# CABINET MEMBER FOR ADULT SOCIAL CARE AND HEALTH

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

**Date:** **Monday, 8th December, 2014**

**Time:** **10.00 a.m.**

## A G E N D A

1. To determine if the following matters are to be considered under the categories suggested, in accordance with Part 1 of Schedule 12A (as amended March 2006) 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. Declarations of Interest

5. Minutes of the previous meeting (Pages 1 - 16)

6. Health and Wellbeing Board (Pages 17 - 25)

7. Petition - Rotherham Deaf Future (Page 26)

8. Emergency Hormonal Contraception (Pages 27 - 42)

9. Introduction of a new approach to Mobile Technology into Rothercare (M-care). (Pages 43 - 49)

10. Adult Services Revenue Budget Monitoring Report 2014/15 (Pages 50 - 55)

**ADULT SOCIAL CARE AND HEALTH**
**Monday, 17th November, 2014**

Present:- Councillor Doyle (in the Chair); Councillors Andrews and Pitchley.

## H17. DECLARATIONS OF INTEREST

There were no Declarations of Interest made at the meeting.

## H18. MINUTES OF THE PREVIOUS MEETING

Consideration was given to the minutes of the meeting held on 20th October, 2014.

Resolved:- That the minutes of the meeting held on 20th October, 2014, be approved as a correct record.

## H19. HEALTH AND WELLBEING BOARD

The minutes of the meetings of the Health and Wellbeing Board held on 27th August and 1st and 24th October, 2014, were noted.

## H20. REPRESENTATIVES ON WORKING GROUPS

Resolved:- (1) That the following appointments be noted:-

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| Obesity Working Group | Councillor Pitchley |
| Rotherham Heart Town | Councillor Wyatt |
| Self Harm and Suicide Prevention Group | Councillor Andrews |

(2) That representation be sought for the Tobacco Control Alliance Group.

## H21. WHITE RIBBON CAMPAIGN

Sam Newton, Service Manager Safeguarding Adults, submitted a report for information on the above Campaign which was for towns to demonstrate their commitment to the aims of the White Ribbon Campaign (WRC).

An action plan demonstrating the town's commitment to reducing domestic abuse had been developed with the Partnership Violent Crime Forum and the Domestic Abuse Priority Group.

On 30th October, 2014, the plan had been approved as "excellent" by the White Ribbon Campaign Director and Rotherham had been provided with White Ribbon Status joining over 40 towns and local authorities who had also gained the nationally recognised WRC Town Award

White Ribbon status required a commitment by partners across Rotherham to involve men in sending a clear message that domestic abuse against women would not be tolerated. In particular it involved men in preventative activities, addressing and altering social norms that led to violent behaviour against women, increasing awareness on the issue and providing services aimed at reducing domestic abuse. The Campaign claimed that by mobilising men, the anti-violence against women and girls message increased the effectiveness and reached and mobilised the entire local community under the goal of ending violence against women and girls.

A number of events and campaigns had been planned from November, 2014, onwards including IYSS 'Rocking against Domestic Abuse', RUFC v Blackpool 'Dedicated White Ribbon' match, NHS 'White Ribbon Community Corner', all licensees and door security conducting promotional events, Wilmott and Dixon displaying WRC van stickers and a wide media campaign across partners and communities.

The Cabinet Member reported that he had submitted an application to become a White Ribbon Ambassador.

Resolved:- (1) That the partnership commitment to achieving the aims of the White Ribbon Campaign be endorsed and supported.

(2) That the work driven by Chief Inspector Wormersley in conjunction with the Domestic Abuse Priority Group and the Partnership Violent Crime Forum be noted.

(3) That a joint media strategy be developed between the Council, Police and Rotherham United Football Club.

(4) That the Council celebrate the award of White Ribbon status with the flying of a White Ribbon flag during the International White Ribbon Campaign period 25th November to 10th December, 2014.

(5) That the Strategic Leadership Team be requested to consider a Senior Officer submitting an application to become a White Ribbon Ambassador.

## H22. INDEPENDENT MENTAL HEALTH ADVOCACY SERVICE (IMHA) - 2015/16 COMMISSIONING INTENTIONS

Janine Parkin, Strategic Commissioning Manager, presented a report on the future of the Independent Mental Health Advocacy Service (IMHA).

The Service was previously commissioned by a Primary Care Trust competitive tender process in 2010 to cover the Rotherham and Doncaster area using special grant funding from the Department of Health. The contract had commenced on 1st October, 2010 for 3 years with the option to extend to June, 2015, subject to performance and

quality. It was a specialist type of mental health advocate granted specific roles and responsibilities through the Local Reform and Community Voices Grant. It helped 'qualifying patients' understand the legal provisions, to which they were subject under, they were entitled to.

The Department of Health had transferred the grant funding from NHS bodies to local authorities in April, 2013. Accordingly, the former PCT contract was novated across to Rotherham and Doncaster with Rotherham taking on the commissioning role for the partnership. The current contract was due to end on 30th June, 2015.

The Council would not receive confirmation from the Department of Health that it intended to continue to fund the Service in 2015/16 until December, 2014, although it was highly likely that it would remain a priority.

It was proposed that the current contract be extended for a period of 3 months, from 1st July to 30th September, 2015, to allow a full 12 months commissioning exercise which would include:-

- Confirmation of strategic and financial commitment by Department of Health to the Service

- Analysis of the current provision (need/demand/gaps analysis) and factor in the requirements of the Better Care Fund Programme

- Joint work on establishing need with Rotherham CCG and other partners

- Consider options for amalgamation of provision sub-regionally using existing mental health commissioning networks

- Benchmarking of activity and demand with other local authorities

- Formal and indepth consultation with Service users

- Complete Equality Analysis

- Development of revised and enhanced Service specifications

- Tender process – PQQ, ITT, Evaluations

Resolved:- (1) That the extension of the current Independent Mental Health Advocacy Service to 30th September, 2015, be approved.

(2) That the possibility of joint commissioning with Sheffield City Council be explored.

(3) That a further report be submitted in March, 2015.

## H23. THE TRANSFER OF INDEPENDENT LIVING FUND (ILF) SUPPORT AND FUNDING TO LOCAL AUTHORITIES FROM 30 JUNE 2015

Shona McFarlane, Director of Health and Wellbeing, presented a report on the transfer of the Independent Living Fund (ILF) to local authorities as from 30th June, 2015.

The ILF was established by the Government in 1988 as a charitable trust which made payments to disabled people on low income who had to pay for personal care. The maximum ILF award was £475 per week.

It was the Government's original intention to close the Fund from April, 2015, and transfer the funding and responsibilities to local authorities. However, the closure programme was stopped due to a Court of Appeal ruling regarding the Government's administration of the process. This had now been resolved and it had been announced in March, 2014, that the ILF would close on 30th June, 2015.

There were currently 105 ILF users in Rotherham 62 of which were known to the Learning Disability Service and the remainder known to other Adult Social Care Teams. All had received information about changes to their future funding and, in recent months, ILF administrators and Local Authority Social Workers had conducted joint reviews of each user.

There were 33 people with a learning disability in supported living schemes who received ILF funding for a significant proportion of their care package. To continue in supported living the ILF funding would need to be replaced by revenue funding from the Local Authority.

ILF policies on deciding funding packages were different to the criteria of Fairer Access to Care Services (FACS). Frequently ILF paid for 'desirable' elements of care that FACS could not. There were also significant differences between ILF rules on user contributions to support packages and Fairer Charging.

It was likely that many ILF users would face a reduction in support funding if FACS was applied across the total care package. In many instances users had received high levels of ILF funding for desirable rather than essential elements of support.

The proposed options were:-

For customers in the community:-

Option A – replicate existing funding packages by replacing ILF with a Direct Payment. Customers would be happy and this would be relatively easy to administer. However, this would replicate what was already a 2 tier system and there may be challenges from customers who did not previously receive ILF funding.

Option B – replicate existing funding packages but agree a phased reduction over a fixed period. There were likely to be fewer complaints and customers could make a more gradual adjustment to the loss of funding. However, this was potentially a very complex administrative process for the Local Authority.

Option C – assess everyone under FACS criteria and award funding accordingly. Whilst this was probably fairer, it would cause hardship and/or some significant readjustments of lifestyle for some very disabled people and their carers.

For people in supported living schemes:-

To allocate an appropriate amount into the Supported Living budget to allow the placements to continue. The alternative would be significantly more costly and inappropriate residential care placements.

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

- Public perception
- Due to the age profile of the customers, the numbers were not expected to decrease significantly and would have an entitlement for many years to come
- Uncertainty of the budget which was not ringfenced
- Could leave the Authority in an overspend position for those receiving 'desirable' elements of care
- Some users would receive exactly the same service as they currently received; others would get the service to meet their needs
- Benchmarking showed that Rotherham was higher in spending terms with regard to meeting learning disability needs

Resolved:- (1) That, following the 2015 transfer to the Local Authority, Option C (as set out above) be approved together with maintaining the necessary support for Supported Living.

(2) That provision be made for those instances were challenges were made by clients and a phased reduction negotiated.

## H24. RESTRUCTURE OF ENABLING AND OUT OF HOURS SERVICE

Sarah Farragher, Contact and Enablement Service Manager, submitted a proposed restructure bringing together 3 strands of work together i.e. Social Work Out of Hours Service, Better Care Fund Service developments and the current Enablement Service.

The proposal was to reshape the current Enabling Service to include Social Work capacity as part of the management of the Service delivery. The new Service would concentrate on reducing Social Care needs at the front end of the Service through:-

- Provision of Enabling which was more focussed on achieving independent outcomes for customers
- Faster throughput for customers where longer term support was needed
- A more responsive approach to picking up packages quickly

The Service would operate 7 days per week and provide a virtual link into the Fast Response Team to avoid hospital and residential care admissions and provide out-of-hours Social work cover.

In order to achieve the restructure a number of establishment changes were required including recruitment of 4 full-time equivalent Social Worker posts, a change in the Out-of-Hours management response to provide more robust support and the development of a professional supervision arrangement for Social Workers based in the Enabling Team.

