CABINET MEMBER FOR ADULT SOCIAL CARE AND HEALTH

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

Date: **Monday, 26th January, 2015**

Time: **9.30 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 meetings held on (i) 8th December 2014 and (ii) 19th December 2014 (Pages 1 - 9)

6. Health and Wellbeing Board (Pages 10 - 25)

7. Health and Wellbeing Board Chairs Summit (Page 26)

8. Sexual Health Strategy 2014 Framework for Delivery 2015 - 2017 (Pages 27 - 54)

9. Care Act 2014 (Pages 55 - 57)

10. Adult Services Revenue Budget Monitoring - November 2014 (Pages 58 - 63)

11. Setting In House Residential Accommodation Charges 2015/16 (Pages 64 - 67)

12. 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)).

13. Review of Non Residential Service Charges (Pages 68 - 73)

14. Fee Setting 2015/16 - Independent Sector Residential and Nursing Care of People over 65 years (Pages 74 - 80)

15. Date of Next Meeting

Monday, 23rd February, 2015, at 9.30 a.m.

ADULT SOCIAL CARE AND HEALTH
Monday, 8th December, 2014

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

Councillor M. Vines was also in attendance at the invitation of the Chairman.

H34. DECLARATIONS OF INTEREST

There were no Declarations of Interest made at the meeting.

H35. MINUTES OF THE PREVIOUS MEETING

Consideration was given to the minutes of the meeting held on 17th November, 2014.

Resolved:- That the minutes of the meeting held on 17th November, 2014, be approved as a correct record.

Arising from Minute No. H21 (White Ribbon Campaign), it was noted that an informal launch had been held at MyPlace.

Arising from Minute No. H31 (Crisis Care Concordat), it was noted that Cabinet had endorsed the Council's commitment to the Concordat as had the Clinical Commissioning Group and South Yorkshire Police.

H36. HEALTH AND WELLBEING BOARD

The minutes of the meeting of the Health and Wellbeing Board held on 12th November, 2014, were noted.

H37. PETITION - ROTHERHAM DEAF FUTURE

Shona McFarlane, Director of Health and Wellbeing, reported receipt of a petition from Rotherham Deaf Future, containing 700 signatures, regarding their request for assistance relating to Council issues and services.

The background to the petition was given including the restructuring of the Assessment and Care Services sometime ago which had resulted in the changes made to the service provided.

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

(2) That the issues raised be investigated and a report submitted thereon as soon as possible.

H38. EMERGENCY HORMONAL CONTRACEPTION

Sue Greig, Locum Consultant in Public Health, presented a report on the proposed 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 the services.

The current Public Health Services contract (from April, 2013) in relation to Emergency Hormonal Contraception with pharmacists operating in Rotherham specified that they provide the service, free of charge, to females aged 16 years and over. This was an alternative choice of provision within the community to that which was offered by General Practitioners, Outreach Nurses and the Rotherham Integrated Sexual Health Service.

It was acknowledged that by extending the Service to 14-16 year old females, providers needed to be especially vigilant in relation to any Safeguarding issues that may arise especially concerns around the possibility of Child Sexual Exploitation. It was acknowledged that there were also specific Safeguarding issues in relation to this vulnerable group of young women which needed to be taken into consideration. Any pharmacist supplying EHC to a young woman aged 14-15 years of age would automatically refer through to the Rotherham Integrated Youth Service where support, appropriate referral and a further risk assessment would be carried out.

The proposal to extend the provision of EHC at pharmacies had been considered by the Local Pharmaceutical Committee who had agreed in principle to the necessary variations to the local contract. The variation would include the necessity for all participating pharmacists to have successfully completed the Council's online training package on CSE and sexual abuse.

Discussion ensued with the following issues raised/clarified:-

- Referral pathway for pharmacists dispensing EHC to young women had been developed
- Electronic recording system in use to allow more accurate monitoring – data collected would give a much clearer picture of the use of pharmacy accessed EHC
- The age/date of birth would automatically cause an alert for a young woman aged 14 and 15 years and highlight the required referral process
- Currently if a 14 year old female went to her GP for EHC it would be down to the GP's professional judgement as to whether a referral was made. Under this proposal pharmacies had to make a referral
- If there were a number of risk factors a referral would be made to MASH and the CSE Team. However, even if there were no concerns a referral would be made to Youth Start for an assessment and further work. If the young person declined the offer it would trigger a note of

concern through the system
- A similar conversation now needed to take place with CASH and GPs with regard to flagging up if a 14/15 year old presented at their service
- The electronic system would enable services to ascertain if there was a pattern
- The Youth Offending Service had not raised any concerns about the possible increased referrals
- It was highly likely that the young person would be known to the Youth Service and would, therefore, be another piece of intelligence
- Monthly monitoring data would be received through the community pharmacy route
- Community pharmacists were skilled professionals and the training would support them in asking the questions to draw out the information – if they did not undertake the training they could not offer the service
- It was hoped to have the first pharmacy offering the service in January, 2015

Resolved:- That the proposal set out in the report for the provision of Emergency Hormonal Contraception Sexual Health Services be approved.

H39. INTRODUCTION OF A NEW APPROACH TO MOBILE TECHNOLOGY INTO ROTHERCARE (M-CARE).

Shona McFarlane, Director of Health and Wellbeing, presented a report for future service delivery of Rothercare to those customers who did not have a landline in their properties.

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 would access Rothercare to increase their safety were having to be declined a service.

There were approximately 30 customers who had been refused the Rothercare Service for this reason.

M-Care (Mobile care) used mobile phones as a gateway to telecare and telehealth for those with lifestyles better suited to using their mobile phone as a link to 24/7 monitoring services. It enabled the customer to go out into their local community knowing that they were safe.

Anyone who used a mobile phone could use M-Care by pressing a speed dial number on their mobile handset to contact Rothercare. The call would be presented to the centre operators in a similar manner to a typical telecare call showing clearly the call was from a mobile phone.

Discussion ensued with the following issues raised/clarified:-

- It would not replace the pendant/fob etc. – it was purely for those

customers who did not have a landline facility to their property
- Clarity would be needed as to the customer's ability to use a mobile phone, ensure it was charged etc.
- Could a customer have both conventional access to the Service and the mobile facility?
- Who could access the Service?
- Where could they access the Service?
- The Service's ability to cope with potential increase in demand

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

(2) That a further report be submitted to the next meeting covering the issues raised above.

(3) That arrangements be made for a visit to Rothercare.

H40. 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 October, 2014.

It was reported that the forecast for the financial year 2014/15 was an overspend of £737,000 against an approved net revenue budget of £69.267m. 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 first 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 underspent
- 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 Carers Service
- The forecast now 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 and realisation of continued work reviewing all CHC applications and high cost placements as part of budget savings target
- 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 over and above budget
- 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 plus review of night cover arrangements offset by underspend

on Community Support and 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
- Independent sector Residential Care forecasting an underspend as 1 client was now supported by another authority
- Underspend on Independent sector Homecare as clients migrated to Direct Payments Scheme
- Slight underspends on Independent Day Care, therapy and equipment support

Safeguarding

- Increase in demand for assessments under Deprivation of Liberty Safeguards putting additional pressure on existing budgets
- Reduced by higher than anticipated staff turnover plus additional one-off income from Health

Supporting People

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

Total expenditure on Agency staff for Adult Services to the end of October, 2014, was £112,128 (no off contract), 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 were within Assessment and Care Management Social Work Teams. There had been no expenditure on consultancy to date.

There had been £112,067 spent up to the end of October, 2014, on non-contractual overtime for Adult Services compared with expenditure of £112,067 for the same period last year.

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

Regional benchmarking within the Yorkshire and Humberside region for the final quarter of 2012/13, showed that Rotherham remained below average on spend per head in respect of Continuing Health Care.

Discussion took place with the following issues raised and clarified:-

– Winter Pressures funding had been received much earlier this year

- Implementation of some of the Better Care Fund activity and work with the Foundation Trust around discharge to assess. This meant that someone who was fit enough to leave hospital but not sufficiently fit to return home would be able to go to a variety of settings to complete their recovery without occupying a hospital bed
- There had been investment in Intermediate Care through the Better Care Fund which would help support the pathway and if necessary bring agency staff in as required to get people through the system quicker

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

ADULT SOCIAL CARE AND HEALTH
19th December, 2014

Present:- Councillor Doyle (in the Chair).

Apologies for absence were received from Councillors Andrews and Pitchley.

H41. DECLARATIONS OF INTEREST

There were no Declarations of Interest made at this meeting.

H42. EXCLUSION OF THE PRESS AND PUBLIC

Resolved:- That, under Section 100A(4) of the Local Government Act 1972, the press and public be excluded from the meeting for the following item of business on the grounds that it involves the likely disclosure of exempt information as defined in Paragraph 3 of Part I of Schedule 12A to the Local Government Act 1972, as amended (information relating to the financial/business affairs of any person (including the Council) and is commercially confidential).

H43. COMMUNITY AND HOME CARE SERVICES TENDER OUTCOME AND AWARD

Further to Minute No. 33 of the meeting of the Cabinet Member and Advisers for Adult Social Care and Health held on 17th November 2014, consideration was given to a report, presented by the Operational Commissioner, concerning the award of contracts for Domiciliary Care Services (Community and Home Care Services) for all adults within the independent sector, from 30th March 2015 to 31st March 2018 with an option to extend the contract for a further year until 31st March 2019.

The report contained detailed information about the outcome of the formal tender evaluation process, including financial information. The matter was being dealt with urgently, in view of the imminent contract award date.

Three alternative options for the award of this contract were explained in the report, including the financial consequences of each option. Details of risk assessments were also reported. It was noted that Option 2 was the preferred option for financial reasons. The conditions and performance of the contract will require all care providers to be compliant with provisions of the Care Act 2014 with effect from 1st April 2015.

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

(2) That the contract for Domiciliary Care Services (Community and Home Care Services) for all adults within the independent sector, from 30th March 2015 to 31st March 2018 be awarded to the eight highest quality providers, with seven delivering to all client groups and one provider

delivering specialist care to carers (all in accordance with Option 2 as detailed in the report now submitted).

(3) That the award of this contact shall include an option to extend the contract for a further period of twelve months ending on 31st March 2019, subject to monitoring and satisfactory performance.

