CABINET MEMBER FOR ADULT SOCIAL CARE

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

Date: **Monday, 28th January, 2013**

Time: **10.00 a.m.**

A G E N D A

1. To determine if the matters are to be considered under the categories suggested in accordance with Part 1 (as amended March 2006) of Schedule 12A to the Local Government Act 1972.

2. To determine any item which the Chairman is of the opinion should be considered later in the agenda as a matter of urgency.

3. Apologies for Absence.

4. Minutes of the Previous Meeting held on 14th January, 2013 (Pages 1 - 5)

5. Health and Wellbeing Board (Pages 6 - 14)
   - minutes of meeting held on 28th November, 2012

6. Exclusion of the Press and Public
   Resolved:- That, under Section 100A(4) of the Local Government Act 1972, the press and public be excluded from the meeting for the following item of business on the grounds that it involves the likely disclosure of exempt information as defined in Paragraph 3 of Part 1 of Schedule 12A to the Local Government Act, 1972 (as amended March, 2006) (information relating to the financial or business affairs of any particular individual (including the Council)).

7. Review of Charging Policy - Terminal Illness (Pages 15 - 19)

8. Date and Time of Next Meeting -
   - Monday, 11th February, 2013, at 10.00 a.m.

CABINET MEMBER FOR ADULT SOCIAL CARE
14th January, 2013

Present:- Councillor Doyle (in the Chair); Councillors Gosling and P. A. Russell.

An apology for absence was received from Councillor Steele.

H48. MINUTES OF THE PREVIOUS MEETING HELD ON 3RD DECEMBER, 2012

Consideration was given to the minutes of the previous meeting held on 3rd December, 2012.

Resolved:- That the minutes of the previous meeting held on 3rd December, 2012, be approved as a correct record.

H49. WORKFORCE DEVELOPMENT - SUPPORT FOR PROVIDERS

The Director of Health and Wellbeing submitted a report on the workforce development support arrangements within the Council and the range of support activities offered together with their uptake.

The Learning and Development Team was responsible for commissioning and contracting training and development activities including a range of core support for providers. Workforce planning advice and guidance, training information, guidance and signposting, funding for external conferences, seminars and workshops were also available. For the more specialised providers, there was potential support regarding practice learning opportunities for the Social Work Degree and Continuing Professional Development for Social Workers.

The Team undertook development work locally with providers on their training requirements and engaged with them at a provider Workforce Development Forum held 4-5 times a year.

Appendix A of the report submitted provided an overview of the range of training courses, qualifications and on-line support offered to providers.

It was noted that providers carried out their own training as well as accessing those offered by the Authority. The training provided was reviewed to ensure it was still required.

Resolved:- That the report be noted and referred to the Contracting for Care Forum for information.

H50. ADULT SERVICES REVENUE BUDGET MONITORING 2012-13

Consideration was given to a report, presented by the Finance Manager (Adult Services), which provided a financial forecast for the Adult Services Department within the Neighbourhoods and Adult Services Directorate to the end of March, 2013, based on actual income and expenditure to the end of November, 2012.

It was reported that the forecast for the financial year 2012/13 was an underspend of £124,000 against an approved net revenue budget of £74.021M.

The latest year end forecast showed a number of underlying budget pressures which were being offset by a number of forecast underspends:-

Adults General Management and Training

- A forecast overspend mainly due to recurrent pressures on ICT budgets

Older People

- A forecast overspend on In-House Residential Care, further increase in demand for Direct Payments and In House Transport
- Offset by underspends within Enabling Care, Independent Sector Home Care, independent residential and nursing care, Intermediate Care, Community Mental Health, Carers Services and slippage on Assistive Technology and recruitment to vacant posts within Assessment and Care Management
- Additional income from Health