External recruitment had commenced for 4 additional Social Workers (3 funded from the Better Care Fund and 1 funded from a re-direction of an existing Home Enabling Officer vacancy) to provide the Social Work Enablement role as well as the permanent recruitment to the Enabling Manager Post (currently Home Enabling Manager).

Consultation on the proposal was well underway with transitional arrangements for closer working of Enabling and Out-of-Hours having started.

Resolved:- (1) That the proposal to combine 3 current priorities – improving and streamlining current Enabling offer, developing a Better Care Fund fast response Social Care Officer and improving the current Out of Hours response, be noted.

(2) That the progress to date be noted.

## H25. SAFEGUARDING ADULTS ANNUAL REPORT 2013-2014

Sam Newton, Service Manager, Safeguarding Adults, presented the Safeguarding Adults annual report 2013-14 produced by the Rotherham Safeguarding Adults Board for information.

Attention was drawn to the following information:-

- 314 referrals investigated and all had a Protection Plan in place to protect them
- Following investigation 85 people were found to have suffered some form of abuse
- Of the 84 contracted care homes, 10 were found to be failing to provide good care
- All new placements to 7 care homes were suspended
- Quality assurance visits were made to all 158 regulated homes and services

- Strategic review and self-assessment of the Board undertaken
- Safeguarding Adults Charter and a partnership agreement of commitment adopted
- 100% of alleged abuse responded to within 24 hours
- 2014-15 priorities
- 1,556 alerts reported through the new Safeguarding Adults Returns
- 314 Strategy meetings convened
- 166 case conferences convened across all Services
- The category of Neglect and Acts of Omission continued to be the highest category of abuse investigated (4% increase). Institutional abuse had also increased (4.5%)

Resolved:- (1) That the Safeguarding Adults annual report 2013/14 be noted.

(2) That the Cabinet Member's congratulations be conveyed to the Adults Safeguarding Board for their work during 2013-14.

## H26. MAKING SAFEGUARDING PERSONAL

Sam Newton, Service Manager Safeguarding Adults, presented a report on the above Local Government initiative that supported Councils and their partners to develop outcomes focussed, person centred Safeguarding practice. The Making Safeguarding Personal (MSP) Approach was embedded in the Care Act 2014 and therefore utilisation of the approach was now essential for every local authority in England.

MSP aimed to facilitate a shift in emphasis in Safeguarding from undertaking a process to a commitment to improving outcomes alongside people experiencing abuse or neglect. The key focus was on developing a real understanding of what people wished to achieve, agreeing, negotiating and recording their desired outcomes, working out with them (and their representatives or advocates if they lacked capacity) how best those outcomes might be realised and then seeing, at the end, the extent to which desired outcomes had been realised.

Adopting MSP facilitated the development of quantitative and qualitative measures than enabled practitioners, teams and Safeguarding Adults Boards to start to see how effective they were. However, it was fundamentally about a change of focus and practice away from putting people through a process and towards engaging with them to identify and realise the outcomes they wanted. It was about using the process to support a conversation or series of conversations and about adapting the process to most effectively improve those conversations and outcomes.

Councils were invited to engage in work at 1 or more of 3 levels:-

Bronze
Working with people (and their advocates or representatives if they lack capacity) at the beginning of the Safeguarding process to identify the outcomes they want and then looking at the conclusion of the process at the extent to which these outcomes are realised.

Silver
The above plus developing 1 or more types of responses to Safeguarding and/or recording and aggregating information about responses.

Gold
The above plus independent evaluation by a research organisation/university.

Rotherham, in taking part in an introductory event, had initially signed up to commence at Bronze level.

It was proposed that a project group be established in order to redesign policies and procedures to make then person centred, develop materials to support practitioners and the people they worked with, develop recording mechanisms, review how advocacy was made available and develop, brief and implement 1 or more of the approaches to support people to resolve their circumstances.

Resolved:- (1) That Making Safeguarding Personal be consolidated at Bronze level be approved.

(2) That engagement at Silver level by developing 1 of the proposed tools/responses to Safeguarding be approved with the aspiration to achieve Gold standard.

## H27. VULNERABLE ADULTS RISK MANAGEMENT

Sam Newton, Service Manager Safeguarding Adults, reported on proposals to case manage vulnerable adults, improve outcomes and develop cross agency working in the support and protection of vulnerable adults in our communities.

A Vulnerable Adults Risk Management (VARM) Framework enabled, on a case by case basis, the assessment, case management and better co-ordination of an effective response to vulnerable adults. It provided a structured escalation process set within the context of the Safer Rotherham Partner and Rotherham Safeguarding Adults Board. It had been developed in partnership with South Yorkshire Police, the Vulnerable Person's Unit and the Safeguarding Adults Team.

VARM was a bespoke cross-agency meeting to develop and co-ordinate activity to address the needs of identified vulnerable adults and provide a multi-agency response where interventions had tried and failed or had not been available. The meetings would be answerable to their own

organisations and would be scrutinised by the Vulnerable Adults Panel. The VARM meeting would be convened by the Vulnerable Persons Unit (VPU).

The work had been commenced by the VPU drawing together information, managing the multi-agency risk and arranging for case specific multi-agency reviews. The activity of each Service, current local multi-agency working and the assessment and case management by the VPU needed to be supplemented and embedded into a risk assessment framework which would:-

- Reduce risk and increase a co-ordinated and effective service to the individual
- Identify key agencies to work with vulnerable adult
- Identify needs to improve outcomes
- Reduce inappropriate use of Services e.g. high frequency callers to Emergency Services
- Achieve this through the use of effective case management, multi-agency working including appropriate information sharing, action plans and continued monitoring to reduce risk and improve outcomes

The meetings would be held within 3 weeks of a new case being identified, the urgency of the meeting dependent upon the vulnerability of the individual and the availability of the professional required. This would be decided by the case workers/co-ordinators within the VPU following appropriate screening and risk assessments. The meeting would be chaired by a Chief Inspector and minutes taken by the VPU.

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

- The VPU was Police led
- 2 Social Workers from Safeguarding sat within the VPU and were screening some of the cases that went through the VARM
- Need for a governance framework

Resolved:- (1) That the Vulnerable Adult Risk Management Framework be supported and progressed for formal adoption across the Safer Rotherham Partnership and Safeguarding Adults Board.

(2) That urgent consideration be given to the resourcing of the Service which, as a result of the recent child sexual exploitation, would be invaluable in identifying adult of CSE providing effective case management and risk reduction. It also provided a means to meet key national Government priorities as outlined in the Care Act 2015 including recognition, assessment and signposting to relevant Services.

(3) That, once the work on the governance arrangements was completed, they be submitted to the Cabinet Member.

## H28. ADULT SERVICES REVENUE BUDGET MONITORING REPORT 2014/15

Consideration was given to a report presented by Mark Scarrott, Finance Manager (Neighbourhoods and Adult Services), which provided a financial forecast for the Adult Services Department within the Neighbourhoods and Adult Services Directorate to 31st March, 2015, based on actual income and expenditure for the period ending September, 2014.

It was reported that the forecast for the financial year 2014/15 was an overspend of £900,000 against an approved net revenue budget of £69.267m, a reduction of £370,000 since the last report. The main budget pressures related to budget savings from previous years not fully achieved in respect of additional Continuing Health Care Funding plus recurrent pressures and increasing demand for Direct Payments. There were also delays on achieving budget savings proposals within Learning Disability Services.

Management actions were being developed with the aim of containing expenditure within the approved cash limited budget by the end of the financial year.

The latest financial forecast showed there remained a number of underlying budget pressures. The main variations against approved budget for each Service area were as follows:-

Adults General

- This area included the cross cutting budgets of Workforce planning and training and corporate charges and was forecasting an underspend due to higher than anticipated staff turnover within the Contract and Reviewing Officers Team and the impact of the moratorium on training budgets

Older People

- Recurrent budget pressure on Direct Payments over budget. Client numbers had increased since April together with an increase in the amount of a number of care packages
- Forecast underspend on Enabling Care and Sitting Service based on current level of Service together with an underspend within Independent Sector Home Care which had experienced a slight reduction in demand since April
- Overspend on Independent Residential and Nursing Care due to delays in achieving the savings target for additional Continuing Health Care (CHC) income. Additional income from property charges was reducing the overall overspend
- Planned delays on recruitment to vacant posts within Assessment and Care Management plus additional income from Health resulting in an overall underspend

- Overall underspend on Rothercare due to savings on maintenance contracts on the new community alarm units and supplies and services
- Underspends in respect of vacancies within Community Support and Carers
- The forecast included one-off Winter Pressures funding from the CCG to increase Social Worker capacity and prevent delayed discharges from hospital

Learning Disabilities

- Independent sector Residential Care budgets forecasting an underspend. Work continued on reviewing all CHC applications and high cost placements
- Forecast overspend within Day Care Services due to a recurrent budget pressure on external transport plus provision for 7 specialist transitional placements from Children's Services. This was being reduced slightly due to staff turnover higher than forecast
- Overspend in Independent Sector Home Care due to increase in demand
- New transitional placements from Children's Services into Supported Living plus additional demand for Shared Lives was being offset by additional CHC and one-off funding resulting in an overall forecast underspend
- Delays in meeting approved budget savings on Contracted Services for Employment and Leisure Services had increased the overspend due to extended consultation to the end of the financial year
- Forecast pressure on changing the provision of residential care to delivering of Supported Living by RDaSH
- Staff turnover lower than forecast within In-house Residential Care reduced by saving on RDaSH administration support

Mental Health

- Projected underspend on Residential Care budget due to a reduction of 3 placements since April 2014 plus additional Public Health funding for substance misuse
- Pressures on employee budgets due to lower than expected staff turnover together with review of night cover arrangements offset by underspend on Direct Payments due to a review of a number of care packages plus additional Public Health funding

Physical and Sensory Disabilities

- Further increase in demand for Direct Payments in addition to a recurrent budget pressure and forecasting an overspend
- Efficiency savings on contracts for Advice and Information
- Underspend on independent sector homecare as clients migrated to Direct Payment scheme

Safeguarding

- Increase in demand for assessments under Deprivation of Liberty Safeguards
- Offset by higher than anticipated staff turnover plus additional one-off income from Health

Supporting People

- Efficiency savings on supplies and services budget

Total expenditure on Agency staff for Adult Services to the end of September, 2014, was £88,350 (no off contract), a significant reduction compared with actual expenditure of £238,867 (no off contract) for the same period last year. The main areas of spend were within Residential Care and Assessment and Care Management Social Work Teams. There had been no expenditure on consultancy to date.

