CABINET MEMBER FOR ADULT SOCIAL CARE

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

Date: **Monday, 15th April, 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 11th March, 2013 (Pages 1 - 4)

5. Health and Wellbeing Board (Pages 5 - 15)
   - Minutes of meeting held on 27th February, 2013

6. Enabling Services Quarterly Update (Pages 16 - 21)

7. Assessed and Supported Year in Employment (Pages 22 - 25)

8. Police Assistance and Conveyance to Hospital for those detained under the Mental Health Act 1983 (Pages 26 - 50)

9. Adult Services Revenue Budget Monitoring Report 2012-13 (Pages 51 - 56)

10. Date and Time of Next Meeting -
    - Monday, 25th March, 2013, at 10.00 a.m.

CABINET MEMBER FOR ADULT SOCIAL CARE
11th March, 2013

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

H74. MINUTES OF THE PREVIOUS MEETING HELD ON 25TH FEBRUARY, 2013

Consideration was given to the minutes of the previous meeting held on 25th February, 2013.

Resolved:- That the minutes of the previous meeting held on 25th February, 2013, be approved as a correct record.

H75. MINUTES OF THE ROTHERHAM SAFEGUARDING ADULTS BOARD

The notes of the meeting of the Rotherham Safeguarding Adults Board held on 9th January, 2013, were noted.

H76. ADULT SERVICES REVENUE BUDGET MONITORING

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 January, 2013.

It was reported that the forecast for the financial year 2012/13 was an underspend of £352,000 against an approved net revenue budget of £71.445M.

It was noted that the net budget had reduced to reflect the realignment of procurement savings and associated costs. Non-recurrent winter pressures funding had also been received from Health which had increased the overall underspend.

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 slight underspend mainly due to savings on postages and telephone charges

Older People

- A forecast overspend on In-House Residential Care, further increase in demand for Direct Payments and In House Transport. There was now a forecast overspend on Independent Sector Home Care due to increased activity over the last few months

- Offset by underspends within Enabling Care, independent Residential and Nursing Care, Community Mental Health, Carers' Services and slippage on Assistive Technology and recruitment to vacant posts within Assessment and Care Management
- Savings now being realised from the Review of Day Care Provision
- Overall underspend on Rothercare due to slippage in Service Review including options for replacement of alarms
- General savings on premises and supplies and services due to moratorium on non-essential spend

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
- Underspend 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
- Saving on premises costs and supplies and services as a result of the moratorium

Mental Health

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

Physical and Sensory Disabilities

- Continued pressure on Independent Sector Domiciliary Care, loss of Continuing Health Care funding for one client being challenged, increase in demand for Direct Payments and forecast overspend on Residential and Nursing Care offset by slippage in developing alternatives to residential provision
- Underspend by independent domiciliary provider as clients were redirected to Direct Payments
- 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 reported within Adult Services

Total expenditure on Agency staff for Adult Services to the end of January 2013 was £307,394 compared with an actual cost of £287,674 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 £329,783 spent up to the end of January, 2013, on non-contractual overtime for Adult Services compared with expenditure of £266,295 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 and clarified:-

- Successful outcome of the CHC funding challenge
- 8 vacancies in Social Work Team had resulted in agency staff being used on a short term basis. Positions now recruited to
- Increase in the number of staff in Assistive Technology in order to promote preventative services, including joint working with Health.

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

H77. REVISION TO RESOURCES ALLOCATION SYSTEMS

The Director of Health and Wellbeing submitted for consideration a proposal to increase the Resource Allocation System (RAS) scorecard to reflect the impact of inflation.

The aim of the RAS, linked to the allocation of personal budgets, was to provide a clear and rational way to calculate how much money it was likely to cost to meet a person's assessed needs as determined in their support plan.

The RAS had to be revised each year to take account of changes in Social Care budgets and support costs. It should take account of key cost drivers affecting personal budgets and not just the overall Adult Social Care budget. The ADASS Framework advised that future proofing the

RAS would need to be determined locally taking account of the local financial climate.

At the moment, the key cost drivers were the costs of Independent Sector Community Based Services. The Council's inflation provisions for these cost drivers had been increased by an average of 1.57% and, therefore, proposed that the RAS scorecard be increased accordingly.

The rates were set out in Appendix 1 of the report submitted.

Resolved:- That the Resource Allocation System be increased by 1.57% for the 2013/14 financial year, the rates as set out in Appendix 1 of the report submitted.

HEALTH AND WELLBEING BOARD
27th February, 2013

Present:-
Members

Councillor Ken Wyatt	Cabinet Member, Health and Wellbeing **(in the Chair)**
Tom Cray	Strategic Director, Neighbourhoods and Adult Services
Helen Dabbs	RDaSH
Councillor John Doyle	Cabinet Member, Adult Social Care
Chris Edwards	Chief Operating Officer, Clinical Commissioning Group/ NHS Rotherham Metropolitan Borough Council
Brian Hughes	Director of Performance and Accountability, NHS Rotherham South Yorkshire and Bassetlaw
Shafiq Hussain	Voluntary Action Rotherham
Councillor Paul Lakin	Cabinet Member, Children, Young People and Families
Shona McFarlane	Director of Health and Wellbeing
Michael Morgan	Interim Chief Executive, Rotherham Foundation Trust
Dr. David Polkinghorn	Rotherham Clinical Commissioning Group
Dr. John Radford	Director of Public Health
Joyce Thacker	Strategic Director, Children, Young People and Families

Officers:-

Kate Green	Policy Officer, RMBC
Tracy Holmes	Communications and Marketing, RMBC
Dr. Nagpal Hoysal	Public Health Consultant
Joanna Saunders	Head of Health Improvement
Dawn Mitchell	Committee services, RMBC

Apologies for absence were received from Christine Bain, Karl Battersby, Martin Kimber, Gordon Laidlaw, Fiona Topliss, Janet Wheatley and Chrissy Wright.

S62. MINUTES OF PREVIOUS MEETING

Resolved:- (1) That the minutes be approved as a true record subject to the following clerical correction:-

S55(e)(Local Medical Committee)
"It was felt that there was GP representation on the Board through the CCG which could reflect the views of GPs as commissioners and not providers."

Arising from Minute No. S54(2) (Information Sharing Protocol), it was noted that RDaSH, NHS Rotherham and the CCG had signed off the Protocol. It was hoped it could be raised as an extra item at the Rotherham Foundation Trust Board meeting the following day.

(2) That the Overarching Information Sharing Protocol be placed on the Council's Risk Register.

Arising from Minute No. S60 (Rotherham HealthWatch), the Chair reported that 7 tenders had been opened and were currently being evaluated. It was hoped that the contract would be awarded to a successful tenderer, however, if that was not the case, there was a fallback position set out in the national guidance.

(Shafiq Hussain disclosed disclosable pecuniary interest in the above item.)

S63. COMMUNICATIONS

(1) Health and Wellbeing Board Work Plan

The Board noted the updated Work Plan illustrating the cycle of reporting up to October, 2013 when an evaluation would then take place.

(2) Health and Wellbeing Strategy Workstream Update

The Board noted a report setting out the progress on each of the workstreams. It was felt that future progress reports would benefit from inclusion of figures so the Board would be able to see what change had been achieved.

(3) Better Health for Women: A Summary Guide

The Board noted the above briefing which should be fed into the Joint Strategic Needs Assessment.

(4) Rotherham Carers' Charter

The Board noted the above which had been considered by the CCG and adopted by the Council.

It was reported that a multi-agency Steering Group had been established, meeting regularly, to progress the accompanying action plan and achieve the plan's objectives.

Discussion ensued on the forthcoming Bedroom Tax and the view that it ought to be included as it would affect carers and foster carers, cross referenced with the work taking place on Welfare Reform.

Resolved:- (a) That Bedroom Tax be included in the Joint Action Plan for Carers cross referenced with the work taking place on Welfare Reform.

(b) That the annual review of the Carers Plan be submitted to the Board.

(5) Conferences

The following conferences were noted:-

2nd Annual Health and Transport Conference: Remaining Healthy Through Sustainable Travel – Transport Planning Society – 10th April, 2013

Rotherham Health and Wellbeing Conference – 17th April, 2013

Health and Social Care Policy Forum and Q&A with Andy Burnham MP, Shadow Secretary for Health – Goole College – 7th March, 2013

S64. HEALTH AND WELLBEING BOARD COMMUNICATIONS PLAN

Tracy Holmes, Head of Corporate Communications and Marketing, submitted a draft Communications Framework.

The primary purpose of the Framework was to ensure effective, consistent and co-ordinated communications, marketing and social marketing activity to support the work of the Board. It set out how strategic and operational communications and marketing activity was undertaken by the range of organisations which contributed to the delivery of the outcomes through Rotherham's Health and Wellbeing Strategy as well as communications activity in support of, and on behalf of the Board itself.

The Framework would be supported by a plan of key actions which summarised the communications and marketing activities/campaigns in support of the work plans for each Priority area. It would be regularly reviewed and monitored by the Board but nominated lead agencies would individually or jointly be responsible for its delivery.

Resolved:- That the draft communications Framework be supported.

S65. ROTHERHAM FOUNDATION TRUST

Michael Morgan, Interim Chief Executive, Rotherham Foundation Trust, gave a verbal update on the Trust as follows:-

- The Trust had received notification from Monitor, the independent regulator of NHS foundation trusts, that it was in significant breach for both finance and Board governance. It had until 18th March, 2013, to provide a plan to Monitor. The proposed plan was to be considered by the Trust's Board on 28th February

- The plan would provide initial short term, 1 year, financial turnaround for the organisation. It would also include a 2 and 3 year financial turnaround

- There would then be a period between 18th March and 15th September, 2013, to provide Monitor with a 3 year strategic plan including the 2 and 3 year financial turnaround in much more detail as would be available for the 18th March deadline

- It was anticipated that the team would be in for 8-12 months. There not only needed to be a financial turnaround but also a cultural change that the team specialised in

- There were 2 ways to turn an organisation around – slash and burn or management style that provided for interaction between the various groups i.e. physicians, consultants, nurses etc. The latter enabled a real perspective of the organisational structure and found to provide a much longer term structure

- Outside independent specialists had been brought in to look at the Patient Record Information System. In the short time they had been there, reassurance had been given that they would probably be able to get the system to a point where there was much more functionality for the specialists and clinics where the majority of the problems were located

- The Ward closures had been put on hold for the present time as it had not been seen as an immediate priority. The new Clinical Director for Medicine had met with approximately 20 of the specialist consultants and unanimously arrived at a new work plan scheme for the organisation. The new scheme would become operational as from 18th March. This was a fundamental building block for the Trust and whereby it may be possible to close a Ward in the future

- If it could be helped areas of staffing that affected patients were never the first starting point. The proposed plan would start in the Executive Suite and Corporate overheads. It did not include Estates and certainly did not include Nursing. The 90 day consultation document issued on 14th December, which finished on 15th March, proposed some rebanding of Nursing and it may be that that would continue.

