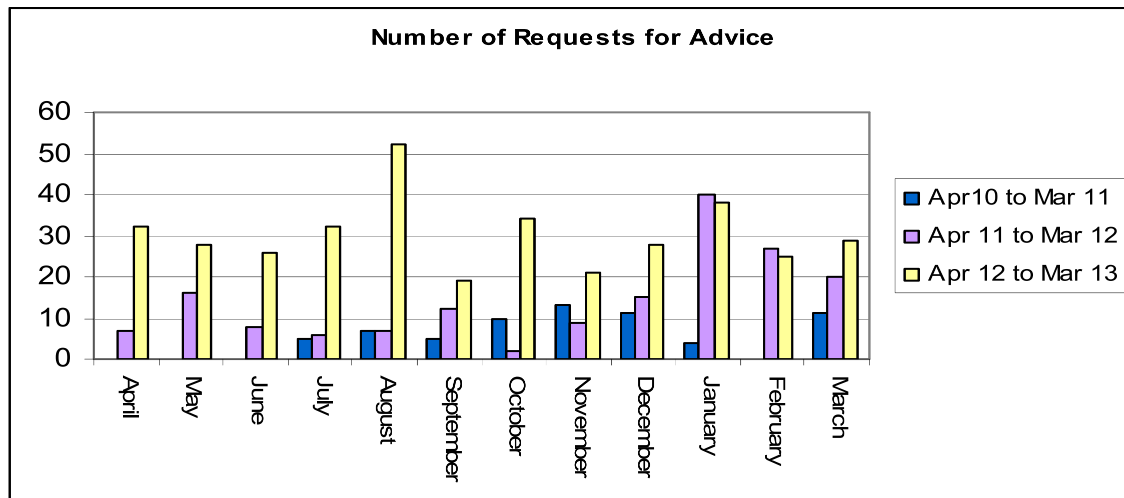
Friends and Family Test introduced nationally from 1st April 2013; not specifically for safeguarding however provides the opportunity for patients to rate care and to give specific comments. Results are carefully reviewed at ward level and are acted upon as appropriate. There will be follow up of FFT ward level actions during 2013/14, to ensure improvements are being made where feedback indicates this is required.

The Frequent Feedback programme of real-time surveys continues on a rolling programme. Results are fed back to wards for action planning. The patient sample is also reviewed by age, to ensure appropriate representation of patients across age groups representative of the Trust's patient population

There are posters and leaflets available in all wards and departments across STHFT

entitled 'Tell us what you think' that explains how to complain (easy read version available too), information is also available on the Trust Internet site. All complaints are monitored in the Patient Partnership (PP) department and any complaints that indicate potential safeguarding concerns are forwarded to the STHFT Adult Safeguarding Team for further scrutiny and consideration of referral into safeguarding procedures.

We accept there is no single system that allows us to easily report and analyse concerns across the partnership that do not meet the Safeguarding threshold for referral into Social Care and consequently the outcomes and view of the service user.
Reflecting back over the past 12 months, please share your local intelligence to describe activity, themes and trends relating to the concerns and alerts you received



The above table indicates a year on year comparison of the number of advice calls taken by the STHFT Lead Nurse and Named Nurse. Both of these posts were filled in July 2010 hence the lack of data from April to July 2010.
This level of recording currently indicates the number of calls received and is not sophisticated enough to offer any detailed analysis. The calls vary across the spectrum of abuse, some calls do not meet the criteria for safeguarding but certainly encompass the principle of prevention of abuse occurring e.g. issues of carer stress.
The current data collection system does not allow interrogation to determine the different kinds of abuse but we are working towards this.

Up until the end of June 2013 the alerts and referrals from STHFT would have gone directly to social care for screening therefore data relating to the numbers of alerts/referrals made is held on Care First. It is acknowledged that many of these referrals did not meet the criteria for further investigation under safeguarding procedures and were either screened out at the point of referral, or following a strategy meeting.
As from 1st July 2013 all alerts/referrals generated in STHFT will be forwarded to the STHFT Safeguarding team for scrutiny and where appropriate, formally referred into safeguarding procedures via Adult Access. This should enable the safeguarding team to compare the number of referrals made from July 2013 – March 2014 to the same time period in 2012-2013, using data held by the Local Authority to understand if the new process has affected the number of referrals that were taken through to strategy and case conference.

Central Training Provided by the Adult Safeguarding Team	Numbers trained 2012/2013
Safeguarding Adults Basic Awareness	234
Safeguarding Adults Update	80
Safeguarding Adults E-Learning	34
Safeguarding Adults Referrer Training	116
Vulnerable Adults Risk Management Model (VARMM)	39
MCA/ Best Interest/DOLS	195
PREVENT	93

The number of advice calls correlates with wider awareness of safeguarding adults related to attendance on formal training and responses to individual requests from staff across hospital and community.

Looking ahead, please share your local intelligence to help predict emerging areas of risk and opportunity, relating to Safeguarding Adults, VARMM and MCA detailing any potential threats and opportunities

Anecdotally on reflection of the past activity there is agreement that the emerging area of risk is self-neglect. This in itself provides an opportunity to explore training needs in this area as the UK evidence base is sparse. The potential to be involved in UK research would be an excellent opportunity to develop this work further to refine the VARMM model further.
Due to current redesign of services and loss of knowledge and expertise in some areas there is a threat to the standards endorsed by the SY procedures. The opportunity this provides is for creative ways of working to safeguard adults and for wider involvement of health in the safeguarding investigations.
Collaborative ways of working could be explored via the Policy and Practice review group.
The demographic element to the changing needs of the Sheffield population, are proving a challenge to the application of the mental capacity act. The ageing population and raised incidence of cognitive problems, long term survival post trauma where people have very complex health and social care needs and capacity may be a complicating factor. The opportunity this provides is for a member of STHFT safeguarding team to support staff with

complex decisions at the time they need to be made to ensure there are no unnecessary delays to treatment or discharge planning.