There had been £92,945 spent up to the end of September, 2014, on non-contractual overtime for Adult Services compared with expenditure of £198,280 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. Potential risks were the future number and cost of transitional placements from Children's Services into Learning Disability Services, any future reductions in Continuing Health Care funding as well as the additional demand and cost of assessments under Deprivation of Liberty Safeguards.

Regional benchmarking within the Yorkshire and Humberside region for the third quarter of 2013/14, showed that Rotherham remained below average on spend per head in respect of Continuing Health Care.

Resolved:- That the latest financial projection against budget for 2014/15, as now reported, be noted.

## H29. ROTHERHAM HEALTHWATCH

Paul Stinson, Commissioning, presented a report on Rotherham Healthwatch.

As set out in the tender process and contract, it had always been the intention that once Healthwatch Rotherham (HWR) had been established, the contract would be novated to HWR to operate as an independent Social Enterprise. The intention to novate the contract by September, 2014, was approved by the Health and Wellbeing Board on 26th March, 2014.

The novation of contract was formally challenged by Parkwood Healthcare Ltd. on 8th August, 2014.

Following advice from the Council's Legal team, the Council entered into a Deed of Termination Agreement with Parkwood Healthcare to end any rights and obligations under the existing contract and to ensure that delivery of the service could commence by Rotherham Healthwatch Ltd. (Social Enterprise) on 1st September.

The termination process as successfully completed by 31st August, 2014, and a new contract established with Rotherham Healthwatch Ltd. on 1st September, 2014 until 31st March, 2015.

The challenge had required a waiver of Standing Orders to contract with the newly established Social Enterprise.

The Cabinet Member reported that he had been kept fully informed throughout the process.

Resolved:- That the retrospective waiver of Standing Order No. 49 (tender invitation and receipt of tenders) for the delivery of Rotherham Healthwatch Ltd. (Social Enterprise) be approved.

**H30. HEALTH VISITING AND FAMILY NURSE PARTNERSHIP DEVELOPMENT FUNDS - SECTION 7A PUBLIC HEALTH SERVICES - PROPOSALS FOR ROTHERHAM SERVICES**

Dr. John Radford, Director of Public Health, reported that NHS England (South Yorkshire and Bassetlaw) had identified some development money available to address inequalities across the NHS England area. The report submitted set out a proposed programme of recurrently funded opportunities for Rotherham to increase the coverage of the Family Nurse Programme and support activity to promote Maternal and Children's Public Health by the Health Visiting Service.

It was proposed:-

Family Nurse Partnership Coverage

- To increase the capacity of the Partnership Team to match that of the area where there was the best capacity and coverage. This would increase capacity so that 24% of first time teenage pregnant women received support from the Programme – currently only 21.8% received support

Improve Breastfeeding Rates in Rotherham

- Baby Friendly Initiative
  The Health Visiting specification required services to "achieve and maintain full accreditation of UNICEF Baby Friendly initiative". All HV services in South Yorkshire and Bassetlaw had achieved full Baby Friendly accreditation with the exception of Rotherham. An Infant

Feeding Co-ordinator was required to facilitate the process plus significant training and other resources such as promotional materials and BFI assessment costs etc. NHS England was offering a 50% contribution to the development and were seeking a commitment from the Rotherham Foundation Trust to the remaining funding. The proposal had been present to the Trust who were committed to supporting the match funding allowing them to maximise skill mix and opportunities for ensuring consistent and sustained support to the achievement of UNICEF BFI

- Baby Friendly Peer Support
  Existing Peer Support (Breast Buddies) was only funded until 31st March, 2015. The Service was crucial to support breastfeeding mums and consisted of a Peer Support Co-ordinator and paid part-time Peer Supporters who delivered support directly to women and also trained volunteers to support women in the community. There were benefits to it being integrated into and managed by the Health Visiting Service in the context of BFI. The proposal was supported by the Foundation Trust

Implement Pregnancy, Birth and Beyond Parent Education in Rotherham

- The Department of Health recommended the above for first time parents. It was currently offered in 2 other areas in South Yorkshire. Development would include co-ordination, training, development of materials, delivery staff and venues across the Borough as part of the integrated Foundation Years Best Start Service. It had been endorsed by the Think Family Steering Group but there were resource issues preventing progress with the initiative.

Due to the national expansion of Health Visitor numbers, Health Visitors were hard to recruit. The proposals relied upon successful recruitment.

Resolved:- (1) That the recommended initiatives be approved as priorities for development.

(2) That the funding proposals be approved and planning to implement activity be commenced in partnership with NHS England and the Rotherham Foundation Trust with immediate effect as per the schedule submitted.

(3) That the implementation of the initiatives be led by the Public Health Team in partnership with NHS England (South Yorkshire and Bassetlaw) as part of the transformation of Health Visiting and Family Nurse Programme Services.

(4) That it be noted that it was essential to ensure there was long term commitment to the Services in particular the Family Nurse Partnership required commitment that the Local Authority would continue to run the Programme and sustain the number of place for a minimum of 3 years post-transition.

(5) That the report be referred to the Health Select Commission for information.

## H31. CRISIS CARE CONCORDAT

Janine Parkin, Strategic Commissioning Manager, submitted a proposal to join partner organisations in South Yorkshire in formally agreeing to the principles in the national Concordat for Mental Health Crisis Care.

The Department of Health 'Mental Health Crisis Care Concordat – Improving outcomes for people experiencing mental health crisis' was published in February, 2014. The Concordat included all age groups from 16 years and beyond.

Signatories to the Concordat had made a commitment to work together to support local systems to achieve continuous improvements for crisis care for people with mental health issues across England.

A Declaration document had been developed by NHS England and sign up at a locality level by partner organisations had been canvassed at a sub-regional level.

In September, 2014, a formal request was made to the Authority to agree to sign up to the Concordat and to join with partner organisations to develop local area action plans to implement the recommendations contained therein.

The deadline for uploading declarations to the national Crisis Care Concordat website was December, 2014, and had been set by the Department of Health.

The Yorkshire and Humber Multi-Agency Mental Health Collaborative was a group that met every 2 months and already had senior representatives from a number of key stakeholders in regular attendance. NHS England suggested that the group could help support the implementation of local action plans as well as be a forum to discuss specific problems and take actions back to their respective organisations.

The Crisis Concordat was a key element of the Better Care Fund (BCF01) workstream which was working to develop a Mental Health Liaison Service that supported the outcomes of the BCF and the principle of 'parity of esteem' between physical and mental health care.

It was proposed that the Council supports the aims of the Concordat formally by becoming signatories to the South Yorkshire Declaration Statement.

Resolved:- (1) That the Cabinet be requested to recommend to Council the signing of the South Yorkshire Declaration Statement on National Crisis Care Concordat and approve the involvement of Council Officers in the implementation of the recommendations contained in the Concordat within the Better Care Fund Action Plan.

(2) That the report be referred to the Health and Wellbeing Board and the Cabinet Member for Children and Education Services for information and support of the action plan.

**H32. 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 items of business on the grounds that they involve the likely disclosure of exempt information as defined in Paragraph 3 of Part I of Schedule 12A to the Local Government Act 1972 (information relating to the financial or business affairs of any person (including the Council)).

**H33. COMMISSIONING FRAMEWORK FOR DOMICILIARY CARE TENDER 2014-15**

Janine Parkin, Strategic Commissioning Manager, reported on the current position with regard to the Community and Home Care Services Tender 2014-15.

The invitation to tender had been published on 19th September, 2014. At the pre-qualification stage the evaluation of the applicant's key policy documents had been evaluated.

Evaluation of the second stage tenders would be complete by 28th November, 2014, with the new contracts issued on 30th March, 2015.

outcome of the pre-tender qualification

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

(2) That a further report be submitted following the procurement exercise to advise on the next steps and tender award.

# HEALTH AND WELLBEING BOARD
## Wednesday, 12th November, 2014

**Present:-**

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|---|---|
| Councillor Doyle | Cabinet Member, Adult Social Care and Health **In the Chair** |
| Councillor Beaumont | Cabinet Member, Children and Education Services |
| Bob Chapman | South Yorkshire Police |
| Tom Cray | Strategic Director, Neighbourhoods and Adult Services |
| Chris Edwards | Rotherham CCG |
| Councillor Hoddinott | Deputy Leader |
| Julie Kitlowski | Chair of Rotherham CCG |
| Ian Jennings | |
| Naveen Judah | Healthwatch Rotherham Ltd. |
| Jan Ormondroyd | Interim Chief Executive, RMBC |
| Jason Page | Rotherham CCG |
| Nigel Parkes | Rotherham C.C.G. |
| Joanna Saunders | Director of Public Health (representing Dr. J. Radford) |
| Carol Stubley | NHS England |
| Janet Wheatley | Voluntary Action Rotherham |

**Also Present:-**

| | |
|---|---|
| Chris Bain | RDaSH |
| Michael Holmes | Rotherham Policy and Partnerships |
| Chris Holt | N.H.S. Foundation Trust |
| Jane Parfrement | Acting Strategic Director of Children and Young People's Services |
| Councillor Sansome | Vice-Chairman of the Health Select Commission |
| Janet Spurling | Scrutiny Services |
| Jasmine Swallow | Policy and Partnerships |
| Paul Theaker | Operational Commissioner |
| Sue Wilson | Performance and Quality Manager |

Apologies for absence were received from Louise Barnett and Natalie Yarrow.