- The Board had approved the hiring of additional nurses – 50 nurses had signed a commitment to start at the Hospital

- There need to be synergy between the Community aspects of the Trust and the Acute Care side

Michael was thanked for his report.

Resolved:- That the Equality Impact Assessments carried out by the Trust be submitted to future Board meetings.

S66. ROBERT FRANCIS INQUIRY - MID-STAFFORDSHIRE NHS FOUNDATION TRUST

The Board considered a resume of the Francis Report – the independent inquiry into the care provided by Mid-Staffordshire NHS Foundation Trust prompted by unusually high hospital mortality statistics.

Its recommendations and conclusions were many and far reaching with implications for commissioners and providers far beyond those of healthcare. The report found that the failures at the Trust were essentially failures of culture and systems and did not single out any 1 individual for blame.

Discussion ensued on the report with the following points highlighted/raised:-

- "Humanity" was missing from the Trust
- Each organisation of Rotherham's Board should report on what actions they were taking in respect of the Report
- A "mirror" should be held up to commissioners and scrutiny to ascertain that the same failures were not occurring
- The Report referred to some form of Annual Statement but it was not known what it would look like at the present time
- Interaction across organisations was fundamental

It was noted that there was to be a Seminar on the Francis Report on Thursday, 18th April, 2013, commencing at 11.30 a.m.

Resolved:- (1) That the findings of the Francis Report be acknowledged.

(2) That the Board ensures that all commissioning and provision of Healthcare in Rotherham follows the principles and recommendations laid out in the Report.

(3) That, as a minimum, all Rotherham healthcare providers, commissioners and Scrutiny submit evidence that supports their assurances that their organisation and practices were in line with all the Francis recommendations and, in particular, in relation to safe staffing levels and the prioritisation of patient safety ahead of financial pressure.

S67. PUBLIC HEALTH OUTCOMES FRAMEWORK: HIGH LEVEL OUTCOMES

Dr. John Radford, Director of Public Health, presented a report on the Public Health Outcome Framework which was designed to assist the Board in understanding how well it was improving and protecting Public Health.

The high level profile allowed the Board to review performance and consider its priorities for Health Services and to make decisions and plans to improve local people's health and reduce health inequalities. The profile presented a set of important health indicators that showed how Rotherham compared to the national and regional average.

The health profile for Rotherham 2012 illustrated:-

- higher than average under-75 death rate from cancer and coronary heart disease

- injuries and falls in the elderly remained higher than average

- preventable sight loss was higher than average

- access to diabetic retinopathy screening was worse than average

- child poverty, obesity levels in Year 6, pupil absence and 16-18 year old NEETS were of concern as they were all worse than average

- breastfeeding initiation and maintenance rates were worse than average

- emergency re-admissions remained higher than average

Resolved:- (1) That the Board regularly review progress against the Public Health, NHS, Adult Social Care and Children's Outcomes Frameworks.

(2) That the alignment of the current Joint Health and Wellbeing Strategy to address issues highlighted within the report be noted.

S68. PERFORMANCE MANAGEMENT FRAMEWORK

This was taken together with Minute No. 69.

S69. WORKSTREAM PROGRESS: HEALTHY LIFESTYLES, PREVENTION AND EARLY INTERVENTION

Dr. John Radford, Director of Public Health, and Dr. Nagpal Hoysal, Public Health Consultant, gave the following powerpoint presentation:-

Approaches
- Joint Health and Wellbeing Strategy
  Stages of Life Course
  Six Priority Outcomes
- Priority Measures
  Alcohol, Obesity, Tobacco, Dementia, NEETS, Affordable Warmth

Life Course Framework
- The Strategy set out a life course framework which had been adopted from the Marmot life course
- Life course: Early Intervention, Prevention and Behavioural Change

- Integral to the 6 Public Health programmes from Strategy
- System-based responsibility under the Health and Wellbeing Board

Healthy Lifestyles, Prevention and Early Intervention
- Outcome: people in Rotherham would be aware of health risks and be able to take up opportunities to adopt healthy lifestyles
- Outcome: Rotherham people would get help early to stay healthy and increase their independence

Communication
- QTV
- Campaigns – MCAT
- Web-based social media/mobile devices/engagement
- Every contact counts

Starting Well
- Children's Strategy
- Health Visitor 0-5 programme
- UNICEF Baby Friendly Initiative
- Troubled Families
- Family Nurse Partnership
- Imagination Library
- Specialist Midwifery

Developing Well
- Children's Strategy
- Looked after Children
- Healthy Schools
- Communication –website campaigns
- School Nurse Contract Revision
- Healthy Weight Framework
- NEETS system reporting framework

Living and Working Well
- Obesity – system reporting framework
- Alcohol – system reporting framework
- Smoking – system reporting framework
- NHS Healthcheck
- Communication – campaigns website development
- Workplace health

Ageing Well
- Affordable warmth – system reporting framework
- Dementia – system reporting framework
- Healthy Ageing
- NHS Healthchecks
- Flu vaccination

Healthy Lifestyles, Prevention and Early Intervention

- Delivery of a shift towards Prevention and Early Intervention and Healthy Lifestyles required a strong partnership approach
- The system-wide reporting framework proposed would enable the Board to hold the partners to account for their individual responsibilities

Discussion ensued on the presentation with the following issues raised/highlighted:-

- Considerable work had taken place in mapping the existing strategies against the Centre for Disease Control Framework for the 3 areas of Obesity, Smoking and Alcohol. Suggested targets would be submitted to the Board

- Linkages with the work of the Children's Board. Starting Well and Developing Well firmly sat within the Children's Board but should there be any issues e.g. partners, governance, they should be reported to the Health and Wellbeing Board

- Key issue of underage drinking – need more rigorous approach to the affordability of alcohol with suppliers, shops etc.

- Low level of referrals for weight issues – no real awareness of Obesity and the associated risks

- Restricting supply – measurable but currently not done. The Council did not have a planning and/or licensing policy restricting the availability of fast food

- Currently if someone was found drunk in Rotherham they were not required to attend a binge drinking course – could be part of an Attendance Order

- Relatively small number of targets across the 3 areas of Obesity, Smoking and Alcohol but all were measurable and quite challenging. If the focus was on a relatively small numbers of measures they would be achievable and make a difference

- How was the Public Health money going to be used to achieve the 6 Priorities?

- Discussion was still ongoing with regard to which Public Health services were contained within the Public Health funding allocation. A budget had not been set within the Council as yet. There would be significant investment in Alcohol, Obesity and Stop Smoking Services but as yet there had been no commitment requested from partners to contribute accordingly

Resolved:- (1) That the presentation be noted.

(2) That the targets and priorities for Public Health be submitted to the next meeting.

(3) That the information contained in the presentation be worked up into measurable proposals.

(4) That the relevant Steering Group consider the NEETS information further.

S70. PRIORITY MEASURE 2: OBESITY

Joanna Saunders, Head of Health Improvements, gave the following powerpoint presentation:-

Why is Obesity a priority?
- Public Health priority nationally and locally
- Can have serious health consequences and impacts on health and social care services
- Can be prevented and treated (NICE)
- Impacts on emotional wellbeing
- Impacts on the economy

What Does a Healthy Weight Framework look like?
- Children
  Tier 1 – Primary activity – School Nurse, GP, Health Visitor
  Tier 2 – MoreLife Clubs
  Tier 3 – Rotherham Institutes for Obesity
  Tier 4 – MoreLife Residential Camps

- Adults
  Tier 1 – Primary activity – GP, Health Visitor, Leisure Services
  Tier 2 – Reshape Rotherham
  Tier 3 – Rotherham Institute for Obesity
  Tier 4 – Specialist Obesity Service

What do we need to do?
- Raise public awareness
- Get more people to engage with services
- Skill people up to live healthier lives
- Make healthy choices the easy choices
- Get everyone to recognise their role and act
- Challenge cultural and “normal for Rotherham” behaviour

What are the current priorities?
- Raise the profile of whole population prevention activity
- Continue to provide a range of services for people who are already overweight or obese

- Maximise the resources already available – training, signposting and referral
- Agree our position on the impact of planning decisions, transport planning

Challenges
- Preventing and treating childhood overweight and obesity in the primary school aged population
- Whole family engagement
- Changing behaviour amongst those that most need to change
- Evidence of what really works
- Funding to support grassroots initiatives

What can the Health and Wellbeing Board do?
- Making Every Contact Count. Power of partners
- Recognition of the importance of health as a driver of deprivation
- Political leadership
- Collaborative commissioning

Health and Wellbeing Board Members commitment
- Commit to all staff doing e-learning on MECC and giving feedback on their performance in signposting and referring to services
- Introduce planning and licensing policy to restrict availability of fast food particularly near schools or in deprived communities and promoting use of green space
- A concentrated effort to address the issue in the primary school population

Discussion ensued on the presentation with the following issues highlighted:-

- Awareness was the big issue
- The message was getting across but people failed to recognise they had a problem
- Many did not have the skills or income to provide healthy food

Joanna was thanked for her presentation.

S71. 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 I of Schedule 12A to the Local Government Act 1972 (contains information relating to the financial or business affairs of any person (including the Council)).

S72. FOOD FOR PEOPLE IN CRISIS PARTNERSHIP

The Chairman presented a brief report on the 12 VCF organisations in the Food for People in Crisis Partnership providing a range of different services.

The report set out the food parcels and cooked meals provided by each during the months of October and November, 2012.

Discussion was now required on how to progress the work in the future to meet the predicted demand.

Resolved:- That consideration be given to establishing a Steering Group to take this issue forward.

S73. DATE OF NEXT MEETING/FREQUENCY OF MEETINGS

Agreed:- That further meetings of the Health and Wellbeing Board for 2013 be held on Wednesdays, commencing at 1.00 p.m. in the Rotherham Town Hall as follows:-

10th April
8th May
12th June
10th July
25th September
23rd October
27th November
18th December
22nd January, 2014 (9.30 a.m.)
19th February
26th March
30th April

Rotherham Metropolitan Borough Council
Neighbourhoods and Adult Services
Health and Wellbeing

ENABLING SERVICES QUARTERLY UPDATE REPORT
TO CABINET MEMBER FOR ADULT SOCIAL CARE
15 APRIL 2013

---

1 Service Performance and Quality

1.1 Carers Corner

During January 2013, the Carers Centre saw an increase in the numbers coming into the centre, despite the poor weather. 320 people were given advice and support at the centre. The centre continues to provide information and advice which are detailed below:

Information/advice provided	No of Visitors
Benefits Support, Advice and Signposting	119
Legal Signposting	6
Carers Forum	19
Social Services Enquiries/Referrals	56
Training/Employment Signposting	11
Information or about other Council Services	19
Directions and Signposting to other sites in Rotherham	9
BME General Advice	23
Housing General Advice	4
General Information	44

The consultation on the Carers Charter Action Plan finished at the end of January and the Action Plan will be presented to Councillor Doyle in February 2012 for agreement.