Learning Disabilities

- A forecast overspend on independent sector Residential Care budgets due to increase in clients and average cost of care packages plus loss of income from Health
- Underspends within Supported Living Schemes due to Continuing Health Care income, use of one-off grant funding and vacant posts
- Recurrent budget pressure on Day Care Transport
- Increase in demand for Direct Payment over and above budget
- Forecast overspend in independent sector Home Care
- 3 new high cost placements in Independent Day Care
- Increase in Community Support placements
- Use of Health funding to support overspend on SYHA residential care costs
- Saving on premises costs and slippage on vacant posts

Mental Health

- Projected slight overspend on Residential Care budget and budget pressure on Direct Payments
- Overspends on employees budgets due to unmet vacancy factor and use of agency staff
- Reduced by savings on Community Support Services

Physical and Sensory Disabilities

- Continued pressure on Independent Sector Domiciliary Care, loss of Continuing Health Care funding for 1 client, increase in demand for Direct Payments and forecast overspend on Residential and Nursing Care
- Offset by underspend on Crossroads as clients were redirected to Direct Payments
- Slippage on developing alternatives to residential care provision
- Vacant posts within Resource Centre and Occupational Therapists
- Underspend on Equipment budget and savings due to vacant part-time post at Grafton House

- Review of contracts with independent Day Care providers
- Forecast savings on contracts with Voluntary Sector providers

Safeguarding
- Underspend on employee budgets due to vacant post plus additional forecast income from Court of Protection fees

Supporting People
- Efficiency savings on subsidy contracts offset against Commissioning savings targets not within Adult Services

Total expenditure on Agency staff for Adult Services so far was £219,672 compared with an actual cost of £253,963 for the same period last year. The main costs were in respect of Residential and Assessment and Care Management staff to cover vacancies and sickness. There had been no expenditure on consultancy to date.

There had been £254,303 spent up to the end of November, 2012, on non-contractual overtime for Adult Services compared with expenditure of £243,927 for the same period last year.

Careful scrutiny of expenditure and income and close budget monitoring remained essential to ensure equity of Service provision for adults across the Borough within existing budgets particularly where the demand and spend was difficult to predict in a volatile social care market. A potential risk was the future number and cost of transitional placements from Children's Services into Learning Disability Services together with any future reductions in Continuing Health Care funding.

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

- Outcome of the Continuing Health Care appeal
- Intermediate Care underspend related to staff vacancies

Resolved:- That the latest financial projection against budget for 2012/13 be noted.

H51. BRIEFING NOTES

Learning Disability Services
The Cabinet Member noted the above briefing note relating to Learning Disability Services which highlighted:-

Partnership Working
Safeguarding
Performance
Day Services
Employment
Customer Feedback

Time to Care
The Cabinet Member noted a briefing note relating to the Unison report into homecare entitled "Time to Care".

Unison had conducted an on line survey which had 431 responses from Unison members and non-members who delivered home care, undertaken in June/July, 2012. Unison claimed the objective of the survey, consequent report and Ethical Care Charter was to establish a baseline of safety, quality and dignity of care by ensuring employment conditions which did not routinely short change clients and ensured the recruitment and retention of a more stable workforce through more sustainable pay, conditions and training levels. It was calling for all councils to commit to becoming Ethical Care Charter.

The briefing note set out the principles of the Charter together with Rotherham's current position which followed the majority of the recommendations in the Ethical Care Charter anyway via Contract and Specification terms and conditions applied to Independent Sector Domiciliary Care.

The Ethical Care Charter sets out a number of principles that Unison wished local authorities to be compliant with. However the item asking local authorities to only contract with organisations who paid the 'Living Wage/£7.45' was not enforceable and could not be legally applied when procuring services. The Authority could not be biased and give work to organisations who paid the Living Wage as it would discriminate against other organisations and conflict with Minimum Wage Legislation.

Resolved:- That consultation take place with regional partners to estimate their response to Unison's request with a report back to the Cabinet Member prior to issuing a full response to Unison.

H52. EXCLUSION OF THE PRESS AND THE PUBLIC

Resolved:- That, under Section 100A(4) of the Local Government Act 1972, the press and public be excluded from the meeting for the following items of business on the grounds that they involve the likely disclosure of exempt information as defined in Paragraph 3 of Part 1 of Schedule 12A to the Local Government Act 1972 (as amended March 2006) (information relating to the financial or business affairs of any particular individual (including the Council).