### S35. QUESTIONS FROM MEMBERS OF THE PRESS AND PUBLIC

There were no questions from members of the public or the press.

### S36. MINUTES OF PREVIOUS MEETINGS

Resolved:- That the minutes of the two previous meetings of the Health and Wellbeing Board, held on (a) 1st October 2014 and (b) 24th October, 2014, be approved as correct records.

With regards to Minute No. 28 (Vaccinations and Immunisations for Pregnant Women) of the meeting held on 1st October, 2014 it was noted that no specific action had as yet taken place, but an update on progress would be provided at the next meeting.

Reference was also made to Minute No. S33 (Response to the Jay Report) and an update was requested on the priorities and actions assigned to N.H.S. England given that the Health and Wellbeing Board was to monitor progress. The recommendations had also requested that discussions take place between the Chairs of the Health and Wellbeing and Local Safeguarding Children's Boards and for the Needs Assessment and Pathways document be distributed to all partners by email once this had been completed.

The Board heard that no further information was available with regards to the actions assigned to N.H.S. England, but that arrangements were in hand for a meeting between the Chairs of the Health and Wellbeing and Local Safeguarding Children's Boards and the Cabinet Member with regards to a way forward.

An update was also provided on the changes to Public Health leadership, reporting mechanisms and the role of the Child Sexual Exploitation Sub-Group and the remit of the Gold Group. Any issues that needed to be forwarded on should be via the Child Sexual Exploitation Sub-Group, which was a sub-group of the Local Safeguarding Children's Board.

## S37. COMMUNICATIONS

### (1) Better Care Fund Plan – Assurance Review

Further to Minute No. S24 of the meeting of the Health and Wellbeing Board held on 1st October, 2014, the Board considered correspondence from the National Director (Commissioning Operations), NHS England, stating that the Better Care Fund plan had been assessed as part of the Nationally Consistent Assurance Review (NCAR). The letter stated that the Better Care Fund plan has been placed in the 'approved, subject to conditions' category.

The Strategic Director of Neighbourhoods and Adult Services outlined the content of the letter drawing particular attention to the eight separate actions and the appointment of the Better Care Adviser, Nick Clarke, who would work on developing an action plan to detail how and by when the agreed actions would be addressed to meet the conditions. Many of the conditions would simply be met by the importing the detail onto the new template, which needed to be completed by the 7th December, 2014 deadline.

It was also noted that the Section 256 Transfer Document had not been included as part of the documentation, but that it be noted that the use of the Better Care Fund was in accordance with the Section 256 Transfer Document.

**(2) Health and Wellbeing Website**

Michael Holmes and Jasmine Swallow demonstrated the accessibility tabs on the new Health and Wellbeing Website, which would be subject to partnership branding.

This also coincided with the launch of the new online survey on the 29th October, 2014 which had had 102 responses initially. Feedback to date had been positive and had been extended to external and internal organisations and partners.

Discussion ensued on the various links to the partner websites and how the website would be managed through the workstream group.

**(3) Health and Wellbeing Board Minutes and Meetings**

The Chairman was in receipt of some correspondence from a member of the public who had raised concern about the use of acronyms in some of the reports being presented. To alleviate this problem it was suggested that all reports have the full description with the acronym in brackets.

It was also suggested that some consideration be given to a bullet point list summary of reports for members of the public rather than them having to sieve through the large number of pages on the agenda.

This needed to be explored further on the feasibility of such a suggestion and whether it was something that could be accommodated within the resources available.

In addition, the member of the public referred to an incident involving the Foundation Trust, where an unregistered locum doctor was employed at the hospital via an agency.

The Chief Officer for the C.C.G. Office provided an overview of the incident, the reasons how it came about and the outcome, which had led to an improved agency framework that provided the relevant assurances that such an incident would not occur again in the future. It was stressed, however, that during the course of the two day locum period there were no concerns for members of the public.

**(4) Budget Consultation Process**

The Deputy Leader provided an overview of the budget consultation process open to members of the public until 31st December, 2014, on three priority areas:-

- Protecting our most vulnerable children and adults.
- Getting back into work and making work pay.
- Making our streets cleaner and better.

The challenge facing the Council was for savings of £23 million next year and £50 million over the next three years.

This was a similar situation being faced across the public sector and formed part of the efficiency programmes around the Health and Wellbeing Board priority outcomes.

## S38. JOINT PROTOCOL BETWEEN HWBB /HEALTH SELECT COMMISSION/HEALTHWATCH

Consideration was given to the report detailing the Joint Protocol between Health and Wellbeing Board/Health Select Commission/Healthwatch, which would ensure that the bodies develop a constructive and productive working relationship with one another. Each body had an independent role and a shared aim to reduce health inequalities and improve health and wellbeing outcomes. The roles were distinctive, but complementary and must add value to each other's work, and avoid duplication. This joint protocol detailed the distinctive roles of each body, and presented examples of working together and reporting arrangements.

The protocol had been considered by each of the respective bodies and was presented to the Health and Wellbeing Board for formal sign up.

It was suggested that slight amendments be made to the document by way of inclusion in the Health and Wellbeing Board box on the diagram, expanding on the role of commissioning and also revisions to the Chairs of the relevant bodies. If the Board were in agreement with these amendments then these would be included and the document signed off.

Resolved:- That the document be revised with the suggestions made above and for this then to be signed appropriately by the Chairmen concerned.

## S39. DISABLED CHILDREN'S CHARTER

Consideration was given to the report which presented the Disabled Children's Charter for Health and Wellbeing Boards and requested that partner organisations sign up to this.

The Board considered the merits of signing up to various different charters and their individual stand from their individual organisations.

The Board discussed at length a uniformed approach to accepting Charters in principle, but agreed not to sign up to individual Charters as a Board. The principles set out in the Charters would be considered and it was this approach that should be taken forward.

Resolved:- That the principles of the Disabled Children's Charter be accepted.

(2) That the Board consider the principles within all Charters submitted to it only and no individual Charter be signed up to going forward.

## S40. EMOTIONAL HEALTH AND WELLBEING STRATEGY

Consideration was given to a report presented by Nigel Parkes, Rotherham Clinical Commissioning Group, and Paul Theaker, Operational Commissioner, which detailed the draft Emotional Wellbeing and Mental Health Strategy 2014-19 which had been developed to support Local Authority, Health Commissioners and service providers to improve the emotional health and wellbeing of children and young people in Rotherham.

The final draft of the Strategy and associated action plan had been widely consulted upon. This had been approved through both the Rotherham MBC and Rotherham Clinical Commissioning Group (RCCG) governance processes and was attached to the report and detailed the key recommendations and actions to be taken forward.

The strategy included sections on the scope of the strategy, the needs of children and young people, services in Rotherham, investment, challenges and risks and recommendations.

The strategy was widely consulted on with a wide range of stakeholders in June and July 2014, including RMBC Children and Young People Services, schools, colleges, NHS providers and VCS providers. There have also been specific consultation sessions with parents/carers and with the Youth Cabinet.

The responses from consultation have been evaluated and the draft Emotional Wellbeing and Mental Health Strategy was substantially amended to take into account the comments that have been made. In addition, the Rotherham Health Watch report on Child and Adolescent Mental Health Services (CAMHs) was reviewed to ensure that the key findings were addressed within the strategy.

The Rotherham Clinical Commissioning Group commissioned Attain, an independent sector consultancy organisation, to review CAMHs and their report was considered by the Clinical Commissioning Group. The Attain

recommendations that the Clinical Commissioning Group agreed to take forward have been included within the Strategy.

The key recommendations outlined within the Strategy were as follows:-

**Recommendation 1** - Ensure that services are developed which benefit from input by young people and parents/carers.

**Recommendation 2** - Develop multi-agency care pathways which move service users appropriately through services towards recovery

**Recommendation 3** - Develop family focussed services which are easily accessible and delivered in appropriate locations.

**Recommendation 4** - Ensure that the services being delivered are effective, appropriate and represent the best value for money for the people of Rotherham.

**Recommendation 5** - Ensure that the services being provided are delivered at the appropriate time as required and not restricted to normal operating hours.

**Recommendation 6** - Ensure that services across all tiers of provision are delivered by appropriately trained staff and that training and support is provided to Universal/Tier 1 services to ensure that patients do not unnecessarily move to higher tiers of provision.

**Recommendation 7** - Ensure well planned and supported transition from child and adolescent mental health services to adult services.

**Recommendation 8** - Explore the option of a multi-agency single point of access to mental health services for children and young people to ensure that appropriate referral pathways are followed.

**Recommendation 9** - Ensure that services are better able to demonstrate improved outcomes for children and young people accessing mental health services.

**Recommendation 10** - Promote the prevention of mental ill-health.

**Recommendation 11** - Reduce the stigma of mental illness.

**Recommendation 12** - Ensure that patients do not face inappropriate delays in accessing services, across all tiers, for assessment and treatment which adversely affect their recovery.

It should be noted that as the governance process progresses for final approval of the Strategy, the key recommendations and actions were already being acted upon. The development of multi-agency care pathways was a priority piece of work and would address a number of

issues in relation to thresholds/access to services and pathways such as post diagnosis ASD. A workshop with stakeholders had been held and was informing the work of small time-limited working groups that have been established for each multi-agency pathway.

The Strategy had been approved by the Cabinet Member for Children and Education Services and by the Rotherham Clinical Commissioning Group Operational Executive and was to be submitted to the Health and Wellbeing Board for final joint Council/ Rotherham Clinical Commissioning Group approval.

The Board appreciated the positive approach to the development of this Strategy and its links to the Mental Health Strategy and suggested that it be reviewed in March, 2015.

It was also suggested that as the Strategy began to evolve the baseline information and detailed outcomes be included so the direction of travel could be measured and closely monitored. Waiting times were key and it was uncertain if the Strategy actually addressed this, what action was being taken to reduce waiting times and what were the aspirational targets.