Unfortunately, the Transition Forum Group had to postpone their planned first meeting; this was re-arranged for February 15th and held at Carers Corner.

Benefits enquiries continue to be the highest subject of enquiry. There is a risk that Carers are missing deadlines and have to wait for the correct advice and information, due to the limited support there is now for benefits advice. Staff at Carers Corner continue to seek where this type of advice can be sought.

1.2 Direct Payments

The number of customers in receipt of a Direct Payment continues to increase with an additional 300 new customers approximately opting to utilise this method to pay for their care and support during the last year.

The performance indicator for this service area is detailed below for individuals in receipt of a Direct Payment:

ASCOF-1Cii Proportion of people using social care who receive direct payments

The Year-end target for this performance indicator is 12% in line with top quartile for our comparator group.

Performance is currently 12.45% with a total of 924 customers in receipt of a Direct Payment in Rotherham.

1.3 Brokerage

The Brokerage Service continues to provide effective support to the care management and assessment teams in the procurement of support packages for our customers. From a performance perspective, no customers are currently waiting beyond 28 days to receive a care package with capacity across the independent sector sufficient to meet customer demands.

1.4 Intermediate Care

Intermediate Care Services in a residential setting are now delivered across three Locality Establishments as follows:

Netherfield – 21 beds
Davies Court – 15 beds
Lord Hardy Court – 15 beds

Netherfield Court was served with a compliance notice in December 2012 and remedial actions taken to rectify this deficit. The Care Quality Commission has re -inspected the service in February 2013 and confirmed that the establishment is now fully compliant.

From a performance perspective, the residential services continue to perform well. The average length of stay is between 15 to 18 days before a customer returns home to live independently and bed occupancy is currently at around 80%. This level of bed occupancy is excellent given the throughput of customers using the service, as clearly beds have to be turned round between admissions and discharges. This compares to average stays of 38 days in 2008/09 and an average bed occupancy of 47%. This performance demonstrates the progress

achieved across the service over the last few years and which is now consistently being maintained.

The performance indicator for this service area is detailed below:

ASCOF 2B - Achieving independence for older people through rehabilitation / intermediate care - The proportion of older people discharged from hospital to their own home or to a residential or nursing care home or extra care housing bed for rehabilitation with a clear intention that they will move on / back to their own home (including a place in extra care housing or an adult placement scheme setting) who are at home or in extra care housing or an adult placement scheme setting three months after the date of their discharge from hospital.

The 2011/2012 outturn was 85.5%, which is top quartile nationally, and our best performance since this area of practice has been measured against a National Performance Indicator. The 2012/2013 outturn will be reported in May 2013 and an update provided in the next quarterly report to the Cabinet Member.

Day Rehabilitation Services continue to be delivered from the worksite based on Badsley Moor Lane. The service continues to be popular with customers and throughput high with high levels of customer turn over. Rehabilitation services for customers with a visual impairment are now delivered from this worksite after a successful period of integration during 2012. This integration has resulted in efficiency gains to the Council and provided the service with the ability to deliver rehabilitation to their customers in a building that is fit for purpose.

2 Update on Agreed Service Changes/ Proposed Service Changes

2.1 Rothercare

Significant changes have occurred across this service in the last year. These include:

- A demerger from the Assessment Direct Team.
- A restructure of the service and the appointment of a new Rothercare Manager.
- The implementation of a new policy and procedure manual to ensure that the service operates consistently, is customer focussed and ensures we safeguard our customers at all times.
- Direct observations of staff is now undertaken to ensure that practice is of the highest standard and we seek the views of our customers during this process.

3 Case studies of good outcomes

Listed below are two case studies detailing the outcomes and comments of customers using these services. Both these customers have fully consented to their case studies being shared:

.

CUSTOMER 1 **Customer at Rotherham Intermediate Care Centre (RICC)**
Links to: **Outcome 1**: Enhancing Quality of the Life people with care and support needs. **Outcome 2**: Delaying and reducing the need for care and support. **Outcome 3**: Ensuring that people have appositive experience of care and support.
Reason for referral to the service – Customer 1 was socially isolated and lacked confidence when she was referred to the Rotherham Intermediate Care Centre by the assessment beds team.
Outcomes – Customer 1 was initially supported to access town using the safest routes and using public transport. Customer 1 as now been discharged after reaching her goals by using public transport and returning independently to going on trips and town shopping. Her confidence has improved since she commenced and she is now more sociable.
Customer Comments – Customer 1 said, “I am absolutely satisfied with the service and I have learnt a lot from attending”.

CUSTOMER 2 **Customer at Rotherham Intermediate Care Centre**
Links to: **Outcome 1**: Enhancing Quality of the Life people with care and support needs. **Outcome 2**: Delaying and reducing the need for care and support. **Outcome 3**: Ensuring that people have a positive experience of care and support.
Reason for referral to the service – Customer 2 was referred to the Rotherham Intermediate Care Centre. She had lost her confidence in daily living skills and shopping.

Outcomes - Whilst attending the unit for exercises and the food preparation day she as become extremely confidence and her mobility has improved and with support on out reach she as now been discharged. She is attending an exercise class independently and is now preparing her own meals without the aid of external support.
Customer Comments - Customer 2 said, "I have really enjoyed attending RICC and I thoroughly enjoyed the food session course.

4 Customer feedback

A mystery shopping survey was undertaken during February 2013 at Netherfield Court. 8 customers carried out the customer to customer survey with the following outcome:

- 100% of customers said that staff are respectful of their wishes
- 100% of customers said they can have a drink or snack when they want
- 100% of customers rated the food as good or fantastic
- 7 out of 8 customers agreed that there are plenty of activities on offer at Netherfield
- 7 out of 8 customers said that they are kept informed of any changes taking place at Netherfield
- 100% of customers said that they are able to have time alone if they do not wish to participate in activities
- 100% of customers are very satisfied that staff have helped them to maintain and promote their independence
- 50% of customers surveyed said that they did not know how to complain if they were unhappy with the service
- 2 out of 8 customers surveyed said that it had not been explained to them what will happen during their stay at Netherfield
- 100 % if customers said staff had explained how they will receive medicine and tablets during their stay

Customer comments included:

- "Staff very helpful, meals are good, feel comfortable here"
- "Cant fault it, everything is okay. Words cannot describe what this place is"
- "I have not been here very long, but what I have seen I would recommend to anyone"
- "They have been very good and understanding. They come to me whenever I call. I just want to thank them all"
- "No complaints what so ever. I am very happy here"
- "The staff are wonderful, treated respectfully. Staff have time to talk to me and they have a nice relationship with other clients"
- "My room is lovely and comfortable"
- "There is lots of care gone into the food here"
- "There's draughts, dominoes and skittles provided"
- "The food is fantastic"

The Service Manager has recently undertaken an unannounced inspection of this service and customers echoed the comments independently provided above.

The Rothercare Service has recently sought feedback from their customers that is summarised below:

- Mrs K a 93-year-old woman who lives alone in a local authority bungalow. She struggles with arthritis and mobility problems and has had to call out the RotherCare alarm staff when she has fallen at home. She has been a RotherCare customer for many years and could not live without the service.

- "It wasn't very long to get out to me – within half an hour maybe quicker as I had a fall and was on the floor, they let themselves in with the key safe, they organised everything and got a paramedic and locked up after themselves on the way out". – Anonymous

- "Very good, makes me feel safe and confident" Mr M.

- "Dealings with them have been brilliant. Feeling very reassured knowing they are here" Mr and Mrs M.

- "They have been very helpful to my wife and know they are there for her" Mr K.

These statements from our customers sum up the value that they attach to the service provided and how this helps them to live as independently as is possible with minimal interventions from the Local Authority.

Contact: David Stevenson – Service Manager
Email: david.stevenson@rotherham.gov.uk
Telephone: 01709 382121, extension 22610

ROTHERHAM BOROUGH COUNCIL – REPORT TOCABINET MEMBER

1	**Meeting:**	**Cabinet Member for Adult Social Care**
2	**Date:**	**15 April 2013**
3	**Title:**	**Assessed and Supported Year in Employment**
4	**Directorate:**	**Neighbourhoods and Adult Services**

5 **Summary**

5.1 The national Assessed and Supported Year in Employment (ASYE) scheme for Newly Qualified Social Workers (NQSWs) is being implemented across the Directorate; this builds on the previous NQSWs schemes with the aim of ensuring that NQSWs receive consistent support in their first year of employment. Implementation has involved working through and resolving a number of complex human resource management / development issues and ensuring a robust and defensible support and assessment process is in place.

5.2 An ASYE e-handbook has been devised to support the delivery of ASYE including protocols for supervisors and assessors to follow, defined roles and responsibilities of all those involved in ASYE, and a planned training programme for both NQSWs and their managers.

6 **Recommendations**

- **Cabinet Member receives this paper and supports the implementation of ASYE across the Health and Wellbeing Department.**

7 Proposals and Details

7.1 In September 2012 a new single sector-wide Assessed and Supported Year in Employment (ASYE) scheme succeeded the existing newly qualified social worker (NQSW) schemes for adults' and children's services. ASYE aims to ensure that NQSWs receive consistent support in their first year of employment so that they are able to become confident, competent professionals. ASYE's most significant differences to the previous schemes are that the outcome for the NQSW are pass or fail, with those failing being unable to use the protected title of 'Social Worker', and successful completion is certificated by the College of Social Work.

7.2 Not surprisingly, the introduction of a one-year ASYE scheme raised a number of human resource management / development complexities for the Directorate which needed careful consideration before implementation. A task and finish group (T&FG) was therefore constituted by the Health and Wellbeing Department's Senior Management Team to implement ASYE.

7.3 Working through the complexities, the T&FG has developed an ASYE e-handbook to support the roll-out of ASYE across the Directorate. Substantial time has been invested to ensure that the e-Handbook and its contents deliver a robust process of support and evidence based assessment for NQSWs that are, above all, defensible against any challenged 'fail' outcome judgements. Protocols have been devised and roles and responsibilities of all those involved in the support and assessment of NQSWs form the e-Handbook 'skeleton' on which the 'flesh' of templates and guidance have been added, and may continue to be added.

7.4 At the start of the ASYE the NQSW will complete a learning agreement which will describe how the Council will support them through reflective supervision, workload reduction (10%), a personal development plan, and protected time for personal development (10%). Assessment will be against the Professional Capabilities Framework at ASYE level using the principles of progressive holistic assessment with formative assessment being undertaken at three, six and nine months and final summative assessment at eleven/twelve months.