Sheffield Homes

How did you contribute to delivering the SASP 2012-13 Business Plan?
We have reviewed our internal procedures and delivered refresher sessions for safeguarding referrers and refresher training/briefings for all relevant staff on VARMM, VAP and safeguarding. Response timescales for referrals have been agreed with Safeguarding Adults.
How did you perform over and above the SASP 2012-13 Business Plan within your organisation to make people feel safer, and describe evidence to support this
Increased use of the VARMM and VAP processes within the Housing Service; this in turn has helped improved partnership working where a vulnerable adult requires support. It has allowed us to develop a support plan even if the case is not managed within the VARMM process going forward, and encouraged better partnership working to resolve issues.
We accept there is no single system that allows us to easily report and analyse concerns across the partnership that do not meet the Safeguarding threshold for referral into Social Care and consequently the outcomes and view of the service user. Reflecting back over the past 12 months, please share your local intelligence to describe activity, themes and trends relating to the concerns and alerts you received
We have logged the following safeguarding referrals for 2011/12 and 2012/13: 2011/12 = 26 Adults 2012/13 = 50 Adults We have seen almost a 100% increase in referrals in the past 12 months. However, although we have seen an increase, not all referrals were accepted as they did not meet the safeguarding threshold for referral into Social Care. Due to the reduction in support providers in the city it can prove problematic in finding alternative support for these customers.
Looking ahead, please share your local intelligence to help predict emerging areas of risk and opportunity, relating to Safeguarding Adults, VARMM and MCA detailing any potential threats and opportunities

Risk -Cases don't meet the safeguarding threshold. More cases being referred to VARMM and there won't be the appropriate support available
Concern that many referrals aren't accepted into safeguarding as they don't reach the threshold. This links into the re-write of the SY procedures - need to improve the understanding of the definition of thresholds for external agencies. It would also be helpful to have suggestions as to other means of support which may be available for the customer.

Sheffield Clinical Commissioning Group

How did you contribute to delivering the SASP 2012-13 Business Plan?

SASPs 2012 2013 Business Plan included a specific objective to continue the development of relationships with GPs. This was to include doing so via the Primary Care Trust/Clinical Commissioning Group and the Named GP for Safeguarding Adults.

NHS Sheffield CCG is pleased to be able to report that considerable work has been undertaken by the above with GPs both as CCG Governing Body members around their commissioning responsibilities and also as providers of GP services to further engage them in the safeguarding process.

As part of the authorisation, process to become a CCG SASPs independent chair contributed to NHS Sheffield CCGs 360 assessment, in which safeguarding was a specific requirement of the authorisation.

SASPs independent chair has met with the CCG Governing Body twice and presented to them an overview of safeguarding priorities and key leadership messages. This has been well received by the Governing Body for it in turn to develop its safeguarding priorities.

Both SASP and NHS Sheffield CCG have ensured that a secure and sound relationship is maintained between the SASP Executive Board and the new local NHS structures. Kevin Clifford has been appointed as Chief Nurse for NHS Sheffield CCG and is its representative on the SASP Executive Board. This provides a Safeguarding Champion at a senior level. NHS Sheffield CCG also maintains its representatives at the SASP Operational Board and its sub groups.

2012 2013 has seen the former Primary Care Trust and subsequent CCG hold its providers to account in respect of their safeguarding responsibilities. We have included within contracts 'minimum safeguarding standards expected of providers' and in 2013 2014 we are developing Key Performance Indicators for providers to submit evidence against to demonstrate assurance that they are meeting the minimum standards.

We have maintained our excellent relationships with our providers and met with them

to gain assurance re their safeguarding activity e.g. policy development, staff training, audit etc. We await their submissions to the joint SASP and SSCB 'Section 11 audit' as further evidence of their commitment to safeguarding.

Terrible instances of abuse were identified at the Winterbourne View care home and the Mid Staffordshire NHS Trust. As a result of the Mid Staffordshire case and the Francis review into it, we have worked closely with providers in their development of action plans that we will monitor, to ensure the issues that can impact on safeguarding are thoroughly addressed.

Until 31st March 2013, when the PCT ceased to exist and the CCG was formed, the former PCT had been the commissioner of GPs as providers of primary care services. This commissioning has now transferred to NHS England, however we work closely with them to support GPs as providers, to meet their safeguarding responsibilities and support the safeguarding process.

As a PCT, we held the first Protected Learning Initiative (PLI) for safeguarding adults in July 2013. We then held a subsequent event a year later in July 2014 to build on the learning from the 2013 event.

On each occasion, approximately 300 GPs attended and evaluations overridingly stated that the events have helped GPs to better support their vulnerable patients.

Following the 2012 PLI the safeguarding adult's service reported that in the period April to June 2012, 2 requests for case advice were received by the Safeguarding Adults Service. Following the PLI and from July 2012 to November 2012 this has risen to 10: an increase of 400% thereby demonstrating the effectiveness of such an event and the impact on communication with the safeguarding adult's service by GPs.