(4) That quality assurance reports on the performance of the contract framework be submitted at quarterly intervals in 2015/16 to meetings of the Cabinet Member and Advisers for Adult Social Care and Health.

(nb: subsequent to the meeting, the Mayor gave the necessary authorisation for this matter to be exempt from the Council's call-in procedure, to enable the contract to commence without delay)

HEALTH AND WELLBEING BOARD
Wednesday, 3rd December, 2014

Present:-

Councillor Doyle	Cabinet Member, Adult Social Care and Health **In the Chair**
Councillor Beaumont	Cabinet Member, Children and Education Services
Tom Cray	Strategic Director, Neighbourhoods and Adult Services
Dr. Richard Cullen	Vice-Chair of the Strategic Clinical Executive, Rotherham Clinical Commissioning Group (representing Dr. Julie Kitlowski)
Chris Edwards	Rotherham Clinical Commissioning Group
Jason Harwin	South Yorkshire Police
Councillor Hoddinott	Deputy Leader
Joanna Saunders	Public Health
Carol Stubley	NHS England
Janet Wheatley	Voluntary Action Rotherham

Also Present:-

David Hicks	Rotherham Foundation Trust (representing Louise Barnett)
Michael Holmes	Policy and Partnerships Officer, RMBC
Ian Jerrams	RDaSH (representing Chris Bain)
Sarah McCall	Observer
Nigel Parr	Neighbourhoods and Adult Services (representing Shona McFarlane)
Chrissy Wright	Strategic Commissioning Manager, RMBC

Apologies for absence were received from Chris Bain, Louise Barnett, Naveen Judah, Dr. Julie Kitlowski, Dr. Jason Page

S43. QUESTIONS FROM MEMBERS OF THE PRESS AND PUBLIC

There were no questions from the member of the public present at the meeting.

S44. MINUTES OF PREVIOUS MEETING

Consideration was given to the minutes of the meeting held on 12th November, 2014.

Concern was expressed that the last sentence of the final paragraph of Minute No. S40 (Emotional Health and Wellbeing Strategy) did not accurately reflect the discussion that had taken place. The following amendment was suggested:-

“Some partners felt it was realistic to provide outcomes as part of their strategy at this stage”.

Resolved:- That, subject to the above amendment, the minutes of the meeting held on 12th November, 2014, be approved as a correct record.

Arising from Minute S36 (Health Action Plan), Carol Stubley, NHS England reported that the Plan being produced in relation to the CSE investigation was in draft form and had been contributed to by NHS England, Clinical Commissioning Groups and other health organisations. There would be a meeting in the next couple of weeks to review and ascertain if there were any gaps in the provision by Health. The Plan and Guidance were expected to be published by 23rd December.

Arising from Minute No.S36 (Vaccinations and Immunisations), Carol Stubley, NHS England, reported that discussions had taken place with Rotherham Foundation Trust. Unfortunately, due to training implications the midwives would have to undertake, the Trust had confirmed that it was not in a position to take it forward at the current time. All women requiring vaccinations would be signposted to Primary Care.

David Hicks, Rotherham Foundation Trust, expressed his disappointment that this it not been able to be facilitated but it was due to capacity and resources. It was hoped, and endeavours would be made, to implement it for the next financial year. The Head of Midwifery had given a commitment to look at it for 2015/16 as it was a real opportunity missed.

The Chair asked that the Board be kept up-to-date with any developments on this issue.

S45. COMMUNICATIONS

NHS England Organisational Alignment and Capability Programme (OACP)

Carol Stubley, NHS England, presented a letter received from Eleri de Gilbert, Director NHS England (South Yorkshire and Bassetlaw) regarding the changes to the organisation's internal structure.

The aim of the reorganisation was, across England, to reduce the number of teams from the current 27 to 12 including the London configuration and to establish 4 regional teams. For South Yorkshire that would mean a move to 1 geographic team which would encompass Yorkshire and the Humber meaning the 3 existing teams (South Yorkshire and Bassetlaw, West Yorkshire and North Yorkshire) would disappear and form into 1. The changes were internal to the NHS and, therefore, there had been internal consultation with staff. The changes would be implemented as from the beginning of 2015.

Whilst moving to 1 geographic footprint, there would still be a presence in each of the localities e.g. in Oak House for South Yorkshire and Bassetlaw.

In terms of the director functions for Yorkshire and the Humber there would be a Director of Operations and Commissioning (replacing the existing area teams – an appointment made and commencing on 5th

January, 2015), a Medical Director, Finance Director and a Nursing Director. There would be a further 3 Directors, each 1 would be locality based i.e. 1 within South Yorkshire and Bassetlaw, 1 for West Yorkshire and 1 for North Yorkshire. The structure for this area had been developed specifically taking into account the large geographic area and the fact that each of the areas had unique issues.

There may be a change in attendance at the Health and Wellbeing Board but there would be more information once the team had been established.

The Chairman stated that he personally felt that the role of a NHS England representative on the Board was invaluable.

Better Care Fund
Chris Edwards, Rotherham Clinical Commissioning Group, reported that a meeting had been held with Nick Clarke, Better Care Adviser. The submission was being revised and would be communicated to the next Board meeting.

Health and Wellbeing Website
Michael Holmes, Policy and Partnership officer, reported that the website was up and running but at some point the Board should consider developing a wider communication plan including the use of social media. There had been no feedback from partners with regard to any additions required .

The website would link to the NHS Constitution.

Crisis Care Concordat
It was noted that the Council had signed up to the Concordat as had the Clinical Commissioning Group, South Yorkshire Police and RDaSH.

RDaSH
It was reported that Chris Bain was to leave her position as Chief Executive of RDaSH.

Resolved:- That the Board's best wishes be conveyed to Chris and appreciation for her work in supporting the Board.

Child and Adolescent Mental Health Services
Scrutiny Reviews that had implications for the Board and/or partners would be circulated at the scoping stage so there was the opportunity for the Board to discuss and possibly have an input.

S46. NHS 5 YEAR FORWARD VIEW

Carol Stubley, NHS England, presented the NHS 5 Year Forward View:-

The NHS have achieved a lot

- Currently #1 healthcare system in the world

- More than 2/3 UK public believe the NHS "works well"
- Cancer survival is at its highest ever
- Operation waiting lists are down – many from 18 months to 18 weeks
- Early deaths from heart disease are down over 40%
- 160,000 more nurses, doctors and other clinicians
- Single sex wards implemented

We are delivering more care – compared with 2009 the NHS is delivering more care

- 4,000 more people are being seen in A&E each day
- 3,000 more people are being admitted to hospital each day
- 22,000 more people have outpatient appointments each day
- 10,000 more tests are performed each day
- 17,000 more people are seeing a dentist each day
- 3,000 more people are having their eyes tested each day

Demand for care is rapidly growing

- We are facing a rising burden of avoidable illness across England from unhealthy lifestyles:
  1 in 5 adults still smoke
  1/3 of people drink too much alcohol
  More than 6/10 men and 5/10 women are overweight or obese
- Furthermore:
  70% of the NHS budget is now spent on long term conditions
  People's expectations are also changing

There are also new opportunities

- New technologies and treatments
  Improving our ability to predict, diagnose and treat disease
  Keeping people alive longer
  But resulting in more people living with long term conditions
- New ways to deliver care
  Dissolving traditional boundaries in how care is delivered
  Improving the co-ordination of care around patients
  Improving outcomes and quality
- The financial challenge remains with the gap in 2020/21 previously at £30bn by NHS England, Monitor and Independent think-tanks

The future NHS – the Forward View identifies three 'gaps' that must be addressed:-

- Health and Wellbeing
  Radical upgrade in prevention
  Back national action on major health risks
  Targeted prevention initiatives e.g. diabetes
  Much greater patient control
  Harnessing the 'renewable energy' of communities
- Care and Quality
  New models of care
  Neither 'one size fits all' nor 'thousand flowers'

A menu of care models for local areas to consider
Investment and flexibilities to support implementation of new care models

- Funding
  Implementation of these care models and other actions could deliver significant efficiency gains
  However, there remains an additional funding requirement for the next Government
  Need for upfront pump-priming investment

Getting serious about Prevention

- Focusing on Prevention
  Incentivise healthier individual behaviours
  Strengthen powers for local authorities
  Targeted prevention programmes starting with diabetes
  Additional support people to get and stay in employment
  Create healthier workplaces – starting with the NHS
- Empowering Patients
  Improve information: personal access to integrated records
  Investment in self-management
  Support patient choice
  Increase patient control including through Integrated Personal Commissioning (IPC)
- Engaging Communities
  Support England's 5.5m carers – particularly the vulnerable
  Supporting the development of new volunteering programmes
  Finding new ways to engage and commission the voluntary sector
  NHS reflecting local diversity as an employer

Developing new Care Models

- We need to take decisive steps to transition towards better care models
- There is wide consensus that new care models need to:-
  Manage systems (networks of care) not just organisations
  Deliver more care out of hospital
  Integrate services around the patient
  Learn faster from the best examples around the world
  Evaluate success of new models to ensure value for money
- There are already examples of where the NHS is doing elements of this
- However, cases are too few and too isolated
- The answer is not 'one size fits all' nor is it 'a thousand flowers bloom'
- We will work with local health economies to consider new options that provide a viable way forward for them and their communities

New deal for Primary Care

- Funding
  Stabilise core funding for two years and increase investment in the sector over the next Parliament

New funding for schemes such as the Challenge Fund
New infrastructure investment

- Commissioning
  Increase CCG influence over commission of primary care and specialised services
  New incentives to tackle inequalities
- Workforce
  Increase the number of GPs in training
  Train more community nurses and other primary care staff
  Invest in new roles, return and retention
- Public Engagement
  Building the public's understanding of pharmacies and on-line resources to reduce demand

Multi-Speciality Community Providers

- What they are
  Greater scale and scope of services that dissolve traditional boundaries between primary and secondary care
  Targeted services for registered patients with complex ongoing needs (e.g. the frail elderly or those with chronic conditions)
  Expanded primary care leadership and new ways of offering care
  Making the most of digital technologies, new skills and roles
  Greater convenience for patients
- How they could work
  Larger GP practices could bring in a wider range of skills – including hospital consultants, nurses and therapists, employed or as partners
  Shifting outpatient consultations and ambulatory care out of hospital
  Potential to own or run local community hospitals
  Delegated capitated budgets – including for Health and Social Care
  By addressing the barriers to change, enabling access to funding and maximising use of technology