8 Finance

8.1 £2,000 funding is available from Skills for Care for each NQSW; it is intended to assist employers to implement an ASYE programme, provide regular support for their NQSWs, and assess each NQSW during their first year of employment.

9 Risks and Uncertainties

9.1 ASYE guidance is such that all staff employed after September 2012 who are within two years of qualification should undertake ASYE. Those who began on NQSW before April 2012 should complete NQSW. Those who have been employed between April and September 2012 and began on NQSW may either complete the NQSW or transfer to ASYE, provided that their employer feels that they can meet all the ASYE standards and could defend a fail outcome.

9.2 If workers are not eligible to undertake ASYE the onus is on the Council, the employer, to ensure that the Social Worker employed is able to meet the standards that would be expected of an ASYE. Those Social Workers employed who can not therefore demonstrate completion of a previous NQSW scheme, and were eligible to do so, will be required to successfully complete the ASYE programme to be employed by the Council, although it can not be called ASYE and they will not be able to gain a certificate from the College of Social Work on successful completion.

9.3 The following actions have been taken forward by the T&FG to robustly implement ASYE and mitigate risk to the Council when employing Social Workers:

9.3.1 Recruitment – the process of selection has been strengthened including questions to identify if an NQSW completed or did not complete a NQSW scheme and why, if they are required to undertake the ASYE, and if they have previously failed ASYE. Appointments in teams of any NQSW may be limited to one NQSW per team, in recognition of the demands placed on the Team Manager who will be required to provide frequent reflective supervision and assessment including direct observations.

9.3.2 Contract - NQSWs will be issued with a non-standard contract of employment that has a requirement to satisfactorily complete the ASYE. This is a contract that is currently used by Resources Directorate for teaching professionals who have a similar requirement to meet capabilities within their first year of practice. This will allow termination of contract if the ASYE outcome is fail.

9.3.3 Grievance – The Council is currently reviewing all of its human resources policies. Officers have been advised about the rights of ASYE to appeal against any ‘fail’ outcome decisions and consider any appropriate, specific clauses into policy. It is expected that the Probationary procedure is used during the first six months of employment with the move to the Capability Procedure after this period.

9.3.4 Absence Cover – a protocol has been devised to ensure that appropriate alternative support and assessment arrangements are put in place for the NQSW during extended period of absence of their Team Manager.

9.3.5 Assessment – Internal moderation arrangements have been put in place at all stages of the three formative assessments and at the summative assessment, with the final assessment to involve external moderation (currently under discussion with neighbouring authorities).

10 Policy and Performance Agenda Implications

10.1 An effective ASYE programme is central to ensuring that the Directorate is able to attract, recruit and retain NQSWs to work in Rotherham and support their development throughout their first year in assessed employment. An effective ASYE programme contributes to a capable, competent and skilled workforce.

11 Background Papers and Consultation

11.1 This paper has been produced in liaison with the Directorate's HR Business partner.

Contact Names:

Nigel Mitchell, Learning and Development Manager
Telephone: (01709) 334066
E-mail: nigel.mitchell@rotherham.gov.uk

Michaela Cox, Service Manager
Telephone: (01709) 382121 ext. 55982
E-mail: Michaela.cox@rotherham.gov.uk

ROTHERHAM BOROUGH COUNCIL – REPORT TO CABINET MEMBER

1	**Meeting:**	**Cabinet Member for Adult Social Care**
2	**Date:**	**15 April 2013**
3	**Title:**	**Police Assistance and Conveyance to Hospital for those detained under the Mental Health Act 1983**
4	**Directorate:**	**Neighbourhoods and Adult Services**

5 **Summary**

The 2008 Mental Health Act (MHA) Code of Practice requires Local Social Services Authorities, defined in section 145 (1) Mental Health Act 1983, the National Health Service and the Local Police Authority to establish a clear policy for the use of the power to convey a person to hospital under S.6 (1) MHA. This policy and procedure outlines the roles and responsibilities of the Approved Mental Health Professionals (AMHP), the ambulance service, medical and/or other healthcare practitioners, and police who may be called upon to facilitate the conveyance of an individual to hospital, or in the case of Guardianship an appropriate placement. The policy is to support good joint working and minimise the distress that service users, their family and friends can experience when admission is necessary.

Due to the number of stakeholders involved, the standards for each service and in some areas the resource constraints it has taken time to agree the wording of the policy. However, the policy is now in its final draft and all stakeholders are committed to its implementation.

6 **Recommendations**

- **For Rotherham Metropolitan Borough Council to confirm its approval of this policy and demonstrate its commitment to this multi-agency policy as a signatory body.**

7 **Proposals and Details**

It is recognised that arranging admission to a mental health unit is unpredictable and that circumstances and levels of risk to the service user and others will vary from one situation to another. However, the overall aim is to:

- To ensure that the person detained under the Mental Health Act 1983 is conveyed to hospital or alternative placement in an appropriate vehicle and in the most human way possible following an assessment of their mental health needs by 2 doctors and an Approved Mental Health Professional

Therefore, in accordance with Section 118 of the Mental Health Act 1983 as amended by the Mental Health Act 2007 (referred to in the policy as the MHA '83), the Department of Health issued a Code of Practice to provide guidance for managers and staff of Health and Social Services to assist them in undertaking duties under the Mental Health Act. The code places a requirement on statutory agencies to draw up a number of policies. Among these is the requirement for the provision of a jointly agreed policy for the conveyance of individuals who have been made subject to the Act.

The Code of Practice also specifies that policy should clearly identify what arrangements have been agreed with the police should they be asked to provide assistance to the AMHP's and the doctors, and how that assistance will applied to minimise risk of the patient causing harm to themselves and maximise the safety of everyone involved in the assessment.

8 **Finance**

There are no financial implications of this report

9 **Risks and Uncertainties**

This policy will be monitored through the Mental Health Legislation Monitoring Group on a monthly basis and reviewed at 3 monthly intervals during the first year following implementation. This will not only ensure its fitness for purpose in its practical application but also provide assurances that where decisions are made and actions compromise the liberty and Human Rights of an individual, that this is done lawfully and informed by good practice.

10 **Policy and Performance Agenda Implications**

None Known

11 **Background Papers and Consultation**

The Mental Health Act Code of Practice
The Mental Health Act Manual

Mental Health Act 2007, New Roles, Guidance for Approving Authorities and employers on Approved Mental Health Professionals and Approved Clinicians. National institute of Mental Health in England
The Mental Capacity Act 2005
Police and Criminal Evidence Act 1984
Criminal Law Act 1995
Human Rights Act – specifically Articles 2,3,5, 8,10,11

Consultation
Consultation has taken place and legal advice sought with and within
South Yorkshire Police
Yorkshire Ambulance Service
Rotherham Doncaster and South Humber NHS Foundation Trust
Rotherham Metropolitan Borough Council

Contact Name: **Marie Staves**
Telephone: (01302)794088
E-mail: marie.staves@rdash.nhs.uk

Rotherham Doncaster and South Humber NHS
NHS Foundation Trust

POLICE ASSISTANCE AND CONVEYANCE, FOR THE ADMISSION OF PATIENTS DETAINED UNDER THE MENTAL HEALTH ACT 1983 TO HOSPITAL

DOCUMENT CONTROL:	
Version:	2
Ratified by:	Mental Health Legislation Committee
Date ratified:	
Name of originator/author:	Social Work Consultant/MHA Manager/South Yorkshire Police/Humberside Police/Yorkshire Ambulance Service/East Midlands Ambulance Service
Name of responsible committee/individual:	Mental Health Legislation Committee
Date issued:	
Review date:	
Target Audience	

CONTENTS

SECTION

FORWARD

In accordance with Section 118 of the Mental Health Act 1983 as amended by the Mental Health Act 2007 (referred to subsequently as the MHA '83), the Department of Health issues a Code of Practice to provide guidance for managers and staff of Health and Social Services in undertaking duties under the Mental Health Act. The code requires statutory agencies to draw up policies for a number of Mental Health Act duties. Among these is the jointly agreed policy for the conveyance of patients. This conveyance of patients detained under the Mental Health Act Policy represents good practice.

It is the intention of the author and the Mental Health Act Manager to negotiate across Rotherham Doncaster and South Humber NHS Foundation Trust and between its partner agencies demonstrating their commitment to improving the efficiency and dignity with which people who are subject to the Mental Health Act 1983 are conveyed to hospital. This policy will be regularly monitored.

Partner Organisations	**Signatories**
Rotherham Metropolitan Borough Council	
Doncaster Metropolitan Borough Council	
North Lincolnshire Council	
South Yorkshire Police	
Humberside Police	
Yorkshire Ambulance Service	
East Midlands Ambulance Service	
Rotherham Doncaster and South Humber NHS Foundation Trust	

COMMITMENT OF SIGNATORY BODIES

Yorkshire and East Midlands Ambulance Service will exercise its authority to convey under S.6 (1) Mental Health Act, using the most appropriate vehicle for the presenting circumstances. All Mental Health Act requests for conveyance under this policy will be graded as requiring an urgent response that is, within two hours, unless exceptional circumstances merit a more immediate level of response.

Rotherham Doncaster and South Humber NHS Foundation Trust recognises the importance of multi-agency work under the Mental Health Act. The Trust is committed to providing an efficient and effective response to requests for support and/or assessment. RDASH NHS Foundation Trust will also ensure that mental health staff have appropriate training to support actions that may be required, such as bed management, in the execution of this policy and procedure.

Rotherham Metropolitan Borough Council, Doncaster Metropolitan Borough Council and North Lincolnshire Council will ensure that there are sufficient numbers of Approved Mental Health Professionals (AMHP's) available under S.114 Mental Health Act 1983 for the purposes of statutory intervention under this policy and procedure and are committed to providing an efficient and responsive 24-hour AMHP Service.

South Yorkshire and Humberside Police recognise the importance of multi-agency work under the Mental Health Act and in particular, to support the AMHP and the Ambulance Service in the delivery of its conveyance responsibilities. The Police recognise that where there is an identified threat or risk of violence or harm to staff carrying out an assessment, or to Ambulance Service personnel, that the assistance of officers may be required. The Police further acknowledge that there are appropriate powers available to them in order to prevent or reduce the risk of harm to others under various pieces of legislation and statutory powers.

INTRODUCTION

The 2008 Mental Health Act (MHA) Code of Practice requires Local Social Services Authorities, defined in section 145 (1) MHA 1983, the National Health Service and the Local Police Authority to establish a clear policy for the use of the power to convey a person to hospital under S.6 (1) MHA. This policy and procedure outlines the roles and responsibilities of each of the organisations that are the signatory bodies. This policy and procedure therefore provides guidance for ambulance service personnel, medical and/or other healthcare practitioners, Approved Mental Health Professionals (AMHP) and police officers.