The Board were informed that G.P. surveys had been undertaken which supported the development of the Strategy to assist with measuring waiting time for appointments and G.P. experiences, which had seen a reduction in waiting time down to eight weeks from fourteen/fifteen weeks and significant improvements in referrals for assessment from March, 2015. This would continue to be reviewed on a six month basis. In addition, the Recovery College was an alternative to the Child and Adolescent Mental Health Service.

The Rotherham, Doncaster and South Humber NHS Foundation Trust confirmed that a whole system approach had been adopted to develop capacity and meet demand. A great deal of work had been undertaken with more to do to move forward and consider how best to use resources to meet the needs across all the tiers of support.

The impact measures contained with the report would take time to monitor and were seen as activities. It was unrealistic at this stage to identify outcomes, but this would become more evident moving forward and would then give the assurances that the service was improving.

Resolved:- That the final draft of the Emotional Wellbeing and Mental Health Strategy 2014-19 be approved.

## S41. SERVICE CO-PRODUCTION IN ROTHERHAM

Consideration was given to a report presented by Sue Wilson, Performance and Quality Manager, which detailed how the Expectations and Aspirations work stream of the Health and Wellbeing Strategy had a

priority in its action plan around co-production of services. This was fully endorsed by the Board's member organisations.

The consultation report, as submitted, provided information around definitions of co-production, examples of where this was already in place in Rotherham and the suggested approach to move this forward across all organisations.

A key action which underpinned this work was:-

"We will co-produce with Rotherham people the way services are delivered to communities facing challenging conditions."

Co-production was about delivering public services in different ways and developing relationships with service users that were equal between professionals delivering these services and those customers and carers in receipt of them.

Co-production was not just about consulting with citizens and "user voice" initiatives, it was much more than this. It was a two stage approach that would take time to develop. It was, therefore, suggested that this be considered on an annual basis to see which areas would lend themselves to be co-produced.

The proposal was for organisations to consider and decide which services would be suitable for co-production and begin to move to this as a concept of working. It was clear, however, that that there were some services which would never be suitable to be co-produced.

On this basis it was suggested that organisations cascade the information internally, which could be reported back to the workstream on the 5th December, 2014 with an opportunity for the Health and Wellbeing Board to look at this in more detail in a workshop style setting.

There were already some good examples of where co-production was working in Rotherham such as Lifeline, Speak Up and the Rotherham Charter for Parent and Child Voice.

In considering the principle of co-production, some of the partners expressed some concern with the work that they were undertaking and the lobbying for equal access. It was envisaged that there could be some duplication of work and asked for reassurances around case management and the benefits to the people of Rotherham.

Partners were advised that they were being asked to explore any opportunities that may lend themselves to this method of working and it was only for partners to indicate the areas which they thought were right and could add value and which may fit together for a different way of working and for this to include the voluntary and community sector.

To assist it was suggested that this subject may best be considered in a workshop style setting to consider the shared leadership and delivery outcomes whilst being realistic about budgets and demographic changes.

Resolved:- (1) That the consultation report and associated case studies be received and the contents noted.

(2) That principles be noted and partner organisations cascade the report and information within their organisations.

(3) That a workshop be arranged for the most appropriate people to consider further a two stage approach to move to co-production of services within their organisation and to establish what co-production in Rotherham would look like.

**S42. DATE OF NEXT MEETING**

Resolved:- That the next meeting of the Health and Wellbeing Board be held at the Town Hall, Rotherham on Wednesday, 3rd December, 2014, commencing at 9.00 a.m.

It was suggested that it would be useful to set out a forward work plan for the Board, incorporating reports on the Health and Wellbeing Strategy workstreams. Due to the number of inspections taking place and the urgent timescales associated with the Better Care Fund, there had been less scope recently to focus on the Strategy.

Rotherham Deaf Future

... make deaf local happy with good access

c/o Springwell Gardens Community Centre
Eastwood View
Rotherham
S65 1NG

Chief Executive
RMBC
Riverside House
Main Street
Rotherham
S60 1AE

Thursday 18th November 2014

Dear Sir/Madam

**Rotherham Deaf Futures Petition**

In 2012 all services from RMBC for the deaf community were cut. Since then we have really struggled with all communication relating to council issues and services. We were used to having a full deaf team to support us and now we have been left with nothing. As a profoundly deaf person it is very difficult to communicate with a hearing person and we feel we have been let down by RMBC.

We understand that cuts have had to be made and getting a full deaf team back is too much to ask for. However, ideally we would like you to employ someone for maybe one morning or afternoon per week, to be based at Riverside House, who signs BSL to help us with any issues or problems we may have.

Please find enclosed a petition which has nearly 700 signatures on it, which supports us in getting some assistance back from the council.
We look forward to hearing from you.

Yours faithfully

**Rotherham Deaf Futures**

K Addy.

**ROTHERHAM BOROUGH COUNCIL –**

**REPORT TO CABINET MEMBER FOR ADULT SOCIAL CARE AND HEALTH**

| | | |
|---|---|---|
| **1.** | **Meeting** | **Cabinet Member for Adult Social Care and Health** |
| **2.** | **Date:** | **8th December, 2014** |
| **3.** | **Title** | **Arrangements for the provision of Emergency Hormonal Contraception (EHC) for young girls aged 14 – 16 (Update)** |
| **4.** | **Directorate** | **Public Health** |

## 5. Summary

This report is to update the Board in relation to the progress made to date on the expansion of the Emergency Hormonal Contraception (EHC) sexual health services commissioned from Community Pharmacies across Rotherham and the development of care pathways and safeguarding reporting mechanisms for all young people accessing these services.

Service providers and commissioners have developed care pathways, reporting mechanisms and training for the expansion of the scheme to young people aged 14 and 15 years of age. Once pharmacists are aware of all the protocols and have accessed all relevant training, including online CSE training, then the scheme can be expanded with the first wave anticipated to be active January 2015.

## 6. Recommendations

**That the Cabinet Member notes the report**

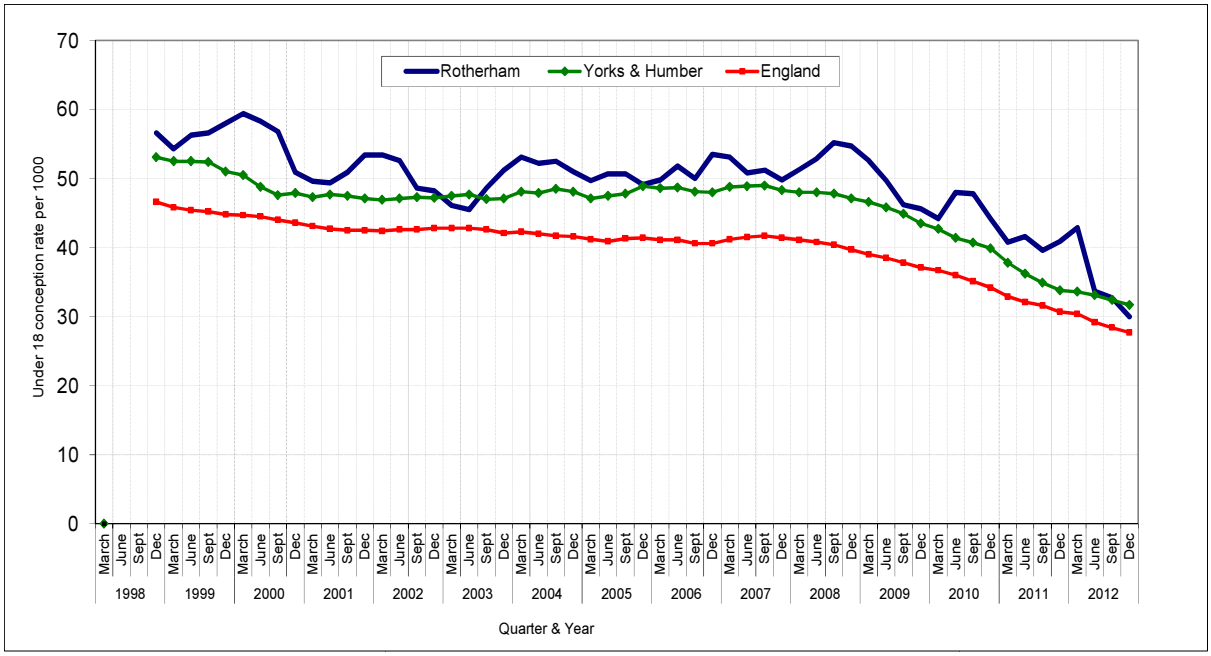
## 7. Proposals and details

The current Public Health Services contract (from April 2013) in relation to Emergency Hormonal Contraception (EHC) with Pharmacists operating in Rotherham specifies that they provide the service, free of charge, to females aged 16 years and over. This is an alternative choice of provision within the community to that which is offered by General Practitioners, outreach Nurses and the Rotherham Integrated Sexual Health Service. The contract is designed to provide greater access and choice for women/young women in Rotherham and aims to reduce unintended pregnancy and termination of pregnancy.

Females under 16 years are not able to obtain EHC at pharmacies under this contract at present denying this vulnerable group of young people a valuable service choice based in the community. It is acknowledged that by extending this service to this age group the service providers need to be especially vigilant in relation to any safeguarding issues which may arise, especially concerns around the possibility of child sexual exploitation (CSE). It was proposed by the Children, Young People and Families Board (October 2014) that the contract be renegotiated to allow for an extended service to females 14 and 15 years and that a referral pathway be introduced to address any safeguarding issues which may arise.

Good progress has been made on reducing teenage pregnancy in Rotherham and it is important for this trend to continue. Rotherham's under 18 conception rate has fallen to its lowest in the period 1998-2012 at 30.0 conceptions per 1,000 females aged 15-17. This represents a 26.7% decrease over the 2011 rate of 40.9 The number of conceptions has decreased from 201 to 144, a decrease of 28.4%. Rotherham's 2012 rate is the lowest rate in South Yorkshire and is close to the England rate of 27.7 (and to Rotherham's 2010 target of 28.3). The rate for under 16 conceptions has also fallen from 9.4 to 6.8 conceptions per 1,000, bringing Rotherham statistically in line with the rest of England.