H53. SUPPORTING PEOPLE PROGRAMME - EMERGENCY ACCOMMODATION PROPOSAL

The Operational Commissioner reported on the current position in Rotherham for young people (16-25 years) who required emergency accommodation as they were at risk of homelessness/were homeless.

At present there was no 'emergency access' accommodation in the Borough outside of the statutory temporary accommodation 'crash pads'. Homeless Link recommended that every authority should put in place a response to emergency housing need to prevent those at risk of homelessness having to sleep on the streets or in inappropriate accommodation.

It was proposed that the supported accommodation provided at Rush House for young people, currently funded through the Supporting People Programme, be reconfigured to provide 3 additional bed spaces as 'emergency access'. The current 6 units would be converted and redesignated as 3 bed spaces for

emergency access. In order to not lose stages of provision or bed spaces, the current bedsit provision would remain at 9 units with a further 6 units of dispersed accommodation sourced. The properties required would be identified in partnership with South Yorkshire Housing Association.

The emergency accommodation would be for a short period of time (10 days) with any extension decided on an individual basis. During the length of stay, a comprehensive assessment of need and risk would be undertaken and support the Service user(s) to develop pathways out of homelessness and into the support of appropriate specialist services.

Resolved:- (1) That 3 additional supported emergency bed spaces, at no additional cost per annum, be provided at Rush House.

(2) That the Supporting People Team, together with key partners and the provider, develop a Service Implementation Plan, which outlined key actions in the reconfiguration of the Service.

(3) That a consultation exercise be undertaken with Service users and an Equality Assessment that will form part of the Service Implementation Plan.

(4) That the current contract be extended for a 2 year period to September, 2015, thus allowing adequate time to implement and assess the reconfiguration of Service.

(5) That Elected Members be supplied with a briefing note including all emergency out of hours contact numbers.

H54. SETTING IN-HOUSE RESIDENTIAL ACCOMMODATION CHARGES 2013/14

The Director of Health and Wellbeing submitted a report proposing an increase in charges for self-funding residents in In-house Residential Care Homes for 2013/14.

In accordance with its statutory duty, the Council was required to set a maximum charge for residential accommodation it provided in Local Authority homes. It was proposed that the maximum charge for all Local Authority residential care homes be increased by 2.5% in accordance with the income targets applied by Financial Services to calculate the Directorate's indicative cash limited budget.

In accordance with established practice, all charges were based on estimated cost and occupancy levels so that residents could be advised of the revised charges as near to the date they became effective as possible.

Resolved:- That the charge for In-house Residential Care Homes be increased, as now set out in the report attached, with effect from April, 2013.

HEALTH AND WELLBEING BOARD
28th November, 2012

Present:-

Members: -

Councillor Ken Wyatt	Cabinet Member for Health and Social Care (Chairman)
Councillor John Doyle	Cabinet Member for Adult Social Care
Mrs. Janet Wheatley	Voluntary Action Rotherham
Mr. John Gommersall	Non-executive Director, NHS Rotherham Trust Board
Ms. Kerry Rodgers	Chief Executive, NHS Foundation Trust
Dr. John Radford	Director of Public Health
Dr. David Polkinghorn	Clinical Commissioning Group
Mr. Chris Edwards	NHS Rotherham
Mr. Tom Cray	Strategic Director, Neighbourhood and Adult Services, RMBC
Kate Green	Policy Officer, RMBC

Also in attendance: - Dr. Ian Turner, Ian Atkinson, Nizz Sabir, Gary Walsh and Gill Harris.

Apologies for absence had been received from: - Councillor P. Lakin, Mr. M. Kimber, Mr. K. Battersby, Mrs. J. Thacker, Mrs. S. McFarlane, Mrs. C. Wright, Mrs. T. Holmes.