In the case of a formal application for admission to hospital other than an emergency application, the period of 14 days beginning with the date on which the person was last examined by a registered medical practitioner is the period within which the applicant or any person authorised by the applicant can take the patient and admit them to hospital.

In the case of an emergency application, the period is 24 hours from when the application was made within which the patient can be conveyed to hospital.

The overall aim of this policy and procedures is:

- To ensure that persons detained under the Mental Health Act 1983 are conveyed to hospital in an appropriate vehicle and in the most humane way possible following an assessment of their mental health needs by doctors and an Approved Mental Health Professional.

2. PURPOSE

The purpose of the policy is to describe best practice in the process of admitting mentally ill patients to hospital by ambulance, and to explain the agreed roles and responsibilities of each of the services involved in an admission under the Mental Health Act 1983. It will contribute to good joint working, and minimise the distress that patients, their friends and family can experience when admission is being undertaken.

It is recognised that arranging admission to a mental health unit is unpredictable, circumstances will vary from one situation to another and each of the services operates under resource constraints. However, this policy, in describing best practice, sets out the standards for each service.

3. SCOPE

This policy is relevant to the personnel of RDASH, Local Authority partners, South Yorkshire and Humberside Police and Yorkshire / East Midlands Ambulance Service and covers:

- Roles and responsibilities
- The Assessment process
- Admission arrangements
- Arrangements for the resolution of disputes

The Policy does not cover the full range of all individuals and professionals who may play key roles in the mental health admission process, but does identify the roles of the AMHP, the Police and Ambulance Service.

The Policy covers Police assistance and the conveyance of an individual detained under the Mental Health Act 1983 to a hospital or appropriate placement where the patient is subject to guardianship.

4. RESPONSIBILITIES, ACCOUNTABILITIES AND DUTIES

4.1 RDASH - Mental Health Legislation Committee

The RDASH Trust's Mental Health Legislation Committee is responsible for:

- Overseeing the implementation of the Act within the organisation.
- The review and issuing of all policies and procedures which relate to the Act.
- Monitoring the Trust's compliance with the legal requirements of the Act.
- Undertaking audit work and agreeing action plans in relation to the Act.
- Providing an annual report on Mental Health Act activity within the Trust to the Board of Directors.

4.2 Approved Mental Health Professional (AMHP)

The Approved Mental Health Professional (AMHP) will take the lead in all matters relating to the conveyance of patients who are liable to be detained under the MHA 1983, they will:

- consult appropriately with staff from other agencies
- establish the most appropriate conveyance arrangements
- complete and document a risk assessment
- share the risk assessment with Ambulance, Police and other colleagues
- be available to offer assistance if the Nearest Relative is the applicant
- ensure that all the necessary arrangements are made for the patient to be conveyed to hospital
- ensure the needs of the patient are taken into account and give particular consideration to:
    - The patient's wishes.
    - The views of relatives or friend(s) involved with the patient.
    - The views of other professionals involved in the application who know the patient.
    - His or her judgment of the patient's state of mind, and the likelihood of the patient behaving in a violent or dangerous manner.
    - Previous experience of conveying the patient.
    - The impact that the use of a police vehicle may have on the patient's relationship with the community, to which he or she will return.

5. POLICY FRAMEWORK

5.1 Who has the authority to convey the patient?

This applies in all cases where patients are compulsorily conveyed under the MHA 1983 (11.3 MHA Code of Practice)

The Approved Mental Health Professional (AMHP) will take the lead in all matters relating to the conveyance of patients who are liable to be detained under the MHA 1983.

A properly completed application for the detention of an individual under the MHA 1983, together with the required medical recommendations, gives the applicant

(AMHP or Nearest Relative) the authority to convey the patient to hospital. They are authorised under the MHA to convey a patient to hospital or appropriate placement and therefore have all the powers of a police constable in respect of, and for the duration, of the conveyance of the patient.

When the AMHP is the applicant he/she has a duty to ensure that all necessary arrangements are made for the patient to be conveyed to hospital. Where an application for compulsory admission to hospital appears likely to take place, it is considered best practice to inform Ambulance Service in advance of the assessment

When the Nearest Relative is the applicant, the assistance of an AMHP should be made available, to give guidance and help on all aspects of conveyance and other matters related to the admission.

A patient will be conveyed to hospital in the most humane and least threatening way, consistent with ensuring that no harm comes to the patient or to others.

5.2 Who is authorised to convey the patient?

All patients subject to an application for admission to hospital or alternative placement under the MHA 1983 will be conveyed by the Ambulance Service using an appropriate vehicle and with suitably trained staff.
In situations where the risk of injury to patient or staff is likely, the assistance of the Police may be required. When called upon to assist, the attending officers will consult with other professionals as to the most appropriate method of transporting the patient to a place of safety, making a joint decision based upon a dynamic joint risk assessment (Appendix 3).

The detained patient should never be conveyed by private car.

If the patient is unlikely to or unwilling to move, the applicant should provide the people who are to convey the patient (including any ambulance staff or police officer involved) with written authority to convey the patient (Appendix 1)**.**
It is this authorisation, which confers on them the legal power to convey the patient against their will, using reasonable force if necessary, and to prevent the patient from absconding en route. Section 5 of the Mental Capacity Act provides powers to use reasonable force in order to act in the patients' best interests. It will be for the attending AMHP and other relevantly trained medical professionals to inform attending officers that the patient lacks the requisite capacity to make an informed decision about their proposed treatment. It will not be for attending police officers to make a capacity assessment. All such decisions should be appropriately documented. If officers are attending in circumstances whereby a warrant has been granted under Section 135 of the Mental Health Act 1983, then this grants powers to use reasonable force if required.

6. PROCEDURE/IMPLEMENTATION

6.1 AMHP responsibilities

6.1.1 <u>Risk Assessment</u>

Where the risk assessment conducted by the AMHP concludes that there is a threat of violence or harm or a risk that the patient will abscond, the AMHP will discuss whether the Police should be in attendance throughout the MHA assessment itself, and/or providing an escort in any subsequent conveyance of the patient to hospital. The risk assessment will be shared with Ambulance Service, Police, and other

colleagues and will be formally recorded (Appendix 3).

The AMHP should request the assistance of the Police if there is an assessed risk of violence during the assessment, conveyance, or admission process. The AMHP, upon acknowledging the need for a Mental Health assessment in the community, should carry out a risk assessment. If there are identified risks, then they should grade that risk in accordance with the attached flow chart (Appendix 6). Police assistance should then be requested from the Police Control Room by telephoning 101. (*this is the number for all police forces now and the call will be directed to the relevant force's control room*). The AMHP should quote 'Operation AMHP' to the call handler, together with the desired level of police support. This will then trigger the police action plan in place for such requests. The AMHP will be given an incident number for use when re-contacting the police. In the event of urgent and immediate assistance being required, then the AMHP should use the 999 system, giving as much information about the situation as is practicable in the circumstances.

If, following the initial request for police assistance, the attending AMHP requires further assistance, or if the situation develops or deteriorates, then the AMHP should re-contact the police, quoting the incident number.

In situations where an increased level of risk is identified prior to the assessment taking place, then the 'Additional Information for Police' sheets (Appendix 4) should be completed, with the information passed to the police. This will enable the rapid and appropriate deployment of resources to assist when required.

It is the AMHPs responsibility to conduct their own risk assessment. The Police will carry out their own risk assessment based upon this information, together with their own sources of information / intelligence in order to develop a deployment / assistance plan. Attending officers will carry out a dynamic risk assessment in consultation with the AMHP and other attending professionals, should they be deployed.

Where the Police have been urgently requested, due to an escalation of risk it would also be advisable to contact the ambulance service and upgrade the response so that there is an immediate ability to transport the patient.

6.1.2 Needs of the patient

The AMHP should ensure the needs of the patient are taken into account and give particular consideration to:

- The patient's wishes.
- The views of relatives or friend(s) involved with the patient.
- The views of other professionals involved in the application who know the patient.
- His or her judgment of the patient's state of mind, and the likelihood of the patient behaving in a violent or dangerous manner.
- Previous experience of conveying the patient.
- The impact that the use of a police vehicle may have on the patient's relationship with the community, to which he or she will return.

6.1.3 Arranging for the conveyance of the patient

As soon as it becomes clear that NHS transport is required, the AMHP should contact the:

Rotherham and Doncaster

Yorkshire Ambulance Service Emergency Operations Centre on 0300 330 0244

For North Lincolnshire

East Midlands Ambulance Service ……

giving as much detail as possible (see Appendix 2).

NB: It should be made clear at this stage, by the AMHP, as to whether the Police are required.

A patient's journey will be entered into the computer system, which will be assigned a unique incident number.

The AMHP may contact Ambulance Control at any stage giving the incident number, to update or discuss the progress of the incident.

If the admission is stopped at any stage it is the responsibility of the AMHP to contact Ambulance Control and cancel the journey.

Due to the complexity of some of the journeys, the discussion between the AMHP and Ambulance Control should make the exact circumstances of the situation completely clear.

If any difficulties arise, the AMHP should ask to be referred to the Emergency Operations Centre Team Leader.

6.1.4 Delegation of conveyance

The AMHP is permitted to delegate the task of conveying the patient to another person, such as personnel from the Ambulance Service or the Police. If the task is delegated, a form of authorisation should be given to the delegated person (Appendix 1).

If the AMHP delegates the conveyance of the patient she/he must be confident that the person accepting this responsibility is competent and fully aware of their responsibilities in relation to this task.

In exceptional circumstances, the AMHP may delegate the responsibility for conveying the patient to a professional worker other than an AMHP and not accompany the patient to hospital. The AMHP must contact the hospital accepting the patient and confirm the papers have been received. It is considered good practice to fax a copy of the papers to the receiving hospital prior the patient arriving there. If the delegated organisation encounters difficulty with the arrangements, it will need a means of contacting the AMHP. The AMHP will provide their contact details on the delegation form (Appendix 1).

6.1.5 Accompanying the patient during conveyance

It is good practice and generally expected that the AMHP will personally accompany, or follow the patient to hospital in their own vehicle. The AMHP retains ultimate responsibility to ensure that the patient is conveyed in a lawful, safe and humane manner, and must be ready to give the necessary guidance to those asked to assist.

The AMHP should take into account the needs of the patient and the views of the Nearest Relative, the Ambulance Service or the Police when deciding whether to accompany the patient to hospital in the same vehicle. If the patient would prefer to be accompanied by another professional or by any other adult, that person may be asked to escort the patient, provided the AMHP is satisfied that this will not increase the risk of harm to the patient or to others.