Primary and Acute Care Systems

- What they are
  A new way of 'vertically' integrating services
  Single organisations providing NHS list-based GP and hospital services, together with Mental Health and Community Care Services
  In certain circumstances, an opportunity for hospitals to open their own GP surgeries with registered lists
  Could be combined with 'horizontal' integration of social and care
- How they could work
  Increased flexibility for Foundation Trusts to utilise their surpluses and investment to kick-start the expansion of Primary Care
  Contractual changes to enable hospitals to provide Primary Care Services in some circumstances
  At their most radical they could take accountability for all health needs for a register list – similar to Accountable Care Organisations

Other New Care Models

- Urgent and Emergency Care Networks

Simpler and better organised systems achieved by
- Developing networks of linked hospitals to ensure access to specialist care
- Ensuring 7 day access to care where it makes a clinical difference to outcomes
- Proper funding and integration of Mental Health Crisis Services
- Strengthening clinical triage and advice

– Specialised Care
Consolidating services where there is good evidence that greater patient volumes lead to greater quality
Working with a smaller group of lead providers willing to take responsibility for developing geographical networks of specialised and non-specialised care
Moving towards specialised centres of excellence for rare diseases
– Viable Smaller Hospitals
Help sustain local hospital services where:
- They are the best clinical solutions
- They are affordable
- They have commissioner support
- They have local community support
- Consider adjustments to payment mechanisms
- Explore new staffing models
- New organisation model including sharing management across sites, satellite provision on smaller sites and Primary and Acute Care systems

– Modern Maternity Services
Explore how to improve our current services and increase choice by:
- Commissioning a review of future maternity units for Summer 2015
- Ensure funding supports choice
- Make it easier for midwives to set up services

– Enhanced Health in Care Homes
Developing new models of in-reach support and services by:
- Working in partnership with Social Services and care homes
- Building on existing success

Implementing new Care Models
– To deliver new care models we need a new type of partnership between national bodies and local leaders
– Working with local communities and leaders, NHS national bodies will jointly develop:
Detailed prototyping of new care models
A shared methodology for assessing the characteristics of health economies
National and regional expertise and support for implementation at pace
National flexibilities in current regulatory, funding and pricing regimes
A new investment model to help ‘pump prime’ and fast track the new care models

Delivering Innovation and Change
To deliver the scale and pace of change required we will also take steps to

- Align NHS Leadership
- Develop a modern workforce
- Exploit the Information Revolution
- Accelerate innovation

Efficiency and Funding

- It has previously been calculated that the NHS faces a gap between expected demand and funding of -£30bn by 2020/21
- To address this gap we will need to take action on 3 fronts: demand, efficiency and funding. Less impact on any 1 of these will require compensating action on the other 2
- Delivery of the more active demand and prevention activities outlined in the Forward View would deliver in the short (e.g. prevention of alcohol harm) and medium term (e.g. action on diabetes)
- The long run efficiency performance of the NHS has been -0.8% annually. We have achieved nearer 2% more recently although this has been based on some actions that are not indefinitely repeatable e.g. pay restraint
- However, with upfront investment and implementation of new care models, we believe that we could achieve 2% rising to 3% over the next Parliament
- Combined with an increase in funding equivalent to flat-real per person (e.g. adjusted for population growth and age) - about £8bn more – would close the gap

Next Steps

- NHS England is now embarking on work with other NHS national bodies and wider stakeholders to implement the commitments in the Forward View

Discussion ensued with the following issues raised/clarified:-

- People were living longer but an increasing number of people with long term conditions
- Ever increasing number of people that needed access to services because of lifestyle factors e.g. alcohol, obesity, lack of exercise
- Culture of change required and for people to take more responsibility for their personal health and lifestyle choice
- Need to be more innovative and creative in terms of creating care models locally reflecting the needs of the local population
- Still expectation that will deliver 3% savings every year for the next 5 years whilst recognising need for upfront investment and double running costs to be incurred
- £8Bn expected funding gap identified
- 2015/16 was the first year of the Plan – guidance would be published

by NHS England on 23rd December

- Difference in opinion as to whether the changes to the funding formula was thought to have a negative effect for Rotherham
- Funding and framework was required to allow patients to be empowered to make their own choices and self-management as well as the vulnerable members of society requiring advocates to access the services
- Although the document was welcomed, the CCG were concerned about the risk to Rotherham with regard to the new formula

Resolved:- That the report be noted.

S47. CARE ACT 2014

Nigel Parr, Professional Standards and Development Service Manager, gave the following powerpoint presentation:-

Care Act 2014

- Received Royal Assent on 14th May, 2014
- The Act was in 3 parts – Care and Support, Care Standards and Health
- Part 1 of the Act consolidated and modernised the framework of care and support law with new duties for local authorities and new rights for Service users and carers
- It replaced many previous laws e.g. Chronically Sick and Disabled Person Act 1970, Community Care (Direct Payments) Act 1996

What is the Act trying to achieve?

- That care and support
  Is clearer and fairer
  Promotes people's wellbeing
  Enables people to prevent and delay the need for care and support and carers to maintain their caring role
  Puts people in control of their lives so they can pursue opportunities to realise their potential

An integrated Act

- Different sections of the Act are designed to work together
- Local authority wide
- Overlap with Children and Families including transitions
- Partnerships and integration
- Leadership

Framework of the Act and its Statutory Guidance

- Underpinning principle
  Wellbeing
- General responsibilities and key duties
  Prevention
  Integration, partnerships and transitions

Information, advice and advocacy
Diversity of provision and market oversight
Safeguarding

- Key processes
  Assessment eligibility
  Charging and financial assessment
  Care and support planning
  Personal budgets and direct payments
  Review

The Wellbeing Principle

- Wellbeing broadly defined 9 areas in particular
- Local authorities should also have regard to other key principles when carrying out their activities such as beginning with the assumption that the individual is best-placed to judge their wellbeing

New Responsibilities of Local Authorities towards all Local People

- Arranging services or taking other steps to prevent, reduce or delay peoples' needs for care and support
- Provision of information and advice including independent financial advice
- Promoting diversity and quality in the market of care providers so that there are services/supports for people to choose from

New Duties – Integration and Market Oversight

- A statutory requirement to collaborate and co-operate with other public authorities including duty to promote integration with NHS and other services
- Duty for local authorities to step in to ensure that no-one is left without the care they need if their service closes because of business failure
- Care Quality Commission oversight of financial health of providers most difficult to replace were they fo fail and to provide assistance to local authorities if providers do fail

New duties – Advocacy, Safeguarding and Transitions

- A duty to arrange independent advocacy if a person would otherwise be unable to participate in or understand the care and support system
- New statutory framework for protecting adults from neglect and abuse. Duty on local authorities to investigate suspected abuse or neglect, past or present, experienced by adults still living and deceased
- Duty to assess young people and their carers in advance of transition from Children's to Adult Services where likely to need care and support as an adult

What might this mean for People needing Care and Support?

- Better access to information and advice, preventative services and assessment of need
- An entitlement to care and support

- A cap on care expenditure which an individual is liable for comes into effect from April, 2016
- A common system across the country:
  Continuity of care
  Fair Access to Care Services replaced by a national eligibility threshold

How will people experience the new system in 2016/17?

- If you have care and support needs you could be supported by
  Assessment of the care and support you need and eligibility for state support
  Information and advice on local services and how much they cost
  Reablement, rehabilitation and other free services
  Support from family networks community
- How much you might pay for your care and support depends on your financial situation
  You have a financial assessment to see what you have to pay
- Costs are capped
  There is a cap on expenditure on eligible care from April, 2016
- Every year the local authority
  Reviews your care needs and financial situation
  Keeps a record from April, 2016, a care account, how much eligible care you have needed in total

What does this mean for Carers?

- The Care Act strengthens the rights and recognition of carers:
  Improved access to information and advocacy should make it easier for carers to access support and plan for their future needs
  The emphasis on prevention will mean that carers should receive support early on and before reaching crisis point
  Adults and carers have the same rights to an assessment on the appearance of needs
  A local authority must meet eligible needs of carers and prepare a support plan
  A carer should be kept informed of the care and support plan of the person they care for
- Children and Families Act 2014

What might this mean for Local Authorities?

- New duties and responsibilities
- Changes to local systems and processes
- More assessments and support plans
- Responsibilities towards all local people
- Better understanding of self-funders and the care market needed
- Training and development of the workforce
- Costs of reforms
- Preparation or reforms needed

What might this mean for Local Authority Partners and Care

Organisations?

- NHS, Housing and Children's Services share the duty to integrate
- Partners and providers will find:
  They may need to respond to the wellbeing principle
  Greater local authority focus on promoting diversity and quality in the market and market intelligence about self-funders needed
  Greater local authority involvement in services focussed on prevention and delay
  National, not local, eligibility criteria
  New statutory Safeguarding arrangements

Summary

- A significant piece of legislation that modernises the framework of care and support law bringing in new duties for local authorities and for Service users and carers
- It aims to make care and support clearer and fairer and to put people's wellbeing at the centre of decisions and embed and extend personalisation
- Local authorities have new responsibilities towards all local people including self-funders
- There are significant changes to the way that people will access the care and support system

Discussion ensued with the following issues raised/highlighted:-

- The Act came into force as from 1st April, 2015
- National eligibility criteria as from April, 2016
- Anticipated additional 5,357 requests for a care assessment in Rotherham as the eligibility criteria was reduced
- Local Authority would have to look on a case-by-case basis to ascertain eligibility
- Engagement with local resources/voluntary and community sector to work in partnership to support the needs of the community at a far greater level than present
- Belief that self-funders that will present themselves/eligible for support would be in the region of 667
- In 2015/16 Rotherham would see an increase in costs of £727,000 in terms of assessments and financial support
- Routine workforce meetings as well as the Association of Directors of Adult Social Services looking at the implementation of the Act to ensure continuity across the region
- A large amount of the Act was desperately needed but there were also great concerns regarding the equity of resources
- A lot of people would be caught by the changing of the cap to £100,000 given the average house price in Rotherham
- The rationale was set against a background of year-on-year budget cuts and greater increase in the population
- Consultation would commence shortly with the voluntary and community sector, however, the eligibility criteria had only recently

been released and officers were working through what the implications would be

- Discussions had started with the Police regarding vulnerable persons and the processes required
- Innovative means of communicating the information to the public were being worked up
- Training would involve legal advisors and be accessible to partners and the voluntary and community sector
- It was anticipated that the forthcoming grant would not be sufficient to meet the additional burden

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

(2) That a schedule of the training events be submitted to the next meeting.