S43. MINUTES OF PREVIOUS MEETING

Agreed:- That the minutes be approved as a true record.

S44. BRIAN JAMES, CHIEF EXECUTIVE OF THE ROTHERHAM FOUNDATION TRUST.

Councillor Ken Wyatt, Cabinet Member for Health and Wellbeing, noted that Brian James, Chief Executive, would be leaving his post at the Rotherham Hospital. The Health and Wellbeing Board wished to record their thanks to Brian for his support of the work of the Board.

All members present wished Brian all the best for the future.

S45. COMMUNICATIONS

(1) Rotherham Tobacco Control Alliance Annual Report: -

The Board noted the annual report for 2011/12 outlining the activity undertaken by the Alliance and its constituent partners highlighting:-

- Highest ever number of 4-week quitters through NHS Services achieved. However, smoking prevalence remained at 24%
- Smoking at delivery rates reduced to under 20% and 194 women had been helped to stop smoking during pregnancy
- Higher than national average smoking rates for young people (11-15 year olds)
- Availability of cheap and illicit tobacco remained an issue and undermined other work to reduce tobacco use

- Performance measures would change in 2013/14 from 4-week quitters to smoking prevalence reduction
- Almost all tobacco-related funding currently invested in Stop Smoking Services

(2) Community Alcohol Partnerships (CAPs) – Progress as of October, 2012: -

The Board noted the progress report highlighting the following:-

- Estimated launch was January, 2013, and initial review in July, 2013, which would inform the next steps for the existing Partnerships. Two further deprived areas would then be identified for roll out
- Public Health representatives and CAP regional leadership met with South Yorkshire Police analysts to agree initial benchmarking required and issues to be measured - as anti-social behaviour issues were often seasonal, the analysts had suggested two years' data to be used as the benchmark
- They were to also provide 'hot spot' areas and crimes in each of the localities – anti-social behaviour highlighting all young and/or alcohol, crime (damage, shoplifting of alcohol, any offences where alcohol was an aggravating factor, alcohol-related violence including domestic and youth related offences) plus NHS A&E admission data, Environmental Health/Warden, litter offences and possibly Designated Public Place Orders, Section 27 Orders and Drink Banning Order data
- CAP regional lead identified the lead retailer (likely to be Tesco in Dinnington and Co-op in East Herringthorpe)
- A teaching pack of aids had been created for 11-16 year olds, and consideration would be given to engaging local colleges
- Stakeholder events would be organised to inform them of the CAP concept
- Residents of the areas covered by the CAPs would be provided with questionnaires, the answers to these would determine the service offer required. Whilst both CAPs would use the same key questions, there would also be the potential for them to add localised questions. The questionnaire outcomes would be incorporated into the benchmarking of the project.

(3) A National Conference for Childhood Obesity was due to take place on 24th January, 2013. The Conference would be held in Rotherham's New York Stadium and would include information relating to the children's agenda.

Agreed: - That the information shared be noted.

S46. HEALTH AND WELLBEING NEEDS OF BME COMMUNITIES IN ROTHERHAM

Nizz Sabir, Vice-Chairman, Rotherham Council of Mosques, was welcomed to the meeting. Nizz had prepared a presentation in relation to the identified health and wellbeing needs of Rotherham's Black and Minority Ethnic (BME) communities.

- Rotherham MBC estimated that there were 19,000 people from BME communities in 2009, which equated to 7.5% of the local population;
- The bulk of the BME community lived in the Central Ward according to the Index of Multiple Deprivation (2007). Key drivers of deprivation related to: -
  - Employment;

- Health and Disability;
- Education and Skills.