A decision should be reached by negotiation with the above, depending on individual circumstances.

6.1.6 Escorts for the conveyance

An escort should only be provided if needed and appropriate. This will depend on individual circumstances, and must be agreed between the AMHP, the Section 12 (2) MHA approved doctor, the GP (if present), personnel from the Ambulance Service and, where appropriate, the Police.

The escort could be the AMHP or, with the AMHPs agreement, any other adult, or another professional person. The escort must have an appropriate level of training to meet the patient's needs and welfare. This should not preclude the Nearest Relative exercising their right to accompany the patient. If the patient has been sedated a suitably trained professional should accompany him.

As a guide, the use of escorts should be considered in the following situations:

- Where the protection and/or support of both the patient and transport service personnel is required;
- Where the presence of a particular escort, e.g. relative, friend, nurse, social worker, will assist in the patient's conveyance to hospital.
- Where the presence of the Police is needed to prevent a breach of the peace or because the patient presents a physical risk to others.

If an escort is required the Ambulance Service will be unable to return the escort to their starting point and provisions should be made for them to arrange their own transport.

Where the AMHP/applicant is not travelling in the same vehicle as the patient the application form and medical recommendations should be given to the person authorised to convey, with instructions that they should be given to the receiving member of hospital staff.

6.1.7 Patients who have been sedated and require conveyance

If the patient has been sedated, the Ambulance Service will advise on the most appropriate vehicle to be used. In such circumstances the patient should be accompanied by a nurse, a doctor or a paramedic experienced in this area.

Where no nurse escort is available for a patient who has been sedated prior to transportation, a paramedic crew with advanced life support skills should be requested in case of adverse drug reaction, cessation of breathing, etc., with the attending clinician giving clear instructions at handover on likely adverse reactions and treatment required.

Please Note: The professional who administers the sedation should be prepared to provide the ambulance service with details of the medication given and the expected duration of its effect.

Only suitably qualified medical practitioners can prescribe medication and/or authorise and arrange any nurse escort. If the medical practitioner has to leave prior to the patient being conveyed to hospital he/she must ensure that the AMHP is informed of how to contact him/her or the duty psychiatrist in his/her absence. In the event of detention under S.4 MHA the assessing doctor will have this responsibility.

6.1.8 Medical Intervention

If it becomes apparent to the AMHP, Assessing Doctor/s or Ambulance Personnel that the patient requires immediate Medical intervention for his/her physical health then the Patient should be conveyed to the appropriate A&E department. It is the responsibility of the AMHP to follow the Ambulance to the A&E department in order to provide necessary information to the treating clinician.

6.1.9 Transfer of the patient into hospital services

In order to expedite the transfer of responsibility for the patient to the hospital, the AMHP should ensure that the receiving hospital is expecting the patient, and telephone ahead with expected time of arrival. The AMHP should ascertain the name of the person who will be formally receiving the admission papers.

The AMHP should arrive at the hospital at the same time as the patient and remain there until he/she has ensured that:

- The admission documents have been delivered, checked for accuracy and received, on behalf of the Hospital Managers.
- Any other relevant information (AMHP Outline Report) is given to the appropriate hospital personnel.
- The patient has been receipted into the care of the hospital.

6.2 Police Responsibilities

6.2.1 Police response

The Police will respond to a request for assistance where there is a threat of violence or harm to the patient, other persons or property, or a risk the patient will abscond. The AMHP and police will agree the most appropriate response to ensure the safety of all concerned - which may or may not require action by the police. The Police will ensure that any action they take is proportionate to the situation presenting. They will also, where this is not inconsistent with their duty to protect persons, or property, or the need to protect themselves comply with any directions or guidance given by the AMHP while the patient is being conveyed to hospital.
In the event that a patient absconds, then the police will respond according to identified risks and provide a tiered response accordingly. The police may apply their missing persons criteria and protocols to such circumstances. The police acknowledge that a person who absconds after they have been placed under a section of the Mental Health Act are classed as being ‘unlawfully at large’, unless advised otherwise by appropriate professionals.

Where an AMHP requests the assistance of the Police, this will be met as far as practicable. The Police will use their discretion on the number of officers to be deployed but their overriding duty is to protect the patient from harm to themselves or others. Where, for operational reasons, the Police find this difficult, there will be discussion between the Duty Inspector or Sergeant for the division concerned and the AMHP.

In exceptional circumstances where there is concern about the safety of the patient or other persons, a police vehicle may be used with the police and AMHP as an escort, if appropriate. If the patient is to be conveyed by the Police, for the safety of the patient and escorts the patient will be searched by the Police to identify if the patient has anything on their person that could cause harm or damage.

Where there is a risk of violence or harm to persons or property, and the police have conveyed the patient to hospital, the admission should be effected as efficiently as possible and the time spent by the Police in hospital should be restricted to the minimum required for safe transfer of responsibility.

6.3 Ambulance Responsibilities

6.3.1 Ambulance Response

When requested, the Ambulance Service has a duty to provide an appropriate vehicle and staff competent to manage the patient's presenting condition and convey the patient to hospital.

Staff employed by the Ambulance Service should, where it is not inconsistent with their duty, comply with any directions or guidance given by the AMHP.

If the crew of the vehicle provided by the Ambulance Service believes that by conveying the patient in their vehicle they would put themselves, the patient or other road users at risk, they may refuse to convey the patient and Police assistance should be requested.

The assessing doctors and AMHP need to agree the estimated time of the patient's arrival at the receiving hospital. The timeframe must be agreed between the AMHP and Ambulance Control and this will normally be within the agreed 2 hour response.

All patients detained under the Mental Health Act who require NHS transport to convey them to hospital are considered an 'emergency' in the sense of requiring transport within two hours.

6.4 Restraint

In the process of conveying a patient to hospital any of the parties can use such force as is proportional and reasonable in the circumstances. Although it is not possible to be definitive as to what proportional means in practice, there should be consultation with the patient, the Nearest Relative and other professionals to assist in this judgement. Each situation must be assessed on its individual merits and be informed by the medical and risk assessment(s) and the AMHP assessment.

All AMHP's must work in line with the RDASH Policy for the prevention and management of work related violence and aggression.

If physical intervention is necessary then the use of minimum force, acting under common law or if the patient lacks capacity then the MCA 2005 may be used. Ambulance staff have not been trained in restraint and therefore they may be required to call for Police assistance if necessary. The circumstances and reasons for doing this must be recorded in the Mental Health Act assessment documentation.

MCA Code of Practice Clearly states that the use of restraint where someone lacks the capacity to consent is allowed when it is a proportionate response to the risk of harm and to *prevent harm to that person* and not to protect harm coming to others

engaged in the process.

6.5 Geographical boundaries in relation to conveyance

Where it is necessary to use NHS transport services to convey the patient to hospital the responsibility lies with the area the journey arises. This is the situation for both NHS and private healthcare patients.
Where a privately funded patient is requesting admission to a particular private hospital, the patient will be responsible for the cost of the transport.

In the geographical area covered by RDASH, NHS transport services are provided by the Yorkshire Ambulance Service (Rotherham and Doncaster localities) and the East Midlands Ambulance Service (North Lincolnshire locality). The patient must be conveyed to a named hospital except in the case where bed availability dictates the use of a bed in another geographical area.

Where patients need to be conveyed longer distances because of a lack of, or suitability of, an appropriate bed locally, the Commissioners in whose area the journey arises remains responsible. Where the AMHP is the applicant in these circumstances, he/she has the duty to ensure that all necessary arrangements are made for the patient to be conveyed to the hospital and will consult closely with the Access Team or receiving inpatient staff.

Where police escorts and/or ambulance transport may be required for conveying patients longer distances, close co-operation between agencies will need to agree the most practical time and suitable way to achieve the conveyance.

6.6 Out of Area patients

For patients who originate from out of area (that is, beyond the geographical boundary covered by this policy and procedure) and require NHS transport to return them home, this remains the responsibility of their Primary Care Trust for that area.
A joint discussion with Ambulance Service should initially take place and focus on the patient's presenting issues and needs. Given that the Ambulance Service is normally involved in the transportation of patients locally, there maybe circumstances where such cases can be transported by the local Ambulance Service as an extra contractual referral and the costs will be fully met by the appropriate receiving authority. However in cases where the Ambulance Service is not able to provide this service staff should seek the services of a Private provider (i.e. Rapid and Secure) to facilitate this conveyance. The needs of the patient are paramount and there should be no delay in conveyance whilst discussions happen over funding, which can be dealt with retrospectively

6.7 Patients requiring specialist placements

For patients who require admission to a specialist hospital where the journey is deemed to be excessive and potentially detrimental to the patient's overall presentation at the time of assessment, consideration should be given, to admitting the patient to a RDASH hospital in the first instance and transfer should then be facilitated between hospitals under section 19 of the MHA 83.

NB: For those patients who are under the age of 18, a Tier 4 CAMHS bed should be sought either, during working hours by the Specialist Commissioners or out of hours by the Consultant on-call.

6.8 Other situations where conveyance will be required

6.8.1 Section 135 (1)

Where a member of the public has had a warrant served on them under s.135 (1) of the MHA 1983, and is required to be conveyed to a hospital subject to detention under the MHA 1983, or to a place of safety for the purpose of a full MHA assessment, the organisation of the conveyance arrangements will be the responsibility of the AMHP.

6.8.2 Section 135 (2)

Where a person who is liable to be detained in hospital has to be taken, or retaken, in the case where they have absented themselves from hospital and a warrant under s.135(2) of the MHA 1983 has been issued to a Police Officer to enter the premise by force. The most appropriate method of conveyance will be organised by a nominated member either of the hospital staff or in the case of a patient who is subject to Supervised Community Treatment (SCT) a staff member who knows the patient. There may be occasions where this conveyance is via the Ambulance Service.

Before the patient is conveyed the applicant should contact the receiving hospital to ensure that they are expecting the patient and provide an estimated time of arrival.

6.8.3 Section 17 / Supervised Community Treatment – non compliance

Where a patient is subject to S.17 MHA leave or supervised community treatment and is non-compliant with the care plan and needs to be returned to hospital, the Responsible Clinician, or other staff acting on his/her behalf, will need to decide the most appropriate form of conveyance. They will also be responsible for the co-ordination of the process to effect the patient's return or recall to hospital.

6.8.4 Supervised Community Treatment – recall

In the situation where a SCT patient is recalled to hospital it is the responsibility of the Responsible Clinician or the hospital managers to provide written authorisation to the most appropriate person to convey the patient -which could be to be any officer on the staff of the hospital to which the patient is to be recalled, any police officer or any AMHP.

7. TRAINING IMPLICATIONS

There are no specific training needs in relation to this policy, but the following staff will need to be familiar with its contents: (Approved Mental Health Professionals South Yorkshire and Humberside Police personnel and Yorkshire and East Midlands Ambulance personnel and any other individual or group with a responsibility for implementing the contents of this policy).