S48. COMMISSIONING FRAMEWORK

Chrissy Wright, Strategic Commissioning Manager, submitted a Commissioning Framework for the Board's consideration.

In order to continuously improve the quality of commissioning across the Council, the document had been developed to provide a framework for commissioning to ensure a consistent high quality commissioning activity in line with national good practice, outcome focussed and met the needs of the citizens and the Council.

The Framework set out a definition of commissioning, the commissioning principles and the legal requirements. It was hoped that the Framework would be agreed by the appropriate bodies including the Board and the Leader of the Council as a public document.

The Framework set out the required commissioning approach particularly with respect to the Council's Standing Orders, Financial Regulations, legislation and equality and diversity.

It was noted that the Framework corresponded with the Health and Wellbeing Strategy and Joint Strategic Needs Assessment.

The document would be refreshed to take account of the Jay report, Corporate Governance and Ofsted recommendations.

Chris Edwards, Rotherham Clinical Commissioning Group, stated that Health carried out Quality Impact Assessments of their strategies and would be willing to share their working practices.

It was noted that comments had been received from the voluntary and community sector which would be collated and forwarded to Chrissy.

Resolved:- (1) That the Commissioning Framework be noted.

(2) That the final document be submitted to future Board meetings.

S49. HEALTH AND WELLBEING STRATEGY REFRESH

Michael Holmes, Policy and Partnerships Officer, submitted a proposed reporting timetable that would enable the Board to review progress to date against its 6 strategic outcomes and locally determined priorities as part of the Health and Wellbeing Strategy refresh and discuss priority areas for the updated Strategy.

It was proposed that reports be submitted on 3 priority areas at the next 4 Board meetings (January to June) with members considering:-

- What progress had been made and what factors had prevented further progress?
- Could tangible achievements be identified?
- was this still a priority and why?

At the end of this process a workshop, either at the June meeting or separately arranged, could focus on the refresh considering outcomes from the Board sessions as well as other relevant issues and potential priority areas.

The Health and Wellbeing Steering Group would support priority leads helping them to prepare for the Board sessions. From May, 2015, it was proposed that a task and finish group be established to work on the refresh.

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

- Work of the workstreams had been delayed due to recent pressures on time and resources
- The refresh would miss the current Clinical Commissioning Group round but would be considered in September/October
- The aim would be to have 1 plan for Rotherham including all partners' strategies but would need clarity on governance and accountability
- Needed to take account of the Jay report, Ofsted and Corporate Governance Inspection
- Need to ensure that the actions of the Improvement Board and Children's Improvement Board were clear and no duplication of work

Resolved:- That the proposed approach and timetable for the refresh of the Health and Wellbeing Strategy be noted.

S50. ANY OTHER BUSINESS

A&E

There had been recent media attention surrounding the capacity of A&E. A&E had been pressured together with staff shortages at key levels in the

organisation.

The methodology used in the past had been the Intensive Support Team which had been really positive and used as a beacon at national conference. However, that now had to become normal practice which the impending Winter Plans did state.

Rotherham's A&E had performed at 95% in the last 2 quarters; the latest performance was just under that figure. The next few months were very dependent upon the weather and issues that the Trust could not control. The Resilience Board regularly discussed this issue.

The long term solution would be the proposed Emergency Care Centre.

South Yorkshire Ambulance Service
There had also been issues recently with regard to ambulance response times and instances when the Police had been called upon to transport members of the public to the hospital.

The Service was currently operating at reasonable levels. Doncaster was operating at 93% patients seen within 4 hours, Sheffield at 94.6%, Rotherham at 94.8% and Barnsley 98%. Rotherham was only 0.2% below what was considered to be good performance nationally. The pressure on emergency services was at a critical level.

Nevertheless, performance levels experienced currently were not acceptable and Rotherham and Barnsley particularly disadvantaged for Model A Response Target (response within 8 minutes). Last month Rotherham had operated at 65% of patients against a target of 75%.

There was very little scope as it was a legal requirement to contract with South Yorkshire Ambulance Service so it could not be market tested. The Good Governance Institute had conducted a review which had only given a partial reassurance and an action plan had been drawn up.

Walk-in Centre
Anecdotal evidence suggested that the Centre was frequently being closed on an evening to patients unless they were children or had life threatening conditions; members of the public were being sent to the A&E.

Resolved:- That Chris Edwards submit an update on all the above issues to the next meeting.

S51. DATE OF NEXT MEETING

Resolved:- That a meeting of the Health and Wellbeing Board be held on Wednesday, 21st January, 2015, commencing at 11.00 a.m. in the Rotherham Town Hall.

Health and Wellbeing Board Chairs Summit (London)

London - 25 March 2015

- The expectations on HWBs have grown far beyond their original statutory duties.
- Their duty to promote integration has been sharply tested by the BCF process.
- There is a need for them to show more effective leadership in influencing commissioning and reshaping local services.
- Growing consensus from a wide range of policy makers and influencers that HWBs should be the system leaders to oversee a single pooled budget and single joint commissioning for all health and social care services.
- There is a need to work together with national stakeholders to develop a shared view of the future role of HWBs, wider system changes, and role and contribution of other local stakeholders.

Times

Registration time: 9.45 am

Start time: 10.30 am

End time: 3.30 pm

ROTHERHAM BOROUGH COUNCIL

1.	**Meeting**	**Cabinet Member for Adult Social Care**
2.	**Date**	**26th January 2015**
3.	**Title**	**Sexual Health Strategy**
4.	**Directorate**	**Public Health**

5. Summary

Following the recommendations of the Rotherham Health and Wellbeing Board in May 2013 the multi agency Sexual Health Strategy Group has been reconvened to produce an updated, comprehensive strategy for Rotherham.

The strategy has now been produced, has been out for consultation and is now being ratified by the various agencies who will be responsible for its delivery.

6. Recommendations

That the strategy is agreed and adopted on behalf of Rotherham Metropolitan Borough Council prior to being presented to the Health and Wellbeing Board for ratification

7. Proposals and details
The 2010 white paper Healthy Lives, Healthy People outlined the Government's aim to work towards an integrated model of service delivery for sexual health services and in March 2013 The Department of Health published 'A Framework for Sexual Health Improvement in England' which set out for commissioners and providers the Government's ambitions for good sexual health and provided information about what would be needed to deliver good sexual health services.

Following the changes in commissioning responsibility partnership working is vital and is stressed in the framework as is the importance for locally directed initiatives to ensure relevant and 'seamless' service delivery.

A local Strategy for Sexual Health, developed by a range of partners, would provide the best framework for this work in Rotherham

In May 2013 the Health and Wellbeing Board recommended the reconvening of a multi agency Sexual Health Strategy Group to produce an updated, comprehensive strategy for Rotherham.

The strategy group, chaired by Councillor Stone, first met in October 2013 and a draft Strategy, agreed by all members, was circulated for consultation in June 2014. Following the period of consultation the group, chaired by Councillor Doyle, agreed on the finalised strategy in December 2014. It was further agreed to take the strategy forward to the Health and Wellbeing Board for ratification.

8. Finance
There should be no additional financial concerns

9. Risks and uncertainties
Developing a comprehensive strategic approach to the commissioning and delivering of sexual health services can help minimise risk in relation to control of infection and in tackling unintended teenage pregnancy

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;
Officer: Gill Harrison, Public Health Specialist
Manager: Sue Greig, Locum Consultant in Public Health
Director: Tony Baxter, Interim Director of Public Health

Sexual Health Strategy for Rotherham 2015 - 2017

1 Introduction

The National Strategy for Sexual Health and HIV (2001) defines sexual health as a key part of our identity as human beings. Good sexual health is an important part of physical and mental health and well-being; the consequences of poor sexual health can impact considerably on individuals and communities.

Poor sexual health is disproportionately experienced by some of the most vulnerable members of our local communities, including young people, men who have sex with men (MSM), people from countries of high HIV prevalence, especially Black Africans, those who misuse drugs and/or alcohol and people from our most deprived neighbourhoods. We must, therefore, ensure that measures are put into place to reduce sexual health inequalities and improve the sexual health of all the people of Rotherham.

Good sexual health includes developing skills and expectations to enjoy loving and age appropriate relationships. Child sexual exploitation (CSE) and abuse damages this development, and leads to increased risk of sexually transmitted infections (STIs), unwanted pregnancy, and of domestic violence and abuse in the future. The negative impacts upon educational attainment, health risk behaviours and mental health problems are also well evidenced.

The Health Working Group Report on Child Sexual Exploitation, January 2014, states that all those concerned with improving the health and welfare of their local population have a responsibility to tackle child sexual abuse.

As of 1st April 2013 every Local Authority has a legal duty to protect the public's health. The Director of Public Health is responsible for ensuring that there are effective arrangements in place for preparing, planning and responding to health protection concerns, including those in relation to the sexual health of the local population.

Through this strategy, we will:

- ensure we have an effective multi agency response to child sexual exploitation and abuse;
- reduce inequalities and improve sexual health outcomes;
- build an honest and open culture where everyone is able to make informed and responsible choices about relationships and sex;
- recognise that sexual ill health can affect all parts of society;
- recognise that sexual health is a health protection issue.

2 Background

The importance of improving sexual health is acknowledged by the inclusion of three key indicators in the Public Health Outcomes Framework (2012):

- under 18 conceptions;
- chlamydia detection (15-24 year olds);
- presentation with HIV at a late stage of infection.