**U18 Conception Rates by Quarter 1998 – 2012**
**Rotherham compared to Yorkshire & Humber and England**
**(rolling 4 quarterly average)**




It is acknowledged that there are also specific safeguarding issues in relation to this vulnerable group of young women which need to be taken into consideration. It was also agreed therefore, by the Board, that a referral pathway for any young woman under 18 years accessing EHC provision in a Pharmacy setting was developed with specific reference to the identification of any concerns in relation to CSE. Consequently it is proposed that any Pharmacist supplying EHC to a young woman aged 14 and 15 years will automatically refer through to Rotherham IYSS where support, appropriate referral and a further risk assessment will be carried out.

The proposal to extend the provision of EHC at Pharmacies to young women aged 14 and 15 has been taken to the Local Pharmaceutical Committee (LPC) who agreed, in principle, to the necessary variations to the local contract. The variation will include the necessity for all participating Pharmacists to have successfully completed the RMBC online training package on CSE and sexual abuse.
The referral pathway for Pharmacists dispensing EHC to young women has now been developed (**Appendix 1**). An assessment against the CSE risk indicator descriptors for all young women asking for EHC will be used together with the newly proposed automatic referral for those aged 14 and 15 years. An electronic recording system (already in use for supervised consumption of drugs at Pharmacies) is now also in use in relation to EHC to allow for more accurate monitoring. Data collected by this system is able to give a much clearer picture of the use of pharmacy accessed EHC.

The electronic recording system has now been modified and, once, 'live' this modification will flag an automatic alert (when indicated by age/date of birth) for a young woman aged 14 and 15 years and will highlight the required referral process. IYSS have produced a protocol and guidelines (**Appendix 2 and 3**) for the referral of young women from accessing EHC via Pharmacies. The number of younger women coming through this referral pathway is not anticipated to be large (based on the under 16 conception rate of 6.8 per 1,000 young women aged 15 and under but numbers will be monitored.

Pharmacists are required to indicate that they have referred the young woman on the electronic recording system before they are allowed to progress. There is an additional new alert which will indicate whether or not the individual has accessed EHC before (either at the same pharmacy or any other pharmacy in Rotherham).

A timetable for delivering training to Pharmacists in the use of the CSE and sexual abuse risk indicator tool, the electronic recording system and the referral process, including the online CSE training is now being put together and the LPC have been consulted once again in relation to operation of the system. Once the training has been delivered the contract variation will be processed and Pharmacists signed up to the new contract will be able to operate the service extension. The first pharmacists, targeted in relation to their EHC activity, are expected to be offering the expanded service in January 2015.

**8. Finance**

There should be no additional financial concerns as the overall contractual value for the Pharmacy EHC contract in Rotherham takes into account an estimated level of activity across all ages.

**9. Risks and uncertainties**

Rotherham has made good progress in relation to tackling unintended teenage pregnancy, the numbers having fallen considerably in recent years. The lack of community based EHC provision for younger, vulnerable young women could reverse this trend. Rotherham also needs to tackle the level of sexually transmitted infections in the population by targeting those most at risk. There are, however, safeguarding issues to be taken into consideration with sexual activity below the ages of 16 years and, therefore, an automatic referral system between Community Pharmacists and IYSS is being introduced.

**10. Policy and Performance Agenda Implications**

There are implications for performance in relation to the Public Health Outcomes Framework (Teenage pregnancy, Chlamydia screening and HIV early detection).

The further development of the safeguarding measures should also be seen as a contribution to measures designed to identify and prevent sexual exploitation.

**11. Background Papers and Consultation**
Public Health Outcome Framework for England, 2013 -2016

**Keywords: sexual health; teenage pregnancy; contraception; young people,**

**Officer: Gill Harrison, Public Health Specialist**

**Manager: Sue Greig, Locum Consultant in Public Health**

**Director: John Radford, Director of Public Health**

**Appendix 1:**

## Proposed Referral Pathway – EHC (Pharmacy)

**Client under 18**

**CSE & sexual abuse risk indictor tool**

**indicators identified**

**Follow exisiting safeguarding pathways**

**indicators not identified**

**client 16-18**

**offer referral to IYSS**

**client 14-15**

**automatic referral to IYSS(NEO alert)**

**IYSS will contact and seek consent* for:**

- **assessment**
- **support**
- **appropriate referral**

**further use of risk indicator tool by IYSS:**

**CSE concerns**

**Follow existing safeguarding pathways**

**no CSE concerns**

**continued support from IYSS**

**(*if consent is declined, history is reviewed and concern is noted and further action following safeguarding pathways followed if necessary)**

Appendix 2

**Rotherham Metropolitan Borough Council**
**Integrated Youth Support Service**

# Pharmacy Administered Emergency Hormonal Contraception Follow-up

## Protocols and Guidelines for Youth Start

**Berridge, Ann**

The free Emergency Hormonal Contraceptive Scheme for women available from accredited Pharmacies across the Borough of Rotherham is to be re-launched and will also be available to young women aged 14-16 years. The Scheme will take effect from ???? following appropriate training and accreditation for the Pharmacies who will be taking part.

In order to continue to address the sexual health local priorities, which are:

- Reduce the number of unintended teenage pregnancies
- Reduce the rates of sexually transmitted infections amongst young people
- Increase the number of young people using regular forms of contraception
- Increase the opportunities to discuss sex and relationships education and promote positive relationship choices thereby addressing the risk of exploitation

a multi-agency group has agreed that young women shall be offered a follow up by IYSS Youth Start. For those under the age of 16, this will be an automatic referral (with the young person's knowledge) and for women aged between 16 and 18 years, this will be an 'offer'. This initiative is to not only to try to address the above local priorities, but to support the Pharmacies in ensuring that robust safeguarding steps are in place and to offer consistency across sexual health and contraceptive services.

The team of Youth Support workers at Youth Start, who have responsibility for sexual health work within the long-standing youth clinic provision, will manage the referrals from the Pharmacies, with other staff aware of the work and able to step in and support the referral process where necessary.

All client contact information will be recorded on Rotherham Youth Support Service MI system and regular monitoring will take place through case management and supervision which will be regularly undertaken with all workers.

Any safeguarding issues will follow the agreed EHC pathway and the Rotherham Safeguarding Children Board procedures.

**Protocols**

1. A referral will be received by telephone from a Pharmacy within three days of the emergency hormonal contraceptive being administered by the Pharmacy. If necessary, Pharmacies will be given a direct dial telephone number where they can leave a message at weekends. This will be picked up and dealt with on the following Monday.

2. The details will be logged on the Youth Start EHC Referral Form. The information will be entered onto the IYSS management information system (IO).

   The information needed from the Pharmacy will be:

   - Full name
   - Date of Birth
   - Address
   - Contact telephone number
   - Email Address
   - Pharmacy Address and Contact person
   - Date of EHC administered

3. A minimum of three separate attempts will be made to contact the young woman. If contact cannot be established, checks will be made via the IYSS management information systems to see if the client is accessing other areas of the Service or if there are possible alternative ways of making contact.

4. If no contact can be established

5. Where contact is established, the young woman will be offered an appointment at either Youth Start or at one of the locality Youth Clinics. At the appointment the following will be covered:

   - Did vomiting occur in the 3 hours following the EHC being taken?
   - Has there been any bleeding or menstruation since the EHC was administered?
   - Is there a need for a STI and or pregnancy test?
   - What contraception, if any, is the young woman using?
   - Advise the need for regular contraception and consistent use of condoms
   - Referral to nurse or other medical professional where needed
   - Give information about all sexual health services for future
   - Sex and Relationship education
   - Discuss previous/current relationship

- Condom teach
- Assessing for any safeguarding concerns

6. If the young woman does not attend the agreed appointment date, contact will be established again to offer a further appointment on a different date.

7. Any identified safeguarding issues will follow RMBC safeguarding procedures.

8. All attempted and successful contacts with a young woman will be recorded on the management information systems. This will include any follow on appointments.

9. Anonymous monitoring data will be provided to appropriate RMBC/NHS departments where requested.

**Guidelines**

1. When a telephone referral is received from a Pharmacy, take the details needed to complete the Pharmacy EHC Telephone Referral Form.

2. Enter client information on I.O. creating a new client where necessary. This should follow the usual Youth Start client recording guidelines.

3. Attempt to make contact with the young woman within 5 working days of receiving the referral and offer an appointment to attend 3 weeks after taking EHC. This will provide an optimum timeframe for assessing the possible need for a pregnancy test and/or STI check.

4. A minimum of three attempts shall be made to contact the young woman using the information received from the Pharmacy.

5. If no contact can be established either because of incorrect details or no response, then make a check on I.O. to see if they are accessing any other part of the service or worker.

6. If this is the case, make sensitive enquiries to see if it is possible to make contact with the young woman via this route.

7. If no contact can be made

8. If contact is established with the young woman then offer her an appointment at either one of the Youth Clinics in the localities or at Youth Start (either Sexwise or drop in).

9. When follow up appointments are not kept, the young person shall be allowed a further 7 days to make contact with Youth Start. When this time has elapsed, attempts to contact the young person will be made. All attempted contacts shall be recorded on I.O. Where attempted contacts have failed on 3 separate occasions, the Project Manager should be informed and further action considered and recorded

10. If she attends, then the EHC Pharmacy Follow Up Form shall be completed. This form shall be attached to the client's paper based Sexual Health Record Sheet at Youth Start and a summary entered on to I.O.

11. Follow the Youth Start induction procedures for new clients and outline the confidentiality policy to **ALL** clients.

12. Check if the young woman vomited within 3 hours of taking the EHC. This can be an indication that the medication was not ingested therefore may not have prevented the pregnancy. If this is the case, a referral to a CASH nurse should be made as soon as possible to discuss further.

13. Was there any bleeding since taking the EHC? Some bleeding disturbance may occur a few days after taking EHC but this should not be taken as her usual menstruation. Check with the client what her usual menstruation cycle is and refer to the nurse if there are any worries or concerns from either the worker or the young woman.