As a Trust policy, all staff need to be aware of the key points that the policy covers. Staff can be made aware through: A number of a variety of means such as;

Trust wide Email	AMHP refresher Training
Team meetings	AMHP Specialist Meeting
Group supervision	One to one meetings / Supervision
Practice Development Days	Mental Health Legislation Training

The Training Needs Analysis (TNA) for this policy can be found in the Training Needs Analysis document which is part of the Trust's Mandatory Risk Management Training Policy located under policy section of the Trust website.

8. MONITORING ARRANGEMENTS

- **Monitoring and Review**

The effectiveness of the local conveyance arrangements will be formally reviewed through the Mental Health Legislation Monitoring Group (MHLMG) at 3 monthly intervals during the first 12 months and annually thereafter. The MHLMG will report directly to Mental Health Legislation Group, convened and chaired by RDASH Mental Health NHS Foundation Trust who will make recommendation and report through to relevant Council Senior Management Teams and relevant partners.

Area for Monitoring	**How**	**Who by**	**Reported to**	**Frequency**
Implementation	Dissemination	MHLMG to include Social Work Consultant / Mental Health Act Manager/ in partnership with SY& H Police and YAS and EMAS	MHLC	3 monthly
Compliance with content of policy particular attention being given to waiting time	Through AMHP report	Social Work Consultant / MHA Manager	MHLC who will ensure that any recommendations made will be forwarded on to partner organisations	3 monthly
Any Incidents which identify issues or concerns relating to implementation of this policy	Issues or concerned will be reviewed and recommendation will be made	Social Work Consultant / MHA Manager/ Liaison officers from SY & H police and YAS &EMAS	MHLC who will ensure that any recommendations made will be forwarded on to partner organisations	As required

9.1 Privacy, Dignity and Respect

Central to any aspect of care delivered to adults and young people aged 16 years or over will be the consideration of the individuals capacity to participate in the decision making process. Consequently, no intervention should be carried out without either the individuals informed consent, or the powers included in a legal framework, or by order of the Court Therefore, the Trust is required to make sure that all staff working with individuals who use our service are familiar with the provisions within the Mental Capacity Act. For this reason all procedural documents will be considered, if relevant to reflect the provisions of the Mental Capacity Act 2005 to ensure that the interests of an individual whose capacity is in question can continue to make as many decisions for themselves as possible.	**Indicate How This Will Be Achieved.** *All individuals involved in the implementation of this policy should do so in accordance with the Guiding Principles of the Mental Capacity Act 2005. (Section 1)*

The Mental Capacity Act	**Indicate how this will be met**
The NHS Constitution states that all patients should feel that their privacy and dignity are respected while they are in hospital. High Quality Care for All (2008), Lord Darzi's review of the NHS, identifies the need to organise care around the individual, '*not just clinically but in terms of dignity and respect'*. As a consequence the Trust is required to articulate its intent to deliver care with privacy and dignity that treats all service users with respect. Therefore, all procedural documents will be considered, if relevant, to reflect the requirement to treat everyone with privacy, dignity and respect, (when appropriate this should also include how same sex accommodation is provided).	*All individuals involved in the implementation of this policy should do so in accordance with the Mental Health Act Code of Practice – Chapter one*

10. LINKS TO OTHER TRUST PROCEDURAL DOCUMENTS

Policy for the prevention and management of work related violence and aggression
Mental Capacity Act Policy
Procedure on the receipt and scrutiny of section papers

11. REFERENCES

Statutory Framework:

- Mental Health Act 1983 as amended by the Mental Health Act 2007
- Police & Criminal Evidence Act 1984
- Criminal Law Act 1995
- Human Rights Act 1998

Guidance:

- Mental Health Act – Code of Practice 2008 (*particularly chapter 11*).
- Police & Criminal Evidence Act 1984 – Codes of Practice
- European Convention on Human Rights – specifically Articles 2, 3, 5, 10, 14

Definitions used in this document:

- The Mental Health Act 1983 as amended by the Mental Health Act 2007
- Local Social Services Authority: Section 145 (1)
- Approved Mental Health Professional: Section 145 (1)
- Community Treatment: Section 17A
- Nearest Relative: Section 26 (3) Patient

Case law:

- There is no recent case law of relevance to this policy and procedures.

12. APPENDICES

APPENDIX 1	–	Delegation Of Authority To Convey
APPENDIX 2	–	Information required by Ambulance Service during booking
APPENDIX 3	–	Risk Assessment
APPENDIX 4	-	Additional information to be provided when requesting Police Assistance
APPENDIX 5	-	Risk Assessment Options
APPENDIX 6	-	Conveyance Flowchart

APPENDIX 1

DELEGATION OF AUTHORITY TO CONVEY

Delegation of Authority to Convey a Patient to a Hospital under the Mental Health Act 1983 as amended by the Mental Health Act 2007

…..…… (Name of Patient)

…..……

…..……

I, ……. (Your name)

have made an application for the admission of the above patient to:

…..…… (Name of Hospital or Registered nursing home)

…..……

I am an *Approved Mental Health Professional/the Nearest Relative (**delete as appropriate)* within the meaning of the Act.

I delegate my authority to convey the patient to the above hospital to:

…..…… (Name)

You may use reasonable restraint to achieve the objective of conveying the person to hospital but you should use the least restriction possible whilst ensuring the patient's and other person's safety.

Signed: …..…… (Your signature)

Of: …..…… (Address on forms)

…..……

Contact mobile telephone details if you need to speak with me about this delegation arrangement: …..……

Date authority issued: …..……

Date authority expires: …..……

APPENDIX 2

INFORMATION REQUIRED BY AMBULANCE SERVICE DURING BOOKING

- What is the address that the patient needs collecting from?
- What's the problem?
- Has the patient been detained under the MHA?
- Where does the patient need transporting to?
- What is the diagnosis of the patient?
- Patients name and date of birth
- Who is authorising the admission/booking?
- Is the patient mobile, or do they require a chair or stretcher?
- Are there any special instructions for the crew e.g. silent approach, rendezvous point away from patient's house?
- Does the condition of the patient present an immediate threat to life?
- Does the patient require Medical Intervention?
- Is the patient ready to travel immediately?
    - Has the paperwork been signed?
    - Are the police required on scene?
    - Has sedation been given, and what is its expected duration of effect?
- Name and telephone contact number for person making the booking.

APPENDIX 3

Risk Assessment

Has there been any recent (12 months) violence towards others?	**Y / N**	What happened?	**Low Medium High**
Have there been any recent attempts at self harm?	**Y / N**	What?	**L/M/H**
Recent police involvement?	**Y / N**	What? When?	
Any evidence that person is reliant upon or uses intoxicants (legal or otherwise)?	**Y / N**	What? How?	**L/M/H**
Uncharacteristic behaviour?	**Y / N**	Witnessed by who? What?	**L/M/H**
Risk of abuse/ exploitation by others?	**Y / N**	Witnessed by who? Suspicion or belief?	**L/M/H**
Any safeguarding issues? Risk to others or self?	**Y / N**	Evidence?	**L/M/H**
Identified health care issues eg medical complaints or surgery (ie pacemaker)	**Y / N**		**L/M/H**

Risk:	Low	Medium	High
Violence			
Challenging Behaviour			
Resistive Behaviour			
Absconding			
Suicide			
Self Harm			

APPENDIX 4

Additional information to be provided when requesting police assistance

Type of premises (house/flat etc) & precise address	
Where in the property does the person live? (ground floor/front bedroom/first floor)	
How many rooms? Condition of rooms? Hygiene? Living standards?	
Does anyone else live there or is likely to be there? Who? Relationship to person?	
How is access to the property gained? (communal entrance/Key code/Phone entry)	
Have measures been taken to facilitate access? Key? Family/Neighbour/Landlord assistance?	
Is there access to the rear of the premises?	
Is the address fortified? (Substantial locks? Security gate? Barred windows?)	
Are there any weapons in the house (other than normal household items)? If so, what?	

APPENDIX 5

Risk Assessment Options

Option 1

Atlas Court create an RWD incident. Pass to the relevant duty Sergeant on patrol for their attention and information only. Previous Incidents at address, Police National Computer and local intelligence checks to be carried out at discretion of supervisors.

Option 2

Incident created. Police National Computer and local intelligence checks carried out on address and nominal details given. Previous incidents checked. The Duty Sergeant to liaise, where appropriate, with AMHP and internal colleagues, to make a decision on the SYP deployment.

Option 3

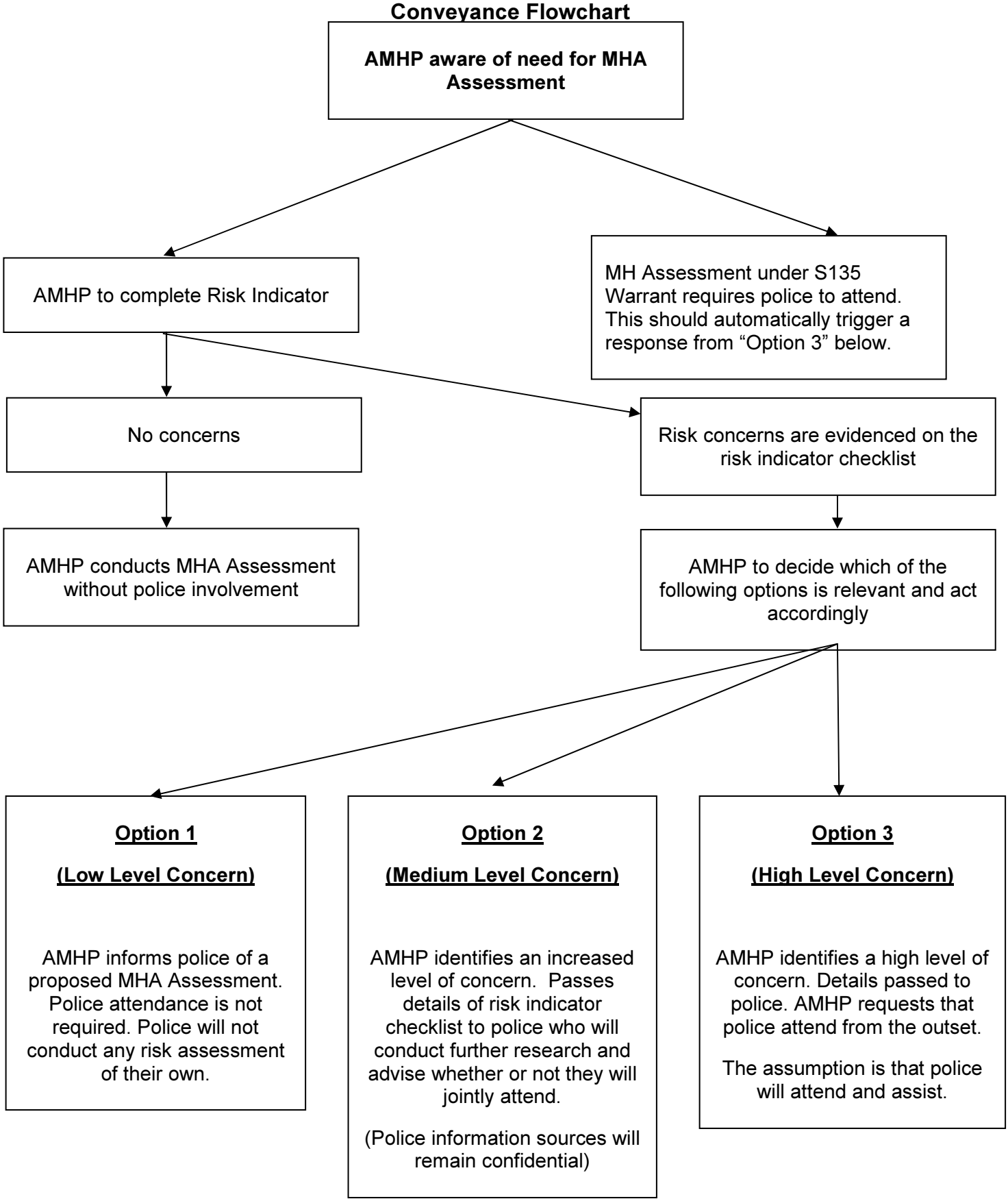
Incident created. Police National Computer and local intelligence checks carried out on address and nominal details given. Previous incidents checked. The Duty Sergeant to liaise, where appropriate, with AMHP and internal colleagues to make a decision on the SYP deployment.