The outcome indicators have been included as markers to give an overall picture of the level of sexually transmitted infection (STI), unprotected sexual activity and general sexual health within a population. The Framework for Sexual Health Improvement in England (2013) acknowledges that effective collaborative commissioning of interventions and services is key to improving outcomes.

The new commissioning arrangements (in place from April 2013) have placed the lead responsibility for the commissioning of sexual health services and interventions within the Local Authority. In addition, Rotherham Clinical Commissioning Group (CCG) and NHS England commission certain sexual health services. It is vital that all commissioning organisations work closely together to ensure that services and interventions are comprehensive, high quality, seamless and offer value for money.

Under the new commissioning arrangements Rotherham Metropolitan Borough Council (RMBC) has been mandated to ensure that their local populations receive effective provision of contraception and open access to sexual health services. Furthermore, they are also mandated to ensure that there are plans in place to protect the health of the population, for example, in relation to STI outbreaks. In meeting these obligations, the following key principles of best practice will be observed:

- use of an effective multiagency response to preventing and protecting children from child sexual exploitation and abuse;
- prioritisation of the promotion of good sexual health;
- the promotion of 'joined up' working under strong leadership;
- a focus on outcomes;
- addressing the wider determinants of sexual health;
- the commissioning of high quality services with clarity about accountability;
- addressing the needs of our more vulnerable groups in Rotherham;
- ensuring that we have good quality data in relation to services and outcomes.

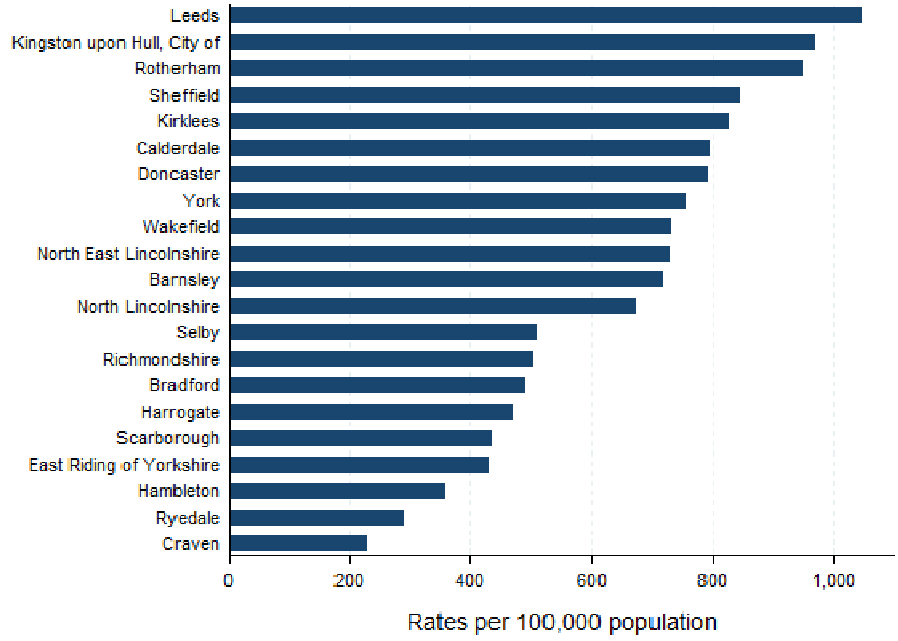
3 Sexual health needs analysis

3.1 Sexually transmitted infections

In the 2013 Local Authority Sexual Health epidemiology report produced by Public Health England (PHE), Rotherham was ranked 60 (out of 326 local authorities in England; first in the rank has highest rates) for rates of new STIs. A total of 2458 new STIs were diagnosed in residents of Rotherham, a rate of 951.4 per 100,000 residents (compared to 810.9 per 100,000 in England); 63% of diagnoses of new STIs in Rotherham were in young people aged 15-24 years (compared to 55% on average nationally)

Overall, Rotherham has significantly higher rate for STIs than that for England and is ranked third highest local authority in Yorkshire and Humber (Figure 1)

Figure 1: Rates of new STIs in each local authority in Yorkshire and Humber 2013



Source: Data from Genitourinary Medicine clinics and community settings (for Chlamydia only) Rates based on the 2012 ONS population estimates

Rotherham is ranked 59 (out of 326 local authorities in England) for the rate of gonorrhoea, which is a particular marker of high levels of risky sexual activity. The rate of gonorrhea diagnoses per 100,000 in this local authority was 51.9 (compared to 52.9 per 100,000 in England).

The rate of chlamydia detection per 100,000 young people aged 15-24 years in Rotherham was 3311.4 (compared to 2015.6 per 100,000 in England).

The high rates for chlamydia detection indicates *good* performance, as it means our services are strong on finding and treating chlamydial infection; and this will, in time,

lead to lower levels of infection circulating in the population. We do have relatively low rates of syphilis and rates of gonorrhea, close to the overall rate for England. These two are seen as markers of more ‘severe’ infection and give us a good indication of the overall health protection risk in the population. The rate of HIV is relatively low in Rotherham; we are not a “high incidence area” for HIV. The pattern we see in Rotherham is more of a young, sexually active population and a relatively controlled level of more serious infection, but we need to ensure that this control is maintained.

3.2 STI reinfection rates

Reinfection with an STI is a marker of persistent risky behaviour. In Rotherham, an estimated 4.2% of women and 4.8% of men presenting with a new STI at a Genitourinary medicine (GUM) clinic during the five year period from 2009 to 2013 became reinfected with a new STI within twelve months. This is significantly lower than national reinfection rates. Nationally, during the same period of time, an estimated 6.9% of women and 8.8% of men presenting with a new STI at a GUM clinic became reinfected with a new STI within twelve months.

Reinfection specifically with gonorrhea is also comparatively low and locally, as nationally, men are twice as likely to be reinfected compared to women. In Rotherham, an estimated 1.2% of women and 2.4% of men diagnosed with gonorrhoea at a GUM clinic between 2009 and 2013 became reinfected with gonorrhoea within twelve months. Nationally, an estimated 3.7% of women and 8.0% of men became reinfected with gonorrhoea within twelve months

3.3 Chlamydia

Chlamydia is an important cause of infertility, pelvic infection in women and testicular inflammation in men, and increases the risk of acquiring other sexually transmitted infections such as HIV.

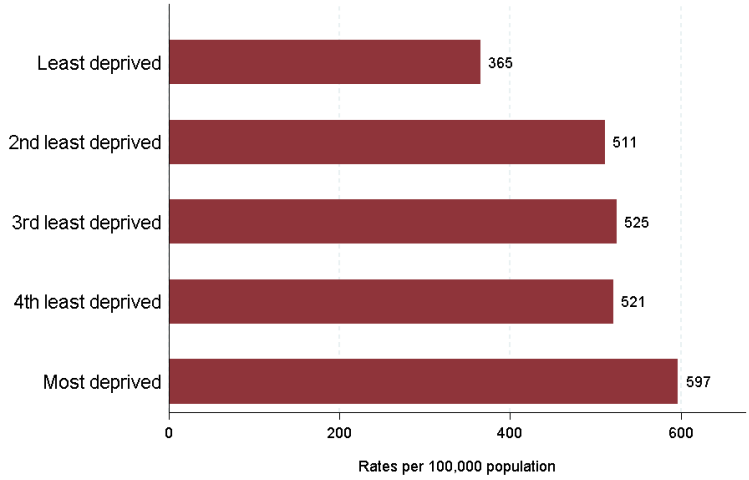
Chlamydia is the most common STI among Rotherham residents in 2013. The measure that we currently use to assess chlamydia is the rate of detection of disease. It may seem counterintuitive, but we want to keep the detection rate of chlamydia in Rotherham high. This is because we know there is a high background rate in the community, and having a high detection rate suggests we are identifying it effectively and treating it. Since chlamydia is most often asymptomatic, a high detection rate reflects success at identifying infections that, if left untreated, may lead to serious reproductive health consequences. The detection rate in Rotherham indicates that we have an effective detection programme in place, but that there is a considerable level of unprotected sexual activity and, thus, high levels of the infection circulating, within the targeted population of young people aged between 15 and 24 years of age.

The initial target, for effective detection, is 2,400 positive tests per 100,000 eligible population. The 2013 detection rate for chlamydia in Rotherham is 3,311.4 cases per 100,000, well above the Public Health Outcomes Framework recommendation. Our relatively high percentage of positive tests shows that testing in Rotherham is being effectively targeted towards the populations most at risk. However, as testing is currently predominantly from the core Integrated Sexual Health Services and Primary Care, we need to continue to ensure that access to testing is adequate for *all* young people, especially the more vulnerable, who may be less likely to access such services.

3.4 Distribution of new STIs and deprivation

Socio-economic deprivation is a known determinant of poor health outcomes; data from GUM services show a strong positive correlation between rates of new STIs and the Index of Multiple Deprivation across England. The relationship between STIs and socio-economic deprivation is probably influenced by a range of factors such as the provision of and access to sexual health services, education, health awareness, health-care seeking behaviour and sexual behaviour.

Rates of new STIs by deprivation category in Rotherham (GUM diagnoses only): 2013



Source: Data from Genitourinary Medicine Clinics
Rates based on the 2011 ONS population estimates
Excludes chlamydia diagnoses made outside GUM

3.5 HIV

HIV is nowadays considered to be a chronic disease which can be effectively managed. Crucially the earlier the diagnosis is made the more effective the treatment regime, and the more likely we are to prevent transmission to an uninfected person. Although overall numbers of those living with HIV is low in Rotherham (the diagnosed HIV prevalence being 1.0 per 1,000 population aged 15-59 years compared to 2.1 per 1,000 in England) we are seeing a larger number who present late with the infection. Between 2011 and 2013, 56% of HIV diagnoses in Rotherham were made at a late stage of infection (defined as CD4 count <350

cells/mm³ within 3 months of diagnosis) compared to 45% in England. Late diagnosis has implications for success and cost of treatment and onward transmission of the disease and is a critical component of the Public Health Outcomes Framework.

3.6 Abortion

The total abortion rate, access to NHS funded abortions at less than 10 weeks gestation, and under and over 25 years repeat abortion rates are indicators of lack of access to good quality contraception services and advice, as well as problems with individual use of contraceptive method and, potentially, poor access to termination services. Unplanned pregnancies can end in abortion or a maternity. Many unplanned pregnancies that continue will become wanted. However, unplanned pregnancy can cause financial, housing and relationship pressures and have impacts on existing children.