2013 has seen the CCGs Named GP for safeguarding adults identify from each GP practice a named lead for safeguarding adults. We have held two training sessions for these leads to support them in their role and will be commissioning further bespoke training for lead GPs on such as the Mental Capacity Act, Domestic Abuse and the MARAC process and supporting their patients who do not meet the criteria for adult protection but require support through other processes e.g. VARMM.

Within 2013 2014, we plan a number of pieces of work in addition to those detailed above to keep Sheffield residents safer. We have undertaken an audit of staff employed within the CCG around their safeguarding knowledge, especially relating to their commissioning responsibilities to safeguard our provider's patients. As the results are analysed we plan to refresh our training strategy and develop safeguarding training for commissioners.

With GP providers, we plan to undertake a training needs analysis and will then develop a strategy to meet GPs training needs.

	How did you perform over and above the SASP 2012-13 Business Plan within your organisation to make people feel safer, and describe evidence to support this

In addition to that described above (the business plan only described development work with GPs as commissioners (the CCG) and GPs as providers) the former PCT and now NHS Sheffield CCG has undertaken a huge amount of work in partnership with Sheffield City Council in respect of ensuring the quality and safety of residents of care homes. NHS Sheffield CCG supports a team to monitor the quality of care in care homes via a rolling programme of quality monitoring visits. This team also ensures that safeguarding is prioritised by care homes. When appropriate they have reported and or contributed to the safeguarding process re care homes.
We accept there is no single system that allows us to easily report and analyse concerns across the partnership that do not meet the Safeguarding threshold for referral into Social Care and consequently the outcomes and view of the service user. Reflecting back over the past 12 months, please share your local intelligence to describe activity, themes and trends relating to the concerns and alerts you received
As an organisation that does not have any direct contact with the public/patient, it is difficult to answer this question. The safeguarding team is asked to look at all complaints where it is felt there may be a safeguarding consideration. Anecdotally these predominantly pertain to the quality of care in care homes.
Looking ahead, please share your local intelligence to help predict emerging areas of risk and opportunity, relating to Safeguarding Adults, VARMM and MCA detailing any potential threats and opportunities
As above, quality and safeguarding concerns in care homes.

Section 4 - Deprivation of Liberty Safeguards Activity

The information below summarises the Deprivation of Liberty Safeguards cases in 2012/2013.

Table 1 Care Homes New Assessments

Year	Number of new assessments	Number authorised	Number not authorised
09/10	49	25	24
10/11	57	34	22
11/12	58	28	30
12/13	**61**	**27**	**34**

Table 2 Hospital New_Assessments

Year	Number of new assessments	Number authorised	Number not authorised
09/10	26	17	9
10/11	46	34	12
11/12	**61**	**35**	**26**
12/13	**55**	**23**	**32**

Reassessments and Part 8 Reviews

Table 3 - **2012/13**

Reassessments in care homes	**44**
Part 8 reviews in care homes	**6**

Table 4 - **12/13**

Reassessments in hospitals	**7**
Part 8 reviews in hospitals	**19**

Table 5

Total activity in 2012/13
Hospitals - 87
Care homes - 111
Total combined work in hospital and care homes = 198 new assessments

Key trends in care homes

- The Number of new assessment requests for care homes has increased slightly however actual number granted fell. They are very marginal figures and the trend for care homes has remained much the same.

Key trends in hospitals

- After the significant increase in the number of applications in hospitals. from the previous year 11/12 the number of hospital assessment fell from 61 to 55 and the number actually granted fell from 35 to 23 on the previous year.

When looking at overall activity including reassessment and reviews we have a further fall in numbers from 235 in 11/12 up to 198 in 12/13.

The main reason is a number of longstanding DOLS during 12/13 ended and thus the number of on-going reassessment fell.

In the context of new activity there were 7 less hospital assessment an increase of 3 care home assessment, no significant difference in activity.

Training

The e learning for both introduction to the Mental Capacity Act and introduction to the Deprivation of Liberty Safeguards have been updated.

Introductory face to face training continues with plans to target specific groups for example MCA in care homes.

For experienced practitioners there is a master class on assessing capacity and making best interests decisions. This has now been expanded to a full day course to cover all the Mental Capacity Act and DOLS. All courses have regular dates throughout the coming year.

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

Report of: Peter Hartland, Chief Executive, St Luke's Hospice

Subject: Hospice Care in Sheffield

Author of Report: Tony Saunders, Corporate Services Manager, St Luke's Hospice, Little Common Lane, Sheffield, S11 9NE (0114 2357572)

Summary:
The Committee requested a report on the nature of hospice care in Sheffield, in particular how it is funded in terms of the charitable/donation based nature of funding, and how the situation in Sheffield compares with the picture nationally.

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	√
Other	

The Scrutiny Committee is being asked to:
We would like the Committee to consider the current situation and it's sustainability in light of the current economic climate, competing demands for charitable funds and uncertainty over future funding from the NHS.

Background Papers:
None.

Category of Report: OPEN

Report of the Chief Executive of St Luke's Hospice
Hospice Care in Sheffield

1. Introduction

1.1 The Committee requested a report on the nature of hospice care in Sheffield, in particular how it is funded in terms of the charitable/donation based nature of funding, and how the situation in Sheffield compares with the picture nationally.

1.2 St Luke's is the only adult hospice in Sheffield. It is a charity (registered number 254402) that provides free, specialist palliative care to adults in Sheffield with life limiting conditions, both in patients' homes, out in the community and in the In Patient Centre (IPC).

1.3 St Luke's is not an NHS facility. We only receive around a third of our funding from the NHS and have seen a marked decline in NHS funding over the last five years. The remaining two thirds is donated by the people of Sheffield, without which St Luke's would close.