The presentation covered a number of underlying detriments to health and wellbeing in the BME community, these were: -

- The BME community was less likely to be in paid employment (e.g. 20% unemployed in Pakistani community compared to 6% in White British community);
- Less likely to have a formal educational qualification;
- Several years ago children and young people from BME communities were shown to be amongst the lowest attaining groups for GCSE results;
- Employment difficulties;
- Housing – impact of overcrowding relating to infant mortality, respiratory conditions in children, rates of serious infectious diseases in adults and infections with Helibacter Pylori, which could have implications for growth and diseases of the digestive system;
- Infant mortality –
  - Babies born to mothers who were born in Pakistan had twice the risk of dying in the first year of their life;
  - South Asian women had more stillbirths than average. This was because of birth defects caused by marriages with close relatives and problems with premature deliveries.
- Lifestyle and Risk Factors -
  - Smoking – more Bangladeshi and Pakistani men smoke than average;
  - High prevalence of smoking amongst Pakistani and Irish males;
  - The Health Survey England (HSE) 2004, also reported high levels of tobacco chewing in BME groups.
- Physical Activity -
  - Low rates of physical activity especially in women of Bangladeshi or Pakistani origin;
  - Female only facilities (Rotherham leisure centre, swimming);
  - Lack of independence;
  - Language barrier;
  - Knowledge of services.
- Diet -
  - Diet typically worse for those born in the UK, compared to first generation migrants;
  - Changing diet with migration;
  - Hard to find familiar foods;
  - Binge eating, a lack of knowledge about dietary intake and food content was an issue;
  - Increasing popularity of fast food, including cultural pressures and aspirations.
- Mental Health:-
  - Research into young Asian women suggested that the factors affecting emotional health were similar across ethnic groups, but access to support was worse for Asian women. Some barriers were: -
  - Male privilege;
  - Fear of not fitting into a tight-knit community;
  - Fear of offending family honour;
  - Social isolation;

  - Language problems;
  - Fear of racism;
  - Surprisingly little research into mental health needs of Asian men;
  - Caring for family members could create burdens on members of the community.
- High risk: -
  - Members of the Pakistani community were six times more likely to have diabetes. Highest risk was in Pakistani women, who also had an increased risk of heart disease, retinopathy, kidney disease and strokes;
  - In Rotherham hospital admissions due to diabetes problems in Pakistani people had increased by 77% between 2003 and 2007.

The members of the Health and Wellbeing Board thanked Nizz for his informative presentation. It was considered that much of the empirical evidence had contributed to the JSNA, but much of the commentary about the experiences of members of the BME community was not included but was an important resource to consider.

- Eleven deprived areas;
- Outline agreement for a project;
- Translation services.

Resolved: - That the information shared be noted.

S47. THE ROLE OF THE LOCAL OPTOMETRIC PROFESSION

Nizz Sabir, Rotherham and Barnsley Local Optical Committee, gave a presentation on the role of the Rotherham and Barnsley Local Optical Committee and the role of opticians and ophthalmologists in the heath sector.

- Primary Health Care specialists;
- Trained to identify defects in vision, signs of injury, ocular disease or abnormality and any problems with general health;
- Education, training and mandatory continuous professional development;
- Regulated by membership (with annual renewal process) of the General Optical Council.

Role of opticians in an aging population: -

- An RNIB report in 2008, 'Future Sight Loss', estimated that 1.8 million people lived with sight loss;

- A projection of needs exercise estimated that there were 102 adults living in Rotherham who required help with their daily activities due to a serious sight impairment;

  - This was predicted to gradually increase over the coming years.

- Since 2004, the Department for Health had been encouraging the delivery of routine and minor emergency eye care outside hospital in community optical practices. This aimed to free up hospital capacity to cope with increasing demand from both the ageing population and new technologies;

  - Community optical practices were successfully and safely delivering local enhanced services in primary care, with high levels of patient satisfaction reported, as part of local integrated pathways linking into secondary care as appropriate. A key benefit of these enhanced services was a reduction in referral rates to GPs, A&E and hospital eye departments.

- Early intervention was being encouraged to increase the effectiveness of the eye care commissioning strategy.

Primary Eyecare Assessment and Referral Service (Pears): -

- Support for national and local strategic priorities;
- Primary rather than secondary care;
- Evidence based practise;
- Patient choice;
- Closer to home.