In 2013, in Rotherham upper tier local authority the total abortion rate per 1,000 female population aged 15-44 years was 12.7, while in England the rate was 16.6. The rank (out of 146 upper tier local authorities) within England for the total abortion rate (1st has the highest rate) was 123.

Among NHS funded abortions in Rotherham, the proportion of those under 10 weeks gestation was 69.5%, while in England the proportion was 79.4%. The earlier abortions are performed the lower the risk of complications. Prompt access to abortion, enabling provision earlier in pregnancy, is also cost-effective and an indicator of service quality and increases choices around procedure. There is considerable room for improvement in earlier access to terminations in Rotherham.

However Rotherham does perform relatively well in terms of repeat termination rates. In 2013, among women under 25 years who had an abortion in Rotherham, the proportion of those who had had a previous abortion was 21.1%, while in England the proportion was 26.9%.

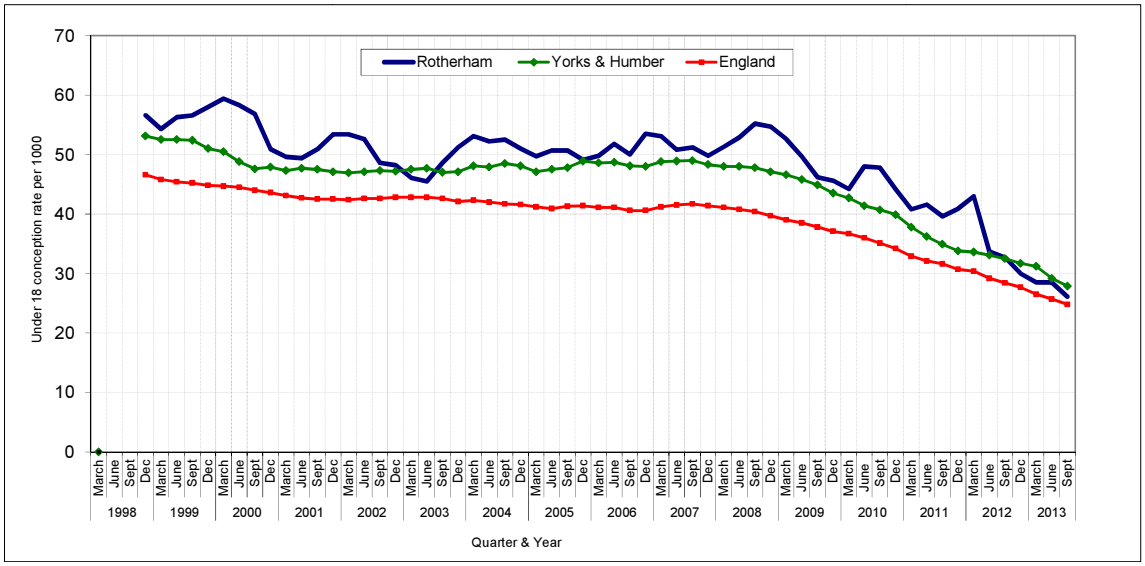
3.7 Teenage pregnancy

Continuing to reduce under 18 pregnancies is a high priority as highlighted by the inclusion of this as an indicator in the Public Outcomes Framework.

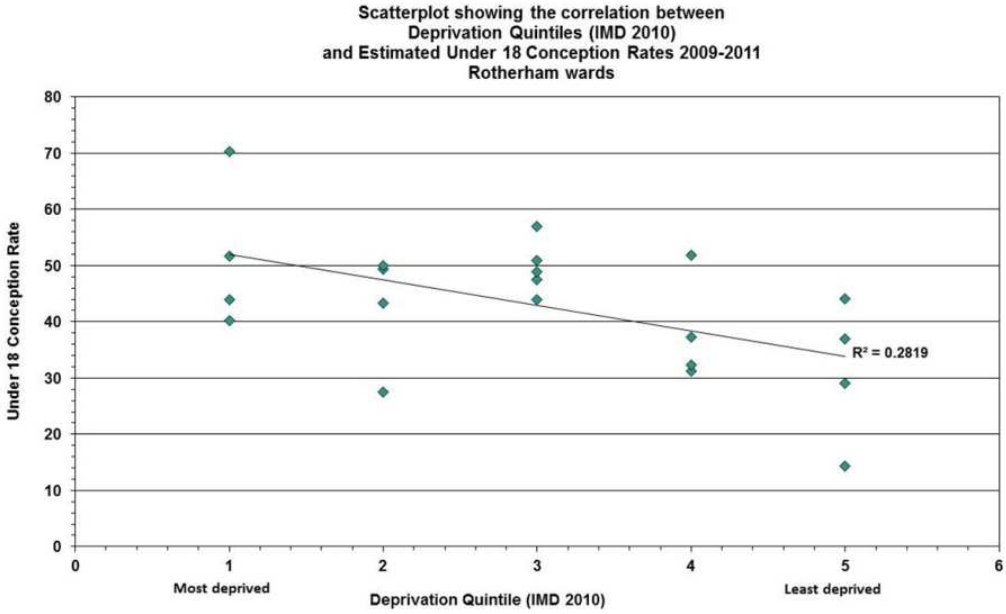
Teenage pregnancy in Rotherham has fallen over the past few years due, in part, to increasing take up of Long Acting Reversible Contraception (LARC). Rotherham's under 18 conception rate fell to its lowest in the period 1998-2012 at 30.0 conceptions per 1,000 females aged 15-17 years. This represents 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%. Data by quarter for September 2013 is at its lowest ever with a provisional rate of 20.1, with quarterly rates decreasing since December 2012. Impressively, this is lower than the England rate (22.2 females aged 15-17 years).

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 – 2013 Q3
Rotherham compared to Yorkshire & the Humber and England
(rolling 4 quarterly average)



In Rotherham (as with the rest of the country) there is a clear relationship between conception rate and deprivation and interventions have been targeted to work with deprived young people to address risk and raise self-esteem and aspiration



3.8 Sexual and reproductive health profile

The Sexual and Reproductive Health Profile for Rotherham is a data set published by PHE which shows a range of sexual and reproductive health indicators as well as indicators covering the wider determinants of health (see Appendix 1).

The indicators show a level of deprivation with high rates of youth offending, young people not in education and training and young people experiencing poverty. We are, however, seeing good progress in the educational attainment of our young people and this has been a contributory factor in the excellent progress in the reduction of teenage conceptions. Overall, given the level of deprivation in Rotherham, we are seeing a promising picture in relation to uptake of contraception, risky behaviour taking and teenage conceptions. However, there are some areas for improvement. Although we do have a good uptake of HIV testing, for example, we do need to improve our rates of early diagnosis to ensure the best health outcomes.

4 A life course approach

In order for people to stay healthy, know how to protect their sexual health and how to access appropriate services and interventions when they need them, everyone needs age appropriate education, information and support.

For all young people it is important that they receive high quality education about sex and relationships. Focusing especially on our young people is crucial, as early established behaviour patterns can affect health throughout life. We need to prioritise prevention for our young people aged 16 to 19 years, who tend to have significantly higher rates of poor sexual health than older people,. It is important that all our young people:

- know how to ask for help and able to access confidential advice and support about wellbeing, relationships and sexual health;
- have the confidence and emotional resilience to understand the benefits of loving, healthy relationships and delaying sex;
- understand consent and issues around abusive relationships;
- make informed and responsible decisions, understand issues around consent and the benefits of stable relationships and are aware of the risks of unprotected sex;
- have rapid and easy access to appropriate services
- whatever their sexuality, have their sexual health needs met.

We will have a comprehensive Sexual Health Service and School Nursing Service in Rotherham providing support to the school curriculum. The School Nursing Service will provide contraceptive advice and/or referrals to sexual health services and support schools in their delivery of puberty education.

All Rotherham schools will be engaged with services and provide consistent and robust Sex and Relationship Education. This will address what is appropriate sexual behaviour and where to seek help or advice,e as well as what the risks are of becoming pregnant or contracting an STI. Our aim is that Head Teachers and Governing bodies will fully support sexual health initiatives within their schools.

We will have a fully integrated Sexual Health Service provided at main clinic sites and at youth clinics across the Borough, providing open access, non-judgemental services for all young people.

We will have General Practitioners (GPs) across the borough who are 'young

person friendly' and provide a range of sexual health and contraceptive services to any young person requesting them.

We will have pharmacies in Rotherham who provide, free of charge to the end user, Emergency Hormonal Contraception to young women who need this service and who signpost into other services when necessary.

For all our adults we need them to have access to high quality services and information. For our older residents we want them to remain healthy as they age. We will ensure that:

- all Rotherham residents understand the range of choices of contraception and where to access them;
- people with additional needs are identified and appropriately supported;
- all Rotherham residents have information and support to access testing and early diagnosis to prevent the transmission of HIV and STIs;
- people of all ages understand the risks of unprotected sex and how they can protect themselves;
- older people with diagnosed HIV are able to access any health and social care services they need;
- people with other physical problems that may affect their sexual health are able to access the support they need.

We* will have *a fully integrated open access Sexual Health Service, providing a full range of contraceptive and STI testing/treatment services for all Rotherham residents.

We will have prompt access to abortion services earlier in pregnancy

GPs across the Borough will offer a comprehensive sexual health service to their patients including a range of contraception and STI testing working in collaboration with the commissioned specialist services.

We will develop and sustain third sector sexual health services to increase access and reduce late diagnoses and we will ensure that all our health professionals fully engage with these services.

Robust care pathways will be adopted across all services to reflect individual and complex needs.

5 Prevention

Sexual health promotion and prevention aims to help people to make informed and responsible choices in their lives. Effective sexual health promotion programmes can help to address the prejudice, stigma and discrimination that can be linked to sexual ill health. Such programmes can help to tackle the factors that can influence sexual health outcomes.

Prevention must be our priority, including in our treatment services.

- we will have a sexual health culture in Rotherham that prioritises prevention and supports behaviour change
- we will make sure that the people of Rotherham are motivated to practice safer sex
- we will increase awareness of sexual health among local healthcare professional as part of the making every contact count approach.