1.4 £4.5m is fundraised annually by St Luke's to cover our operating costs. This represents £8 per head of population in Sheffield, every year, just to keep doing what we do now.

1.5 We are currently rebuilding and extending our IPC. This is costing £5.3m and is not paid for by any contractual NHS funding; we are fundraising £5m through a capital appeal, in addition to the £4.5m we raise annually to run the charity.

2. The nature of hospice care in Sheffield, funding streams and national comparison

2.1 St Luke's was the first hospice to open outside of London, and the current ambition is to retain a/the leadership role in providing specialist palliative care across the city of Sheffield.

2.2 Since opening in 1971 St Luke's has been caring for patients aged 18 and over in Sheffield who have life-limiting conditions – as well as their families, carers and friends. Over the years we have grown and in 2013 we cared for over 5,000 people in total, of which 1,400 were patients. The majority of these were cared for in the community.

2.3 Our care is offered free of charge in all settings, although we receive less than one third of our funding from the NHS – so we have to raise over £4.5m annually through fundraising just to continue to deliver our services. We aim to be efficient and effective in all we do.

2.4 We treat all conditions, not just cancer. We are here for all faiths and none. We employ and develop our own medical, nursing and health professionals, and train students. We have 180 employees, over 600 active volunteers, and thousands of donors and supporters.

2.5 St Luke's teams aim to deliver 'holistic' care to the whole person, and whole family, wherever possible; treating body and soul, heart and mind. 'Hospice care' is not about buildings; it is about the people delivering the care aspiring to 'add quality to life' at a time of need.

2.6 We provide specialist palliative care – in people's homes and community, through day care services, and ultimately through our highly specialised Inpatient Centre (IPC). We work closely with GPs and other healthcare providers. In many other cities these services are provided by Macmillan Cancer Support. In Sheffield, they are all provided by, and funded by, St Luke's Hospice.

2.7 We have entered a period of significant change and uncertainty in the national and local healthcare environment. There are many providers trying to develop support for end of life care, at different levels, within a complex system; NHS funding for end of life care services remains uncertain and under review; competition for funding is growing, from national and local charities, as well as from other providers entering the traditional hospice service areas. The aging population means that more end of life patients have frailty, secondary conditions, and dementia – requiring additional care and assistance.

2.8 The year ended 31 March 2013 was another year of decline in our contractual funding from the NHS (now through the local CCG) which is exacerbated in real terms through inflationary pressures. In 2012-13 our total contractual NHS funding of £2.3m provided just 31% of our total expenditure. Our NHS funding is contractual. The current contract is one year in length and ends on 31 March 2014. We are currently in negotiations as to the level of funding and length of contract after this date.

2.9 This situation is fairly typical of the national picture. A recent Help the Hospices survey published in the Health Service Journal on 20 June 2013 stated the following: "On average only a third of hospice costs are covered by the NHS - although funding levels vary across the country - with the rest coming from charitable funds. Nearly a fifth of those surveyed (18 per cent) said funding levels had fallen this financial year, and in some instances hospices had seen funding frozen for five years."

2.10 The remaining two thirds of our income is donated by the people of Sheffield.

2.11 We rely on a wide variety of types of donations from those who simply donate money to those who proactively go out and raise money on behalf of St Luke's. Thousands of people across the city donate in a large or small way each year. The small fundraising team support donors wherever possible, driving income from a wide variety of income streams.

2.12 St Luke's runs a national award winning chain of retail charity shops. For three years running it was the most profitable shop chain (of its size) in the country. Current turnover is £1.9m and profit is £1.3m which is an extremely high rate of return compared to other charity shop chains. There are 11 shops across the city from Stockbridge and Chapeltown in the north to Gleadless and Crystal Peaks in the south.

3 What does this mean for the people of Sheffield?

3.1 St Luke's is valued and respected for its quality of care, and the privacy and dignity this brings. Our services form a core part of 'end of life care' in Sheffield.

3.2 St Luke's is not an NHS facility. We only receive around a third of our funds from the NHS – the remainder must be raised from the people of Sheffield.

3.3 St Luke's will close if the people of Sheffield do not support us through donations.

3.4 It costs over £7m annually to run the charity. The remaining two thirds – over £4.5m – must be raised from charitable donations. Our fundraised income streams rely entirely on the generosity of donors. This includes the charity shops – 98% of all goods sold through the retail chain are donated goods. These goods are donated by the people of Sheffield and bought by the people of Sheffield.

3.5 The nature of the hospice movement is that the UK is divided up geographically with local hospices serving the increasingly complex and growing needs of their local populations. St Luke's is Sheffield's hospice. This naturally imposes geographical limits as to where we can fundraise. St Luke's can only fundraise in Sheffield. There are separate independent charitable hospices in Rotherham, Barnsley, Chesterfield and so forth.

3.6 This means that, with a population of roughly 550,000, the £4.5m that we need to fundraise each year translates to over £8 per head of population. Given that this population includes children, the unemployed, retired and all manner of socioeconomic groups, the scale of the challenge facing St Luke's every year, just to provide the current level of service, is enormous.

3.7 The £8 per head covers the normal running costs of St Luke's. In order to develop our services, to invest in our infrastructure and to be at the forefront of palliative care in order to provide the best possible care for the people of Sheffield, we sometimes incur additional expenditure. For example, the £5m capital appeal to modernise and extend the IPC is being paid for through fundraised income, raised in addition to the £4.5m each year required for running costs.