14. Check if there have been any further incidences of unprotected sex since taking the EHC. If so, refer to the nurse for possible repeat of EHC or other advice.

15. If the young woman has not had her usual menstruation cycle since taking the EHC (and it has been a minimum of 3 weeks), then a pregnancy test should be offered following the Youth Start Pregnancy Testing Guidelines.

16. Assess the need for an STI check and either offer a Chlamydia urine test or refer to CASH nurse for a full STI test.

17. Discuss the relationship history of the young woman, offering support around positive relationships, making positive choices, and saying no.

18. If the young woman is in a relationship and is wanting to continue sexual activity, then ascertain what contraception is being used. If no regular method is used, discuss what methods the young woman will consider, giving appropriate information and leaflet, and refer to nurse for contraception assessment.

19. Ensure that a condom teach is undertaken and condoms are issued following the Youth Start Condom Issuing Guidelines.

20. Provide information and leaflets giving details of all sexual health services in Rotherham.

21. **ALL** attempted and successful contacts shall be recorded on I.O.

**IF THE ADVICE WORKER HAS ANY CONCERN ABOUT THE WELL BEING OF THE YOUNG WOMAN, THE NEED FOR MEDICAL ADVICE SHOULD BE EXPLAINED AND CASH CONSULTED.**

**CHILD PROTECTION ISSUES SHOULD ALWAYS BE ADDRESSED IN LINE WITH ROTHERHAM SAFEGUARDING CHILDREN BOARD. DETAILS OF SUCH PROCEDURES CAN BE FOUND AT: www.rscb.org.uk OR FROM THE RMBC INTRANET.**

Appendix3

# PHARMACY EHC FOLLOW UP REFERRAL SHEET

**Date of Telephone Referral ……..**

**Name of Worker taking telephone referral ……**

## YOUNG WOMAN'S DETAILS

**First Name** ……

**Surname** ……

**Address** ……

…… **Post Code** ……

**Client No**… ……

**Date of Birth** ……...

**Contact Phone No**. …… **E Mail Address** ……

**Date of EHC administered** ……

## PHARMACY'S DETAILS

**Name of Pharmacy …….**

**Address …….**

**…… Post Code**

**Telephone No. …….**

**Staff Member giving referral ……..**

**Notes**

**ROTHERHAM BOROUGH COUNCIL – REPORT TO MEMBERS**

| | | |
|---|---|---|
| **1.** | **Meeting:** | **Cabinet Member for Adult Social Care and Health** |
| **2.** | **Date:** | **8 December 2014** |
| **3.** | **Title:** | **Introduction of a new approach to mobile technology (M-Care)** |
| **4.** | **Directorate:** | **Neighbourhoods and Adult Services** |

## 5. Summary

The Rothercare Service provides advice, support and emergency assistance to Rotherham's most vulnerable residents. Over the past two years Rothercare has gone through considerable changes in its working practices and has also seen a large rise in its call handling and customer base.

Due to the ending of the Health and Wellbeing service and some residents within Rotherham deciding to use mobile phones instead of having landlines in their properties, some people who could access Rothercare to increase their safety are having to be declined a service.

This report highlights these issues and makes recommendations for future service delivery to ensure the customer experience is maximised and that customer safety is maintained.

## 6. Recommendations

- **Note the issues outlined within this report;**
- **Agree the recommendations for the introduction of M-Care.**

## 7. Proposals and Details

### 7.1 Outline of Service

Rothercare currently has a customer base of 8372 customers with a total of 11607 individual pieces of equipment being monitored such as the box and pendant, bed and chair sensors, door alarms, environmental packages (figures correct as of 15 August 2014).

The basic Rothercare equipment is a box and pendant which remains the property of the Council and is installed by the Rothercare staff. The cost to the customer is currently £2.77 +VAT per week for the leasing of the equipment. Other peripherals such as bed and chairs sensors are provided and installed by the Assistive Technology Team free of charge and monitored and responded to by the Rothercare Service. The peripherals also remain the property of the Council.

All customers currently require a functioning landline to receive the Rothercare Service regardless of what equipment is provided. Without a landline the service currently cannot be offered to those customers wishing to have the service.

There are approximately 30 customers presently who have requested the Rothercare Service but do not have landlines fitted within their homes, the majority of these ex-customers of the Health and Wellbeing Check service and a small amount who have contacted Rothercare themselves directly to enquire about the service or via Social Workers.

### 7.2 Previous Solutions

Previously Global System for Mobile (GSM) diallers had been offered to customer who did not have a landline with Rothercare paying £20.00 per month for individual Sim cards. The Customer Contract Agreement was the same which placed the emphasis on Rothercare if the GSM diallers had not been charged correctly or there was a fault with it as Rothercare supplied the equipment. Due to connectivity problems from certain locations within the Borough it was decided to remove the GSM diallers.

Historically some customer have had their phone line bill paid for them and currently there are 10 customer receiving Rothercare where this still applies. The current process means the whole bill is paid by Rothercare and then individual invoices are produced to redeem the call costs etc. from the customer. This can be labour intensive and if a customer does not pay the invoice then time and effort is spent chasing up the outstanding amount.

## 7.3 Proposals for future delivery

### Introduction of M-Care (mobile care)

M-Care stands for mobile care, and refers to the use of mobile phones harnessed to extend telecare and telehealth services to far more people. M-Care uses mobile phones as a gateway to telecare and telehealth for people whose lifestyles are better suited to using their mobile phone as a link to 24/7 monitoring services, rather than the traditional carephone. M-Care has also extended to smart phone devices which collect and receive data relevant to the individual's health and social care. This way, the customer is able to go out into their local community, knowing that they are safe regardless of what happens.

M-Care is very simple. Anyone who uses a mobile phone can use M-Care by simply pressing a speed dial number on their mobile handset to contact Rothercare. The call will be presented to the centre operators in a similar manner to a typical telecare call, showing clearly the call is from a mobile phone, and a normal two way conversation can then take place.

M-Care allows Answer-link (The Monitoring Platform) to receive incoming calls from any standard mobile phone. All M-Care calls are received and managed as ‘alarm calls’ at the Control Room and not general telephone calls, despite coming in from a standard mobile phone.

M-Care can be targeted at customers with a wide range of needs, and may be used as part of an overall telecare and/or telehealth service package. Its benefits include:

- Increasing the confidence of the individual using the service
- Reduced anxiety
- Greater independence
- Improved quality of life and well being
- Increased peace of mind and reassurance for family members and carers.

Advantages:

- Opens up the service to a wider customer base including under 65s
- Expands the service to monitoring within the community which can increase the independence, health and well-being of customers further
- Increased revenue into the service
- Better way of communicating with customer who have hearing or speech issues
- There is Telecare Services Associate (TSA) good guidance practice to follow for M-Care

Disadvantages:

- Restricts the service to customers whose homes only have a working landline
- Excludes a large number of customers from accessing the service
- Increase in staffing levels to deal with increase customer base and connectivity of equipment.

## 8. Finance

The adoption of M-Care has no cost implication in relation as to equipment M-Care will run off the customers own mobile device. The release of the SMS facility on the Answerlink System to allow customers to use text messaging for communication if they have hearing or speech issues has been profiled into the recent refresh/upgrade of the monitoring platform. The cost to the customer for monitoring M-Care would be £2.77 +VAT per week.

## 9. Risks and Uncertainties

9.1 M-Care users would be made aware of the potential impact/risks, through a M-Care Customer Agreement, which would highlight such issues as:

- Poor signal coverage
- Keeping the battery charged
- Keeping the account topped up/contract
- How the service will be monitored and responded to

9.2 Customers with no telephone landline being left unsupported and vulnerable by not being able to access the Rothercare Service

9.3 Mobile phone will not have the ability to support any perivals such as bed or chair sensors, falls detectors.

## 10. Policy and Performance Agenda Implications

10.1 The following objectives from the Neighbourhood and Adult Services Service Plan 2014/5:

- We will help more people live at home through increased use of assistive technology and equipment
- Protecting our most vulnerable people and families, enabling them maximise their independence.
- We will improve service accessibility and responsiveness by changing our current call centre arrangements and our accessibility

10.2 The government's Preventative Agenda which promotes the use of and referral to preventative, local community based and enabling services as key to reducing the future burden on adult social care services.

10.3 The Department for Health's adult social care outcome domains:

- Enhancing quality of life for people with care and support needs
- Delaying and reducing the need for care and support
- Ensuring that people have a positive experience of care and support
- Safeguarding Adults whose circumstances make them vulnerable and protecting from avoidable harm

10.4 The following actions from the Think Local, Act Personal document:

- Make public information accessible and fully available.
- Supporting prevention and avoiding crisis admissions

**Appendix 1:** **Case Study from Carelink North Lincs**

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Jontek limited
CARING THROUGH INNOVATION

# Case Study
## North East Lincolnshire Carelink

## New Service Users and New Partnerships with m-Care



### Solution

- Comprehensive m-Care service
- Fully mobile solution
- Allows new services to be offered

### Benefits

- New partnership potential
- Telecare service available when no landline
- Enhanced income opportunities

### Background

North East Lincolnshire Carelink is a charity organisation providing the installation and monitoring of Telecare services to approximately 5,000 clients.

### Vision

Following a day at one of the Jontek road shows, they were very interested in a new concept to monitor clients using standard mobile phone technology. This new functionality could address various issues such as Lone Working and the ability to 'plug the gap' for clients who were previously unable to receive an alarm service because they didn't have a land line.

### Challenge

There were a number of different challenges faced by Carelink, which made the concept of m-Care so important. Carelink had already been using mobile phones for Lone Workers to contact the Control Centre, but with historic technology these calls would simply come though as 'lower priority' voice calls and there was no audit trail of follow up actions.

If a client was referred to Carelink, but didn't have a landline and couldn't afford to have one installed, there was no option other than to decline the service. In addition, it was recognised that clients on the Carelink service felt secure at home, knowing they were being monitored 24/7, but felt vulnerable when they were out and about in the community, as they no longer enjoyed the comfort of being able to contact Carelink should they require assistance. This may lead to clients going out less, which would affect their lifestyle and possibly have a negative effect on their quality of life.