All health professionals in our commissioned services will prioritise prevention and encourage and support behaviour change.

A 'culture' of prevention will be embedded within all services, not just our specialised commissioned ones. All professionals will make every contact count and be aware of how they can play a part in ensuring good sexual health for all Rotherham people.

All services, agencies, health professionals, workplaces, schools and colleges will encourage practices that promote good sexual health.

6 Safeguarding

The *Jay Independent Inquiry into Child sexual Exploitation in Rotherham 1997-2013* commissioned by RMBC and published in August 2014 set out the scale and nature of child sexual explotation (CSE) in Rotherham and made far reaching recommendations for improvements, which have and continue to be responded to by all partners. The CSE Strategy and Action Plan is led by the Local Safeguarding Children Board,

It is important that all service providers are aware of child protection and safeguarding issues and the possibility of abuse and/or exploitation and work collaboratively to protect all children under 18 years of age. Sexual health services have a particular role to play in identifying risk and managing the impact of sexual abuse and or exploitation and, by working together with others and sharing intelligence, contributing to the protection of vulnerable young people and the pursuit and prosecution of perpetrators.

The Sexual Offences Act 2003 provides that the age of consent is 16 and that sexual activity involving children under 16 is unlawful. The age of consent also reflects the fact that children aged under 16 are particularly vulnerable to exploitation and abuse.

We know that approximately 25% of young people under 16 in Rotherham are sexually active (Rotherham Lifestyle Survey Report 2013). It is important, therefore, that any young person under 16 who is sexually active should have confidence to attend sexual health services and have early access to professional advice, support and treatment.

We will ensure that:

- all our providers of sexual health services are aware of the child protection procedures in Rotherham and work proactively and collaboratively to protect and support our vulnerable young people.
- all our providers of sexual health services have robust guidelines and referral pathways in place for risk assessment and management of child sexual abuse, including child sexual exploitation;
- all our young people have equitable access to confidential sexual health services including emergency contraception and abortion;

We will have robust referral pathways and consistent approaches to identify risk and vulnerability to Child Sexual Exploitation which will be adopted by all services.

Services will offer the best evidence based support and protection for young people who are victims and/or at risk from sexual abuse and/or exploitation.

Survivors of abuse of any age, and parents and families affected by child sexual abuse and/or exploitation will have access to support

We will adopt interventions, based on evidence of best practice, in relation to preventing potential perpetrators from abusing/exploiting vulnerable young people.

7 Health improvement

Prevention is key to good sexual health and there are some issues where additional focus is needed to improve outcomes.

In the prevention of unwanted teenage pregnancies (under 18 years) there is strong evidence to suggest that high quality education about relationships and sex and access to, and correct use of, effective contraception is key. In Rotherham there is a clear relationship between teenage conception rate and deprivation and interventions have been targeted to work with young people from the most deprived areas to address risk and raise self-esteem and aspiration.

Increased use of the highly effective LARC methods to prevent unwanted pregnancy could potentially lead to a perception that a condom is unnecessary. The best way for sexually active people of any age to avoid an STI is to use a condom when they have sex. Promotion of, and access to, all methods of contraception is important.

Our most vulnerable young people often lead chaotic lifestyles, are often found in the care system and/or have special educational needs. Interventions need to be targeted effectively.

- young people in Rotherham will receive appropriate information and education to enable them to make informed decisions
- young people in Rotherham will have access to the full range of contraceptive methods
- young people in Rotherham will have the appropriate support to ensure that they have ambitions, stay engaged, reach high levels of educational attainment and have the best start in life

All services and professionals working with young people will give consistent messages in relation to prevention of unwanted pregnancy and STIs.

We will have a wide range of services offering sexual health advice, information and treatment and a full range of contraceptive services available across the Borough in a variety of settings to ensure we engage with all our young people.

We will develop specialised services to work with hard to reach, vulnerable groups such as the Roma community and young people in care, and adopt specific, evidence based, targeted interventions.

We will reinforce aspiration as the 'social norm' in all sections of society.

8 Health protection

The Health and Social Care Act (2012) places the overall responsibility for Infection Prevention and Control with the Director Public Health. The legislation enables and requires the Local Authority to intervene and take action to protect the health of the population. Protecting the public from infection relies on maintaining rates of testing and early treatment to prevent spread. Those who are infected must be confident that they will be treated well when getting tested and treated.

Researchers looking at barriers to getting tested and treated for STIs have identified a number of recurrent themes, which include

- not being able to afford testing or treatment
- concerns about the confidentiality
- concerns about stigma
- feeling that the services were not appropriate because of cultural or language barriers

The strategic responsibility of the Local Authority includes prevention, surveillance, planning and response to local incidents and outbreaks.

- RMBC and all partners will support preventive actions to protect the health of the population
- all sexual health incidents and outbreaks to be dealt with effectively at the most appropriate level
- we will have local plans and capacity to monitor and manage acute incidents to help prevent the transmission of sexually transmitted infections and to foster improvements in sexual health

We will have comprehensive Health Protection plans agreed and in place. We will have reporting systems and care pathways which are used effectively and monitored.

Our services will make early diagnosis their priority and encourage people to take up opportunities for testing. We will promote testing for STIs in a positive way to reduce stigma and make it more acceptable.

We will ensure services are free at the point of use to ensure that lack of money does not become a barrier to accessing services.

We will ensure that services respect confidentiality and provide for the diverse cultural and linguistic needs of our population.

9 Improving outcomes through effective commissioning

Evidence demonstrates that spending on sexual health interventions and services is cost effective and has a marked effect on other healthcare costs. Preventing unwanted pregnancies and reducing levels of sexual ill health in the population also impacts on social care budgets, benefits, housing and the overall economy of Rotherham. Good sexual health has a clear role to play in improving health and reducing health inequalities.

The new commissioning arrangements for sexual health services have been in force since 1st April 2013. RMBC is mandated to commission for comprehensive sexual health services which includes contraception, STI testing and treatment, Chlamydia screening as part of the screening programme and HIV testing. Rotherham CCG commissions abortion services, sterilisation, psychosexual counselling and Gynaecology (including any use of contraception for non-contraceptive purposes). The third commissioner of Rotherham's sexual health services is NHS England which is responsible for commissioning HIV treatment and care and the Sexual Assault Referral Centre (SARC). It is vital for commissioners to work closely together to ensure that the care and treatment the people of Rotherham receive is of high quality and is not fragmented.

A key principle of sexual health services is that they are open access, confidential and free of charge for the user. There are strong public health reasons why this should continue.

- our commissioners will work in partnership with all key players to develop a joint commitment to improving sexual health in Rotherham
- we will have challenging but achievable outcome measures for our services using robust data and needs assessment
- we will ensure value for money from our services and interventions and they will be developed and delivered to tackle the wider determinants of sexual health in Rotherham and targeted at groups who may be vulnerable and at risk from poor sexual health
- our interventions and services will be commissioned from high quality providers who have appropriately trained staff meeting recognised national professional guidelines

We will have a joint sexual health commissioning strategy agreed at a local level and all commissioners will have consistent, agreed outcome measures with providers.

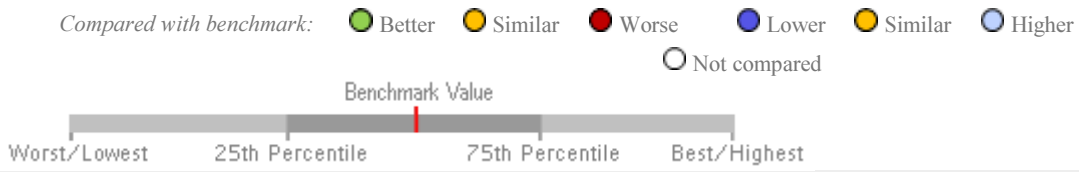
Robust data will be collected by all providers and an information sharing system will be in place with commissioners.

Providers will provide good quality, value for money services. They will work within their agreed budgets and to target their evidence based services appropriately.

All providers of sexual health services will evidence levels of competence/training and will ensure continual professional development of all their staff.

Appendix 1

Sexual and Reproductive Health Profile



Indicator	Period	Rotherham		Region	England	England		
		Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Syphilis diagnosis rate / 100,000	2013	1	0.4	3.7	5.9	90.9		0.0
Gonorrhoea diagnosis rate / 100,000	2013	134	51.9	37.5	52.9	533.2		3.6
Chlamydia diagnosis rate / 100,000 aged 15-24 (PHOF indicator 3.02) <1,900 1,900 to 2,300 ≥2,300	2013	1,039	3,311	2,169	2,016	840		5,758
Chlamydia diagnosis rate / 100,000 aged 15-24, pre-2012 data <2,000 2,000 to 2,400 ≥2,400	2011	819	2,591	2,277	2,097	948		4,911
Chlamydia proportion aged 15-24 screened	2013	10,730	34.2%	24.4%	24.9%	10.6%		58.2%
Genital warts diagnosis rate / 100,000	2013	410	158.7	125.2	133.4	288.6		70.7
Genital herpes diagnosis rate / 100,000	2013	171	66.2	51.3	58.8	182.9		21.4
All new STI diagnoses (exc Chlamydia aged <25) / 100,000	2013	1,399	846	674	832	349		3,269
STI testing rate (exc Chlamydia aged < 25) / 100,000	2013	26,826	16,213	12,429	14,685	6,588		53,921
STI testing positivity (exc Chlamydia aged	2013	1,399	5.2%	5.4%	5.7%	4.0%		9.9%