4. Recommendation

4.1 We would like the Committee to consider the current situation and it's sustainability in light of the current economic climate, competing demands for charitable funds and uncertainty over future funding from the NHS.

Report to Healthier Communities & Adult Social Care Scrutiny & Policy Development Committee
15 January 2014

Report of: Director of Care & Support

Subject: Adult Social Care Performance – Quarter 2 2013/14

Author of Report: **Robert Broadhead, Head of Care and Support, Adults Assessment & Care Management, 0114 2735891.**

Summary:

The Adult Social Care Performance Management Framework was discussed at the meeting of the Committee held on 16th January 2013 and a progress report was requested for January 2014**.** This briefing paper summarises recent performance against the main Adult Social Care performance measures and demonstrates recent performance improvements in terms of reducing customer journey waiting times.

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	√
Other	

The Scrutiny Committee is being asked to:

Recognise recent progress in improving performance within Adult Social Care and support the further improvement in this area.

Background Papers: None.

Category of Report: OPEN

Report of the Director of Care & Support – Adult Social Care Performance – Quarter 2 2013/14

1. Context

1.1. The Adult Social Care Performance Management Framework was discussed at the meeting of the Committee held on 16th January 2013 and a progress report was requested for January 2014**.**

1.2. At the start of 2012/13, adult social care customers were experiencing long customer pathway waiting times and we had a backlog of assessments and reviews. Since then we have significantly improved assessment waiting times and cleared the backlog. We have also started a focused piece of work to review and reassess people which should improve our performance on reviews**.**

1.3. These improvements are as a result of a number of interventions including focusing staff resource to work through the assessment backlog and using intense 10 week cycles of activity with teams to improve and redesign processes to make them as efficient as possible.

1.4. The Community Access and Reablement Service is also continuing to work with customers to meet their needs earlier through prevention or reablement services. This is therefore reducing the demand on longer term service provision.

1.1 Customer pathway journey times are reducing

1.1.1 The average time taken to carry out adult social care assessments for new customers has improved significantly from the average of 90 days in 2012/13 to 58 days in quarter 2 of 2013/14. This is based upon completing 837 assessments in quarter 2. The target is to reduce the waiting time to 50 days by quarter 4 with the further aim to reduce it to 28 days by mid-2014/15.

1.1.2 Performance on completing and agreeing the support plan after the assessment for new customers is also improving and reduced from an average of 48 days in 2012/13 to 35 days in quarter 2. This is based upon 506 completed and agreed support plans in quarter 2. We expect to meet the 28 day target by quarter 4.

1.1.3 The average time taken to carry out adult social care reassessments for existing customers whose needs have changed has gradually improved from the high of 106 days in quarter 1 2012/13 to 82 days on average for 2012/13 and has reduced further to 74 days in quarter 2 2012/13. We expect this to improve significantly as a result of the focused review and reassessment work that is currently underway.

1.2 The backlog of assessments has reduced

1.2.1 The number of new customers either waiting for assessments or with their assessments currently underway has been reducing with time (from 747 at the end of June 2012 to 525 as at the end of October 2013). This is well on the way to reducing to a more manageable level given that we complete about 300 assessments a month.

1.2.2 The number of new customer assessments not yet allocated to a worker has also been reducing from 575 at the end of June 2012 to 211 as at the end of October 2013.

1.2.3 The number of reassessments for existing customers whose needs have changed not yet allocated to a worker has also reduced (to 79 as at the end of October 2013 from 140 as at the same time last year).

1.2.4 Performance on reviews was 56% in quarter 2, which is higher than the 48% in 2012/13 but remains low. We expect performance to further improve as a result of the planned reassessment/reviews work and a target to meet the Yorkshire & Humber average of 72% has now been set.

1.2.5 The Community Access and Reablement Service customers are generally having their needs met earlier and are currently contacted by the service within 2 to 3 working days on average from referral to discuss their needs. This is against a 2 working day target. The service provides advice, information and signposting to other services and access to reablement services where this is needed.

1.2.6 Out of 245 customers approaching the Community Access and Reablement Service in November, only 64 (26%) went onto need an assessment for long term support. This is as a result of prevention activity resulting in 63% of customers not even requiring reablement or assessment.

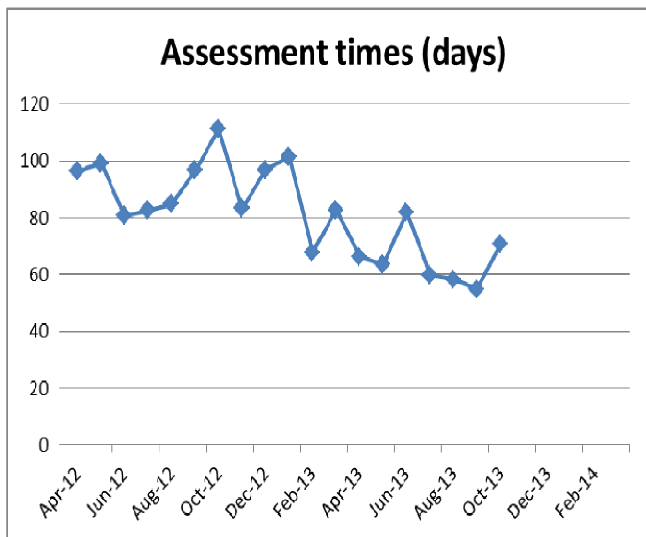
1.2.7 There have however been some delays recently on starting the reablement period when reablement is required, with an average waiting time of 25 working days against a target of 12 working days. We do need to improve in this area.