## Solution

m-Care is the provision of assistance, support and advice services to service users in their own homes and out in the community, as they go about their daily lives. Service users are able to use their own mobile phone to alert the 24/7 Response Centre if they need help.

Due to the nature of m-Care being based around the use of a mobile phone, Carelink identified there were additional tasks which needed to be completed in order to set up the m-Care service initially. This included new procedures, terms, and conditions which had to be established to safeguard both Carelink and the service user at all times.

The responsibility for installing and maintaining traditional alarms lies with Carelink, however the responsibility for a mobile phone (m-Care) would lie with the service user. It was crucial that all areas of responsibility were clearly defined, for example, keeping the battery charged and keeping a mobile phone in credit.
Carelink stress to the user that it is their responsibility to keep Carelink updated of any changes, most importantly if their mobile number changes.

## New Partnerships

North East Lincolnshire Carelink work closely with the Humberside Police and commenced with discussions on using the m-Care service for 'Women's Aid'. The Police and Women's Aid used 'cell route units' in most cases, which work out quite costly and during times of recession all agencies are looking to cut costs.

Once Carelink explained the m-Care option, the Police and Women's Aid decided to pilot some connections for a period of time. Again, new procedures terms and conditions were written. The Police or Carelink are able to provide the m-care number directly to the client, programming it directly into the clients phone as a speed dial. This is of benefit to the client as they have the security they require straight away and the Police do not have to pay for any equipment to be installed in the client's home.

The pilot is up and running and to date both parties are more than happy with the system and are planning to continue using the service.

## The Benefits of m-Care to Carelink

Lone Workers – When m-Care was implemented at Carelink, the first step was to start using it for Lone Working to support staff which work remotely. With m-Care technology they are able to treat the Lone Worker calls as 'potential alarm calls' where necessary, offering a higher priority service for Lone Worker safety.

Clients with no landline - As Carelink was going through the process of replacing all hardwired alarms with dispersed units, there were some clients without a landline and m-Care was extremely useful in this scenario. Another example of this is when Carelink managed to successfully gain a new contract working with Supporting People. Many clients who qualified to have a Lifeline did not have a landline in their property, so Carelink decided to offer them the m-care facility.

## Results

Once the initial planning and preparation was done, m-Care was easy to set up and manage and they haven't looked back. Carelink believe strongly that m-care is the best solution for a range of groups of clients and this has to be assessed at the time of connection by the Telecare professional.

Out of the 98 clients they have using m-care at present, 22 are staff, 13 are Carelink clients, 20 are Police clients (used for Domestic violence and witness protection) and 43 are for Supporting People.

They have received over 1000 calls in the last quarter from m-Care alone with an average call answering time of 7 seconds.

## Moving Forward

Moving forward, Carelink envisage the m-Care service will become more widely required as mobile phones are often the preferred method of communication and more people are deciding to move away from traditional landlines in favour of mobile technology.

Carelink are now looking at the bigger picture and the possibilities of offering m-Care to a younger clientele base and those with Learning Difficulties. As the needs of their m-Care clients develop over time, they may also require Telecare or Telehealth services, therefore offering a complete service range to a wider group.

**ROTHERHAM BOROUGH COUNCIL – REPORT TO MEMBERS**

| | | |
|---|---|---|
| **1** | **Meeting:** | **Cabinet Member for Adult Social Care and Health** |
| **2** | **Date:** | **Monday 8th December 2014** |
| **3** | **Title:** | **Adult Services Revenue Budget Monitoring Report 2014/15** |
| **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 2015 based on actual income and expenditure for the period ending October 2014.

The latest forecast for the financial year 2014/15 shows an overall overspend of £737k against an approved net revenue budget of £69.267m, this represents a reduction of £163k since the last report. The main budget pressures relate to budget savings from previous years not fully achieved in respect of additional continuing health care (CHC) funding, recurrent pressures and increasing demand for Direct Payments plus delays on achieving budget savings proposals within Learning Disability Services.

Management actions are being developed with the aim of containing expenditure within the approved cash limited budget by the end of the financial year.

## 6 Recommendations

**That the Cabinet Member receives and notes the latest financial projection against budget for 2014/15.**

## 7 Proposals and Details

### 7.1 The Current Position

The approved net revenue budget for Adult Services for 2014/15 is £69.267m. The approved budget includes budget savings of (£4.472m) identified through the 2014/15 budget setting process with no investments for demographic pressures including transitional placements from Children's services.

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 | 1,810 | 1,676 | -134 | -7.40 |
| Older People | 27,846 | 28,028 | +182 | +0.65 |
| Learning Disabilities | 22,125 | 22,770 | +645 | +2.92 |
| Mental Health | 4,759 | 4,536 | -223 | -4.68 |
| Physical & Sensory Disabilities | 5,375 | 5,689 | +314 | +5.84 |
| Safeguarding | 686 | 713 | +27 | +3.93 |
| Supporting People | 6,666 | 6,592 | -74 | -1.11 |
| | | | | |
| **Total Adult Services** | **69,267** | **70,004** | **+737** | **+1.06** |

7.1.2 The latest financial forecast shows there remains a number of underlying budget pressures. The main pressures being in respect of continued increase in demand for Direct Payments and unachieved budget savings within Older People's independent sector residential and nursing care. In addition budget pressures remain within Learning Disability Services on external transport provision together with delayed implementation on the de-commissioning of employment and leisure services plus pressures on supported living schemes. These pressures are being reduced by a number of forecast non recurrent under spends including additional one off grant funding.

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

**Adults General (-£134k)**

This area includes the cross cutting budgets (Workforce planning and training, and corporate charges) are forecasting an underspend due to higher than anticipated staff turnover within the Contract and Reviewing Officers team and the impact of the moratorium on training budgets.

. **Older People (+£182k)**

- Recurrent budget pressure on Direct Payments over budget (+£391k). Client numbers have increased (+80) since April together with an increase in the average cost of care packages.
- Forecast under spend on Enabling Care and sitting service (-£20k) based on current level of service together with an under spend within Independent sector home care (-£59k), which has experienced a slight reduction in demand (-35 clients) since April.
- An over spend on independent residential and nursing care (+£631k) due to delays in achieving the savings target for additional Continuing healthcare income. Additional income from property charges is reducing the overall overspend.
- Planned delay's on recruitment to vacant posts within Assessment & Care Management plus additional income from Health is resulting in an overall underspend (-£400k).
- Overall under spend on Rothercare (-£111k) due to savings on maintenance contracts on the new community alarm units and supplies and services.
- Other under spends in respect of vacancies with Carers services (-£30k).
- The forecasts include one off Winter Pressures funding from the CCG of £220k to increase social work capacity and prevent delayed discharges from hospital.

**Learning Disabilities (+£645k)**

- Independent sector residential care budget is forecasting a underspend of (-£72k). Realisation of continued work reviewing all CHC applications and high cost placements as part of budget savings target.
- Forecast overspend within Day Care Services (+£147k) due to a recurrent budget pressure on external transport plus provision for 7 specialist transitional placements from Children's Services. This is being reduced slightly due to staff turnover higher than forecast.
- Overspend in independent sector home care (+£37k) due to increase in demand over and above approved budget.
- New transitional placements from Children's Services into Supported Living, plus additional demand for Shared Lives is being offset by additional CHC and one off funding resulting in an overall forecast underspend (-£109k).
- Delays in meeting approved budget saving on contracted services for employment and leisure services has increased the overspend (+£199k) due to extended consultation to the end of the financial year.
- Forecast pressure on changing the provision of residential care to delivering of Supported Living by RDASH (+£365k).
- Staff turnover lower than forecast within In House Residential Care (+£99k) reduced by saving on RDASH administration support (-£21k).

**Mental Health (-£223k)**

- A projected under spend on residential care budget (-£160k) due to a reduction of 3 placements since April plus additional Public Health funding for substance misuse.
- Pressures on employee budgets due to lower than expected staff turnover plus review of night cover arrangements (+£20k) offset by underspend on Community Support and Direct Payments (-£83k) due to a review of a number of care packages plus additional Public Health funding.

**Physical & Sensory Disabilities (+£314k)**

- Further increase in demand for Direct Payments (+ 34 clients since April) in addition to a recurrent budget pressure is forecasting an overspend (+£471k).
- Efficiency savings on contracts for advice and information (-£18k).
- Independent sector Residential care is now forecasting an underspend (-£50k) as one client is now supported by another authority.
- Underspend on Independent sector homecare (-£75K) as clients migrate to direct payments scheme.
- Slight underspends on independent day care, therapy and equipment support (-£14k).

**Safeguarding (+£27k)**

- The increase in demand for assessments under Deprivation of Liberty Safeguards (144 to date compared to a total of 56 in 2013/14) is putting additional pressure on existing budgets (+£104k). This is being reduced by higher than anticipated staff turnover plus additional one off income from health (-£77k).

**Supporting People (-£74k)**

- Efficiency savings on contracts due to reduced activity and supplies and services budgets due to the moratorium on non- essential spend.

### 7.1.3 Agency and Consultancy

Actual spend on agency costs to end October 2014 was £ 112,128 (no off contract), this is a significant reduction compared with actual expenditure of £235,327 (no off contract) for the same period last financial year. The main areas of spend is within Residential Care and Assessment & Care Management Social work Teams.

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 October 2014 was £112,067 compared with £235,357 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 which has not been funded for transitions in 2014/15. To-date there has been 28 transitional placements from Children's to Adult Social care services.
Another significant risk is the additional demand and cost of assessments under Deprivation of Liberty Safeguards reported earlier in the report.
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 third quarter of 2013/14 shows that Rotherham remains below average in terms of activity in respect of continuing health care (16$^{th}$ out of the total 23 CCG's).

## 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 26th February 2014 –Proposed Revenue Budget and Council Tax for 2014/15.
- The Council's Medium Term Financial Strategy (MTFS).

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.

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