Liaison with Force Incident Manager/Duty Inspector may be required to make decisions on resources deployed and any specialist resources. May require a police risk assessment to be carried out.

Expected outcomes to be discussed and agreed, together with incident command structures and individual roles. If level of concern is sufficiently severe, then AMHP should give consideration to a S135 Warrant application.

APPENDIX 6

Conveyance Flowchart



ROTHERHAM BOROUGH COUNCIL – REPORT TO MEMBERS

1	**Meeting:**	**Cabinet Member for Adult Social Care**
2	**Date:**	**Monday 15 April 2013**
3	**Title:**	**Adult Services Revenue Budget Monitoring Report 2012-13**
4	**Directorate :**	**Neighbourhoods and Adult Social Services**

5 Summary

This Budget Monitoring Report provides 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 for the period ending February 2013.

The forecast for the financial year 2012/13 at this stage is an overall underspend of £490k, against an approved net revenue budget of £71.445m, an increase in the under spend of £138k since last months report.

6 Recommendations

That the Cabinet Member receives and notes the latest financial projection against budget for 2012/13.

7 Proposals and Details

7.1 The Current Position

The approved net revenue budget for Adult Services for 2012/13 was £74.147m. Included in the approved budget was additional funding for demographic and existing budget pressures (£2.294m) together with a number of savings (£6.258m) identified through the 2012/13 budget setting process.

7.1.1 The table below summarises the latest forecast outturn against approved budgets:-

Division of Service	**Net Budget**	**Forecast Outturn**	**Variation**	**Variation**
	£000	£000	£000	%
Adults General	1,829	1,810	-19	-1.03
Older People	32,828	32,087	-741	-2.26
Learning Disabilities	17,283	17,979	+696	+4.03
Mental Health	5,408	5,370	-38	-0.70
Physical & Sensory Disabilities	6,223	6,001	-222	-3.57
Safeguarding	711	687	-24	-3.38
Supporting People	7,163	7,021	-142	-1.98
Total Adult Services	**71,445**	**70,955**	**-490**	**-0.69**

7.1.2 The latest year end forecast shows there are a number of underlying budget pressures mainly in respect of an increase in demand for Direct Payments (+£1.704m) across all client groups plus pressures on residential care and external transport provision within Learning Disability services (+£617k). These pressures are being offset by a number of forecast non recurrent underspends together with management actions.

The main variations against approved budget for each service area can be summarised as follows:

Adults General, Management & Training (-£19k)

This includes the cross cutting budgets (Workforce planning and training, and corporate charges) are forecasting an slight under spend mainly due to savings on postages and telephone charges.

Older People (-£741k)

- Overspend on In-House Residential Care due to a recurrent budget pressure on Part III income (+£112k) plus additional staffing costs due to sickness cover at Davies Court (+£83k), reduced by non recurrent winter pressures funding (-£75k).
- Increase in Direct Payments over budget (+£979k), this includes 106 new clients since April most of which are clients who previously received independent sector domiciliary care and have requested to remain with their current service provider.
- Overspend on In House Transport (+£41k) due to slippage on the approved budget savings from the review of Transport services and agency costs to cover sickness, partially reduced by additional income.
- Forecast under spend on Enabling Care (-£325k) based on current budget and level of service which is under review. However, there is now a forecast overspend on Independent sector home care (+£91k) due to increased activity over the last few months. This is after a reduction of £655k commissioning and contract savings achieved as part of the new framework agreement. These budgets have now been revised to partly address the shift in service provision to Direct payments as mentioned above.
- An underspend on independent residential and nursing care (-£372k) due to 56 less clients receiving service than budgeted. More self funders receiving care is resulting in a reduction in the average cost per client plus additional income from health.
- Forecast under spend at this stage in respect of Community Mental Health budgets uncommitted including slippage in developing dementia services (-£225k).
- Under spend on carers services due to vacancies and slippage in carers breaks (-£192k), reducing pressures on direct payments.
- Forecast slippage on Assistive Technology based on spend to date against approved budget (-£138k).
- Slippage on recruitment to vacant posts within Assessment & Care Management and community support plus additional income from Health Including winter pressures funding (-£344k).
- Savings from the review of day care provision (-£203k).
- Overall under spend on Rothercare (-£146k) due to slippage in service review including options for replacement of alarms.
- General savings on premises and supplies and services due to moratorium on non essential spend (-£27k).

Learning Disabilities (+£696k)

- Overspend on independent sector residential care budgets due to an increase in clients and the average cost of care packages plus loss of income from health, reduced by lower activity on respite care (+£444k).
- Underspend within supported living schemes due to CHC income, use of one off grant funding and vacant posts (-£201k).

- Recurrent budget pressure on Day Care transport (+£258k) including income from charges reduced by under spend on in house day care due to vacant posts and savings on supplies and services as part of the review of service (-£85k).
- Increase in demand for Direct Payments over and above budget (+£109k).
- Forecast overspend in independent sector home care (+£78k) due to slippage in meeting budget savings agreed as part of budget setting.
- Three new high cost placements in independent day care is resulting in a forecast overspend of +£67k.
- Increase in community support placements is resulting in a forecast overspend of £57k.
- Saving on premises costs and supplies and services as a result of the moratorium (-£31k).

Mental Health (-£38k)

- Projected slight under spend on residential care budget (-£14k) due to more discharges last month, including high cost care packages.
- Budget pressure on Direct Payments (+£129k) offset by savings on Community Support Services (-£156k).
- Minor overspends on employees budgets due to unmet vacancy factor and use of agency staff (+£3k).

Physical & Sensory Disabilities (-£222k)

- Continued Pressure on Independent Sector domiciliary care (+£95k) due to continued increase in demand for service.
- Loss of CHC funding for one client at Rig Drive (+£25k), successful appeal backdated to Sept 2012.
- Increase in demand for Direct Payments (+ 36 clients), forecast overspend (+£487k).
- Underspend on community support (-£61k) as clients are redirected to direct payments.
- Forecast overspend on Residential and Nursing care offset by slippage in developing alternatives to residential provision (-£542k).
- Vacant posts within Resource centre and Occupational Therapists (-£35k).
- Underspend on equipment and minor adaptations budget plus additional winter pressures funding (-£153k).
- Review of contracts with independent Day Care providers (-£25k).
- Forecast savings on contracts with Voluntary Sector providers (-£13k).

Safeguarding (-£24k)

- Underspend on employee budgets due to vacant post plus forecast additional income from court of protection fees.

Supporting People (-£142k)

- Additional savings relate to a reduction in actual activity on a number of subsidy contracts.
- Efficiency savings of £234k on subsidy contracts are also being offset against commissioning savings targets and therefore not reported within Adult Services.

7.1.3 Agency and Consultancy

Total expenditure on Agency staff for Adult Services for the period ending February 2013 was £375,818 (of which £2,937 was off contract). This compares with an actual cost of £308,020 for the same period last year (of which £1,974 was off contract). Primarily, these costs were in respect of residential and assessment and care management staff to cover vacancies and sickness.

There has been no expenditure on consultancy to-date.

7.1.4 Non contractual Overtime

Actual expenditure in respect of non contractual overtime to the end of February 2013 was £354,923 compared with £292,238 for the same period last year.

The actual costs of both Agency and non contractual overtime are included within the financial forecasts.

7.2 Current Action

To mitigate any further financial pressures within the service, budget meetings and budget clinics are held with Service Directors and managers on a regular basis to monitor financial performance and further examine significant variations against the approved budget to ensure expenditure remains within the cash limited budget by the end of the financial year.

8. Finance

Finance details including main reasons for variance from budget are included in section 7 above.

9. Risks and Uncertainties

Careful scrutiny of expenditure and income and close budget monitoring remains essential to ensure equity of service provision for adults across the Borough within existing budgets particularly where the demand and spend is difficult to predict in such a volatile social care market. One potential risk is the future number and cost of transitional placements from children's services into Learning Disability services.

In addition, any future reductions in continuing health care funding would have a significant impact on residential and domiciliary care budgets across Adult Social Care.
Regional Benchmarking within the Yorkshire and Humberside region for the six month period ending December 2012 shows that Rotherham remains slightly below average on spend per head in respect of continuing health care.

10. Policy and Performance Agenda Implications

The delivery of Adult Services within its approved cash limit is vital to achieving the objectives of the Council and the CSCI Outcomes Framework for Performance Assessment of Adult Social Care. Financial performance is also a key element within the assessment of the Council's overall performance.

11. Background Papers and Consultation

- Report to Cabinet on 22 February 2012 –Proposed Revenue Budget and Council Tax for 2012/13.
- The Council's Medium Term Financial Strategy (MTFS) 2011-2014.

This report has been discussed with the Strategic Director of Neighbourhoods and Adult Services, the Director of Health and Well Being and the Director of Financial Services.

Contact Name: Mark Scarrott – Finance Manager (Neighbourhoods and Adult Services)*, Financial Services x 22007, email Mark.Scarrott@rotherham.gov.uk.*