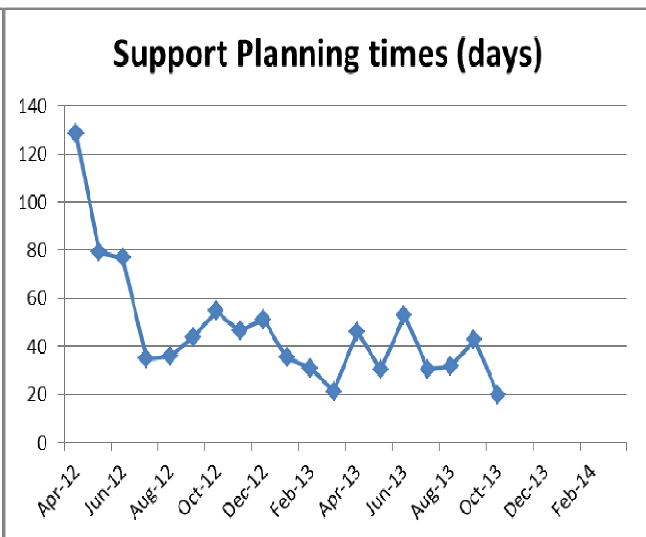
1.2.8 The average time within the Community Access and Reablement Service reablement period is currently 8.4 weeks on average in quarter 2 against a target of 6 weeks. The Hospital & Intermediate Care pathway reablement period is however currently averaging just 5.3 weeks and is meeting the target of 6 weeks.

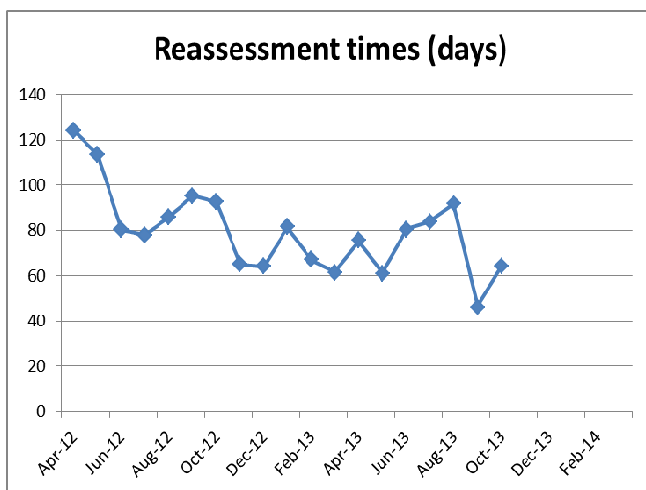
1.2.9 Further graphs showing the improvement in the length of time taken to complete assessments and to reduce the backlog are included within Appendix A.

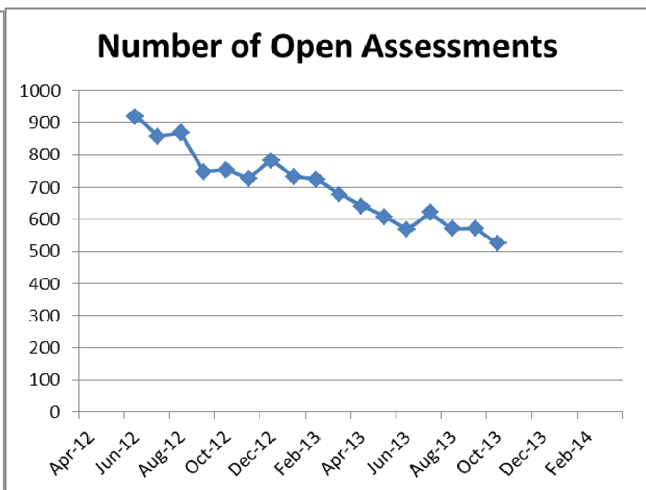
1.2.10 Recent performance is also displayed visually on the adult social care pathway diagram within Appendix B.