Optical issues had many links to other health concerns, many of which were addressed as priorities within the JSNA: -

- Smoking's role in increasing the likelihood/severity of: -
  - Aged-related Macular Degeneration;
  - cataract development;
  - Diabetes' related sight-loss.
- Obesity's role in increasing the likelihood/severity of: -
  - Diabetic retinopathy;
  - Age-related Macular Degeneration;
  - Cataracts.

- Diabetes' role in changing eye sight: -
  - Diabetic control increased the risk of diabetes sight problems;
  - Dyslipidaemia;
  - Strategies that sought to prevent diabetes and improve the quality of diabetes care would help prevent avoidable diabetes sight loss.

- Mental Health: -
  - Higher incidence of mental health in those suffering from sight loss;
  - Higher incidence of falls due to low vision and cataracts.

- Social effects: -
  - Independence;
  - Confidence.

Role of Optometric profession: -

- Work with the local Health and Wellbeing Board and Clinical Commissioning Groups;
- Work with other health and social care providers;
- Encourage a multi-disciplinary approach;
- Early intervention;

- Quality, innovative, patient-centred, patient satisfaction, patient choice;
- Improve efficiency and reduce costs;
- GPS, Ophthalmologists, Orthoptists and social care providers.

The members of the Health and Wellbeing Board thanked Nizz for his informative presentation.

Resolved: - That the information be received.

S48. HEALTH AND WELLBEING PERFORMANCE MANAGEMENT FRAMEWORK

Tom Cray, Strategic Director for Neighbourhood and Adult Services, gave a presentation outlining a proposed Performance Management Framework, which represented the aims and priorities of the Health and Wellbeing Board. The proposed Framework sought to track progress against national outcome framework measures without overshadowing locally agreed priorities.

The proposed Performance Management Framework took into account the priorities and strategies of: -

- Rotherham's Joint Strategic Needs Assessment's Priority Measures: -
  1) Starting Well;
  2) Developing Well;
  3) Living and Working Well;
  4) Aging Well.

- Health and Wellbeing Board's Priorities: -
  - Smoking;
  - Alcohol;
  - Obesity;
  - (Dementia).

- Rotherham Partnership Priorities (as part of the 'Poverty' work-steam): -
  - NEETS;
  - Fuel Poverty.

The suggested reporting mechanisms in the proposed Performance Management Framework were: -

- Exception reporting based on the Board's 'Priority Measures';
  - Form and frequency needed to be agreed.
- Not all outcomes from the national Frameworks had to be reported or considered if they were not deemed to be local priorities based on the evidence available (JSNA);
- Other national measures were managed through other partnership/organisational arrangements.

It was intended that the proposed Partnership Framework would: -

- Contain SMART targets and action plans;
- There would be accountable lead managers for all measures;
- There would be a reporting and communication framework:

- All measures would be monitored and reported to the right people (across agencies);
- 'Exception Reporting' to the Health and Wellbeing Board;
- Enable challenge and problem solving at all levels;
- Address poor performance quickly and effectively.

Implementation of the Performance Management Framework: -

- Reports on the progress against all 'Priority Measures' would be considered at each Board meeting;
- One Priority Measure for scrutiny and problem solving would be the focus of each meeting;
- A quarterly report on national outcome measures, shared outcomes and customer experience would be provided.

Discussion ensued and the following issues were raised: -

- Six themes could be taken two per quarterly meeting;
- Theme Leads to be invited to the meeting to contribute to the discussion;
- There was support for the addition of dementia as the sixth theme;
- Children's issues, and impact on children, to be considered throughout the themes;
- A thread from conception to end of life should be represented throughout the consideration of each theme;
- Cultural differences and needs should be reflected.

The Board confirmed their agreement to the proposed Health and Wellbeing Performance Management Framework with the addition of information in relation to children's voice and cultural issues.

Resolved: - (1) That the proposed Performance Management Framework be agreed with the additions discussed.

(2) That each meeting of the Health and Wellbeing Board consider two themes (smoking, alcohol, obesity, dementia, NEETS and fuel poverty), with the theme's lead officer invited to attend the relevant meeting.