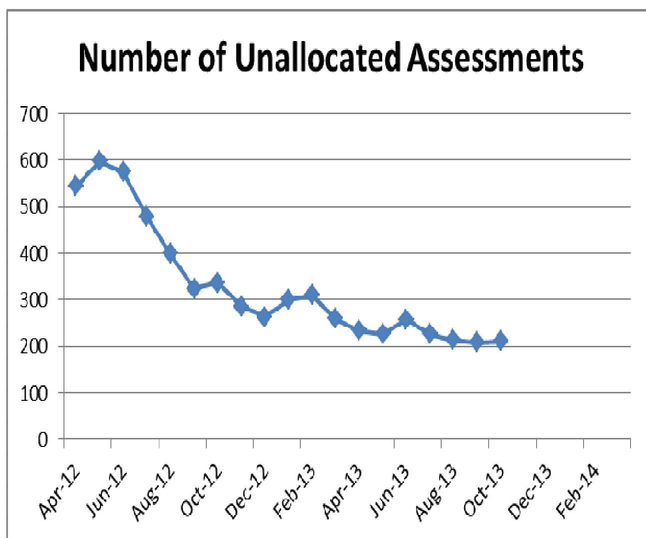
Appendix A – Assessment times

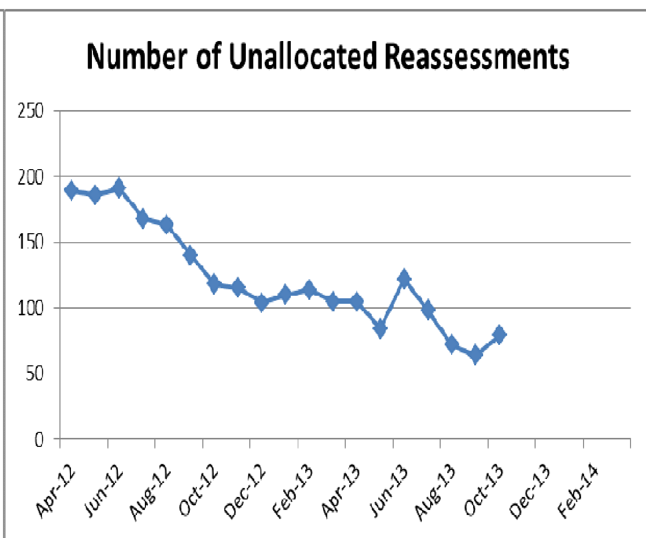




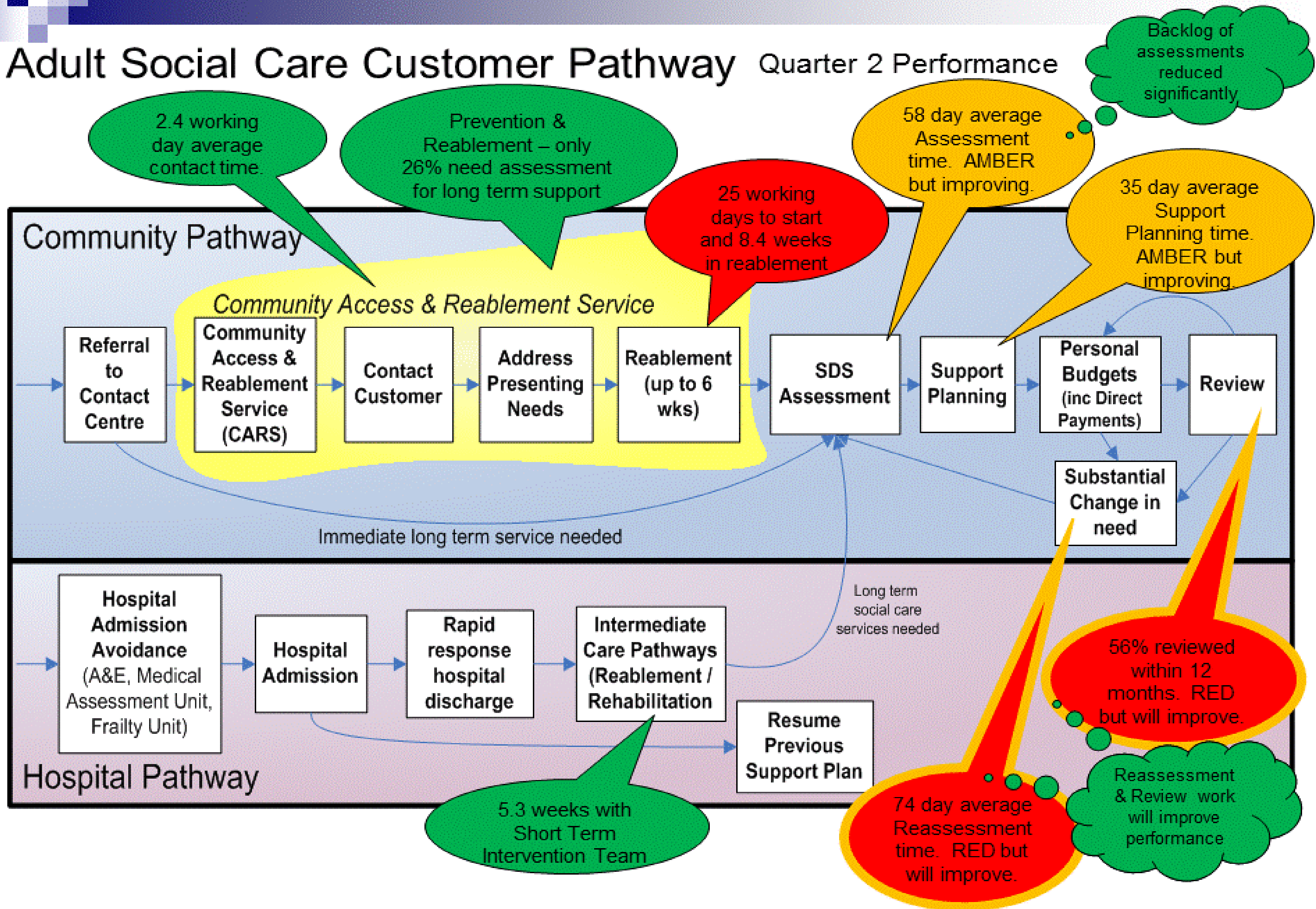








Appendix B – Customer Pathway Diagram



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Healthier Communities & Adult Social Care Scrutiny & Policy Development Committee
Work Programme

Chair: Cllr Mick Rooney **Vice Chair**: Cllr Roger Davison
Meeting papers: click here

Meeting Date	Topic	Overview	Lead	Report Deadline
20th November 2013	• Right First Time Programme	Report given at Scrutiny Committee Meeting in May 2013. Update report requested in 6 months' time.	Kevan Taylor & Zak McMurray	Friday 1st November 2013
	• Dementia Strategy	Report given at Committee Meeting in May 2013. Further report requested in 6 months. "To outline the approach to dementia care across the City – including Continuing Health Care funding criteria and the role of bed based facilities in the strategy."	Sarah Burt & Michelle Fearon	
	• Memory Clinic	Report given at Scrutiny Committee meeting in March 2013. Further report requested, "(i) that the Director of Planning, Performance and Governance, Sheffield Health and Social Care NHS Foundation Trust, looks, in conjunction with the Primary Care Trust, at what steps could be taken to further reduce waiting times for memory management services, and for the Director to attend a future meeting of this Committee, in approximately three months' time, to report on the Trust's initial thoughts on this issue"	Jason Rowlands, Director of Planning, Performance & Governance, Michelle Fearon, Service Director for the services concerned within the Trust and Sarah Burt, Senior Commissioning Manager, NHS Sheffield CCG.	
	• Nutrition & Hydration Working Group – draft report	Presenting final draft report and recommendations for consideration / approval by the full Scrutiny Committee.	Cllr Gary Weatherall, Chair of the Working Group	

<table>
<tr><td colspan="5">Briefing papers
Home of Choice - Following an update at the Scrutiny Committee meeting in January 2013. The Committee requested: “That the Director of Care and Support to undertake a revaluation of the Home of Choice Programme”

Items for information
Contracts & Partnership Monitoring Advisory Board - Minutes from July meeting</td></tr>
<tr><td rowspan="3">15th January 2014</td><td>• St Lukes Hospice – introduction</td><td>An overview of the Hospice and the services it provides.</td><td>Chief Executive Peter Hardman / Deputy Chief Executive Judith Clarke</td><td rowspan="3">Friday 3rd January 2013</td></tr>
<tr><td>• Hospice Care in Sheffield</td><td>The nature of care in St Lukes Hospice, Sheffield, in particular how Hospice Care is funded in terms of the charitable / donation based nature of funding and how the situation in Sheffield compares with the picture nationally.</td><td>Chief Executive Peter Hardman

Jackie Gladden, NHS Sheffield CCG’s Strategic Lead for End of Life Care – tbc</td></tr>
<tr><td>• Safeguarding Adults Annual Report</td><td>An overview of the Safeguarding Adults Annual Report</td><td>Sue Fiennes, Chair of the Adult Safeguarding Executive Board

Simon Richards, Head of Adult Safeguarding</td></tr>
<tr><td colspan="5">Briefing papers
Care & Support Performance Update - The Committee, “requests the Head of Adult Services, Care and Support to submit a progress report on the new performance measures to this Committee in 12 months’ time” (Jan 16th 2013)

Items for information
CCG Governing Body Minutes – papers for the meeting on 9th January 2014</td></tr>
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19th March 2014 – planned agenda items	• GP Practices	Agreed at Scrutiny Committee meeting on 17th July 2013 The Committee identifies (i) the need for discussions “(A) with the National Commissioning Board’s Local Area Board regarding GP practices in the City, including the numbers, location and skill mix.” Request report to include, statistics in terms of total numbers of GP’s in the City, data mapping the population and deprivation levels in each area of the city along with the number of GP’s in that area and information on the skills mix.	Tbc	
	• CAMHS final draft Report - tbc	Presenting a final draft report and recommendations for consideration / approval by the full Scrutiny Committee.	Cllr Mick Rooney, Chair of the Working Group	
	• Public Health Investment (budget allocation)	Agreed at Scrutiny Committee meeting on 17th July 2013. The Committee identifies (i) the need for discussions (B) between the Committee and Jeremy Wight, Director of Public Health, regarding public health investment.	Jeremy Wight, Director of Public Health will be invited to report.	
	• Dilnot Commission & Care Bill 2013	This may be approved early in 2014, if so the Committee may wish to include it on this agenda.	Moira Wilson will be invited to report.	
	• Developing the Social Model of Public Health	A follow up report was requested at the extraordinary meeting on 5/11/2013. To include an implementation plan, targets for the work and how outcomes will be measured.	Chris Shaw, Director of Health Improvement, SCC	

Briefing Papers

Major Trauma Update - Report given to the Scrutiny Committee on 17th April. “The committee, requests that a further report on this issue be submitted to a meeting of the Committee in 12 months’ time, focusing on the progress made with regard to the proposed improvements to rehabilitation services”. Report request - Daniel Mason – CCG

Self-Directed Support (SDS) Update - Report given to the Scrutiny Committee on 17th April
"The committee, requests Eddie Sherwood to submit a further progress report on Self Directed Support and Personalisation, to a meeting of the Committee in approximately one year's time". Contact Moira Wilson – regarding SDS update and the two updates below

Support Planning & Brokerage Framework Agreement - Extract from minutes on 8th May
"the Forward Plan for the period 3rd April 2013 to 31st July 2013, be received and noted and that consideration be given to the inclusion on the Committee's Work Programme of items relating to the Individual Service Fund Framework Agreement and Support Planning And Brokerage Framework Agreement and Sheffield's Public Health budget allocation for 2013/14"

Individual Service Fund Framework Agreement - As above

Items for information
Contracts & Partnership Monitoring Advisory Board - Minutes from October meeting - tbc
CCG Governing Body Minutes – papers from 9th January 2014 meeting - tbc

Working Groups (Task & Finish)

- Nutrition & Hydration Working Group
- Child and Adolescent Mental Health Services (CAMHS) Working Group

Other areas

Adults with Congenital Heart Disease - A review is taking place of services for Adults with Congenital Heart Disease – similar to the Children's review that took place last year. A briefing session open to all Elected Members has been arranged for 30th January 2014.

Paediatric Cardiac Surgery (on-going) - To scrutinise outcomes for children in Yorkshire and the Humber following the decision to reconfigure children's heart surgery centres. Scrutiny through the Yorkshire and Humber Joint Scrutiny Committee.

Please note: the Work Programme is a live document and so is subject to change.