S49. OVERARCHING INFORMATION SHARING PROTOCOL

Gary Walsh, Information Governance and Quality Manager, submitted a proposal for the Health and Wellbeing Board to accept ownership of an Information Sharing Protocol. It was intended that the Protocol would be used by all agencies within the Health and Wellbeing Board.

The Overarching Information Sharing Protocol (OSIP) was a multi-agency protocol and used by many organisations within Rotherham as evidence and compliance to Information Sharing best practice. The previous OSIP was owned by the Rotherham Information Governance Group but, following recent organisational changes, no longer met.

The OISP was part of a 3 tier model enabling partner organisations to utilise well established appropriate and transparent information sharing systems

(either manual or electronic). Processes placed the Service user at the centre of how their information was processed in accordance with their rights to privacy and confidentiality. It was a statement of the principles and assurances that governed information sharing.

The protocol must not be seen as a legal document that allowed all information to be shared between organisations. All information sharing must be undertaken in accordance with the Data Protection Act, Human Rights Act, common law duty of confidentiality and any other specific statute that authorised or restricted disclosure.

Discussion ensued and the following issues were raised: -

- Was the proposed protocol compatible with professional information sharing codes for GPs, Social Workers and other professions? In particular, GPs/Doctors had specific guidelines around sharing of notifiable diseases.
- Need to ensure that all Partner Boards had the opportunity to comment and agree the Protocol.

Resolved:- (1) That the report be received and its content noted.

(2) That further work be undertaken on the proposed Protocol in relation to ensuring it was compatible with professional guidelines.

(3) That Partner Representatives present the revised Protocol to their Boards for comment and agreement.

(4) That the revised Protocol be presented to a future meeting of the Health and Wellbeing Board.

S50. PUBLIC HEALTH RESPONSIBILITIES IN RELATION TO SEXUAL HEALTH

Resolved: - That the report be presented to the next meeting of the Health and Wellbeing Board.

S51. EXCLUSION OF THE PRESS AND PUBLIC

Resolved:- That, under Section 100A(4) of the Local Government Act 1972, the press and public be excluded from the meeting for the following item of business on the grounds that it involves the likely disclosure of exempt information as defined in Paragraph 4 of Part 1 of Schedule 12A to the Local Government Act, 1972 (as amended March, 2006) (information relating to any consultations or negotiations, or contemplated negotiations, in connection with any labour relations matters).

S52. UNSCHEDULED CARE REVIEW

Consideration was given to the report presented by Dr. Ian Turner, GP Specialist in Unscheduled Care, and Ian Atkinson, Senior Commissioner, which outlined the scope of a review that had been planned into unscheduled (urgent) care provision in Rotherham.

The review planned to look at issues of access, whether clear pathways existed for patients and service users, to remove duplication and waste, and ensure that the highly skilled unscheduled care workforce was deployed in the most effective setting. The review aimed to ensure that sustainable and high quality access to unscheduled care was available to the people of Rotherham in the longer term.

It was envisaged that a full public consultation would be entered into between December, 2012, and March, 2013.

Consideration was given to the scope of the review and provided feedback on the content.

- Streamlining options available to patients to avoid confusion;
- Travel considerations relating to location of unscheduled care provision(s);
- Cultural norms and whether members of the Black and Minority Ethnic communities used a particular method of unscheduled care.

Whilst Rotherham's unscheduled care providers would form part of the review, other sources of unscheduled care and information would not be involved in the scope. These included: -

- NHS Direct help-line and the 111 NHS Service;
- Visit local pharmacists;
- Call 999.

Resolved: - (1) That the information shared be noted.

(2) That the Health Select Commission be informed of the scope of the review into Rotherham's unscheduled care provision.

S53. DATE OF NEXT MEETING

Agreed:- That a further meeting of the Health and Wellbeing Board be held on Wednesday, 16th January, 2013, commencing at 1.00 p.m. in the Rotherham Town Hall.

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