Indicator	Period	Rotherham		Region England	England	England		
		Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
<25) %								
HIV testing uptake, MSM (%)	2013	46	97.9%	94.5%	94.8%	86.1%		100%
HIV testing uptake, women (%)	2013	2,292	82.6%	71.9%	75.8%	29.0%		94.4%
HIV testing uptake, men (%)	2013	2,185	85.9%	81.7%	84.9%	58.4%		95.9%
HIV testing coverage, MSM (%)	2013	37	94.9%	85.9%	86.1%	63.3%		100%
HIV testing coverage, women (%)	2013	2,092	75.7%	63.8%	65.6%	26.0%		85.2%
HIV testing coverage, men (%)	2013	2,029	79.7%	75.7%	77.5%	50.6%		86.9%
HIV late diagnosis (%) (PHOF indicator 3.04) <25%25% to 50%≥50%	2011 - 13	14	56.0%	51.6%	45.0%	77.3%		25.9%
HIV diagnosed prevalence rate / 1,000 aged 15-59	2013	157	1.05	1.26	2.14	0.37		14.70
Population vaccination coverage - HPV (%) (PHOF indicator) <previous year's England value≥previous year's England value	2012/13	1,537	91.5%*	89.4%	86.1%	62.1%		96.2%
Abortions under 10 weeks (%)	2013	421	69.5%	76.3%	79.4%	55.6%		87.4%
Under 25s repeat abortions (%)	2013	62	21.1%	26.3%	26.9%	49.2%		13.9%
Total abortions rate / 1,000	2013	613	12.7	14.5	16.6	32.4		9.0
GP prescribed LARC rate / 1,000	2013	2,879	60.3	66.9	52.7	7.5		96.3
Pelvic inflammatory disease (PID) admissions rate / 100,000	2012/13	151	311.9	229.2	228.3	693.9		70.9
Ectopic pregnancy admissions rate /	2012/13	45	92.9	88.4	94.7	173.1		14.0

Indicator	Period	Rotherham		Region	England	England		
		Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
100,000								
Cervical cancer registrations rate / 100,000	2009 - 11	-	10.4	10.5	8.8	17.4		3.0
Under 18s conceptions rate / 1,000 (PHOF indicator 2.04)	2012	144	30.0	31.7	27.7	52.0		14.2
Under 16s conceptions rate / 1,000 (PHOF indicator 2.04)	2012	32	6.8	6.8	5.6	15.8		2.0
Under 18s conceptions leading to abortion (%)	2012	67	46.5%	41.3%	49.1%	27.3%		79.5%
Under 18s abortions rate / 1,000 (based on year of conception)	2012	67	14.0	13.1	13.6	7.1		25.8
Under 18s births rate / 1,000 (based on year of conception)	2012	77	16.1	18.6	14.1	33.8		3.0
Sexual offences rate / 1,000 (PHOF indicator 1.12iii)	2013/14	212	0.82	1.10	1.01	0.38		2.43
Under 18s alcohol-specific hospital admissions rate / 100,000	2010/11 - 12/13	63	37.4	44.1	44.9	117.3		15.2
Percentage people living in 20% most deprived areas in England	2012	86,125	33.3%	27.8%	20.4%	83.8%		0.0%
Under 16s in poverty (%) (PHOF indicator 1.01ii)	2011	11,525	23.2%	21.7%	20.6%	43.6%		6.9%
GCSE achieved 5A*-C inc. Eng & Maths (%)	2012/13	2,224	63.6%	59.5%	60.8%	43.7%		81.9%
16-18 year olds not in education employment or training (%) (PHOF indicator 1.05)	2013	620	6.4%	5.7%	5.3%	9.8%		1.8%
Pupil absence (%) (PHOF indicator 1.03)	2012/13	763,158	5.93%	5.45%	5.26%	6.31%		4.36%
First time entrants to	2013	134	535	459	441	847		171

Indicator	Period	Rotherham		Region	England	England		
		Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
the youth justice system rate / 100,000 (PHOF indicator 1.04)								

Sexual Health Strategy for Rotherham 2015 – 2017

Framework for Delivery

Strategic Priorities	Actions	Responsibity (lead in bold)
Prevention and early diagnosis of STIs and sexual ill health • increase in awareness of sexual health among local healthcare professionals as part of the making every contact count approach • all children and young people to know how to ask for help and to be able to access confidential advice and support about wellbeing, relationships and sexual health • all young people to have the confidence and emotional resilience to understand the benefits of loving, healthy relationships and delaying sex • all young people to understand consent and issues around abusive relationships • all young people to make informed and responsible decisions, understand issues around consent and the benefits of stable relationships and are aware of the risks of unprotected sex • older people with diagnosed HIV to access any health and social care services they need • people with other physical problems that may affect their sexual health to access the support they need • young people to receive appropriate information and education to enable them to make informed decisions • young people to have the appropriate support to ensure they have ambitions, stay engaged, reach high levels of educational attainment and have the best start in life	Ensure that sexual health is included in appropriate training packages – produce action plan for delivery including timelines Map the provision of Sex and Relationship Education across Rotherham schools. Ensure all young people in schools have access to good quality SRE - target schools where this is not in place – produce action plan including timelines Ensure the delivery of good quality SRE and HIV prevention in all educational settings – review activity – produce action plan to target young people not in education and LAC Review support for vulnerable individuals and groups to access sexual health services – produce action plan for delivery including timelines Review and rewrite the Sexual Health Policy for LAC and Children leaving care with particular reference to CSE	**RMBC PH** **School Improvement Service**/Head Teachers/Governing Bodies **School Improvement Service**/Head Teachers/Governing Bodies/ IYSS **RMBC PH /**CCG//The Gate general practice **RMBC PH/**LAC team

Reduction in unintended conceptions and repeat terminations • have a sexual health culture in Rotherham that prioritises prevention and supports behaviour change • make sure that the people of Rotherham, especially those most at risk of poor sexual health, are motivated to practice safer sex • young people to have access to the full range of contraceptive methods • all young people to have easy access to confidential sexual health services including emergency contraception and abortion	Review youth clinics provision – produce action plan including timescale Review and assess the current Hardwear scheme and relaunch Deliver EHC in the community (pharmacy) to age 14-16, including CSE referral pathway	**RFT/RMBC IYSS** **RFT/RMBC IYSS** **Pharmacy/RMBC IYSS**
Commissioning and delivery for good sexual health taking a life course approach • young people to have rapid and easy access to appropriate services • all young people, whatever their sexuality, to have their sexual health needs met • all Rotherham residents to understand the range of choices of contraception and where to access them • people with additional needs to be identified and appropriately supported • all Rotherham residents to have information and support to access testing and early diagnosis to prevent the spread of HIV and STIs • people of all ages to understand the risks of unprotected sex and how they can protect themselves	Review the School Nursing Service specification to include performance monitoring of sexual health promotion and sexual health services Ensure the provision of support for consistent and robust Sex and Relationship Education across Rotherham schools – produce action plan including timescales Commission pharmacy EHC services to extend access to 14-16 year olds Ensure all providers of services to young people undertake child sexual exploitation (CSE) training appropriate to their level of intervention	**RMBC PH** School Nursing/**School Improvement Service**/Governing Bodies **RMBC PH** **LSCB**

Commissioning and delivery of high quality, open access, integrated sexual health services • commissioners to work in partnership with all key players to develop a joint commitment to improving sexual health in Rotherham • challenging but achievable outcome measures for our services using robust data and needs assessment • interventions and services to be commissioned from high quality providers who have appropriately trained staff meeting recognised national professional guidelines • Ensure that commissioned providers have a commitment to training for staff to ensure that there are enough well trained staff locally • ensure value for money from our services and equity of access and outcomes	Conduct a sexual health needs assessment to inform commissioning Review service specification for the Integrated Sexual Health Service (ISHS) to ensure value for money, and effective targeting of those most vulnerable to poor sexual health, including sexual abuse and/or exploitation Review Primary Care sexual health services to maximise uptake of LARC Review service specifications for termination services to drive improvement in access to termination <10 weeks gestation Review service specifications for support services from the third sector to maximise take up by vulnerable groups especially in relation to HIV prevention and earlier diagnosis Deliver an integrated sexual health service (ISHS) at main clinic and outreach sites – produce action plan including timescales for integration	**RMBC PH** **RMBC PH** **RMBC PH** **CCG** **RMBC PH** **RFT**

Commissioning an evidence based and sustainable response to child sexual abuse and exploitation • robust referral pathways and consistent approaches to identify risk and vulnerability to Child Sexual Exploitation adopted by all services. • evidence based support and protection provided for all young people who are victims and/or at risk from sexual abuse and/or exploitation • survivors of abuse of any age, and parents and families affected by child sexual abuse and/or exploitation have access to support • evidence based interventions are adopted to prevent potential perpetrators from abusing/exploiting vulnerable young people.	Conduct a CSE needs analysis to inform commissioning Develop and implement a joint commissioning strategy in response to the CSE needs analysis, including provision for post abuse support Ensure all commissioned services have appropriate guidelines and referral pathways in place for risk assessment and management of CSE and workforce training appropriate to the level of intervention provided by the service	**RMBC PH** **RMBC, RCCG, NHS E, PCC** **LSCB**

ROTHERHAM BOROUGH COUNCIL – REPORT TO CABINET MEMBER

1	**Meeting:**	**Cabinet Member for Adult Social Care and Health**
2	**Date:**	**26 January 2015**
3	**Title:**	**Care Act 2014 – Communications, Updates and Briefings**
4	**Directorate:**	**Neighbourhoods and Adult Services**

5 **Summary**

The Care Act 2014 represents the most significant change to Adult Social Care in three decades. It brings together much of the relevant legislation from the 1948 National Assistance Act to present day, repealing some laws and putting into statute some elements which to date have only been covered through guidance.

An initial report was presented to Cabinet on 16 June 2014, outlining the scope of the legislation and how RMBC is proposing to approach the changes. A key element of these changes is communication, and ensuring timely information is provided to key decision makers and senior manager.

Key information will be available in stages and it is proposed to manage this through a series of briefings. Key decisions will always be handled through Council decision making process.

6 **Recommendations**

- **Cabinet Member approves the mechanism of briefing notes to provide key information on the delivery of preparations for the Care Act 2014.**

7 **Background Information**

The Care Act 2014 supports legislation change across Adult Social Care. RMBC has established a Care Act Steering Group with a series of sub-groups and enabling groups. Each group has taken responsibility for delivering on elements of the Act.

These are:

Sub Group	Lead
Information, Advice and Guidance	Sarah Farragher
Assessment/Eligibility and Transition – the customer journey	Michaela Cox /John Williams
Finance, Deferred Payments, Charges and Care Accounts	Mark Scarrott
Policy Group	Michael Holmes
Communication and Customer Engagement	Tanya Palmowski
Commissioning	Janine Parkin
Safeguarding	Sam Newton
Carers	Janine Moorcroft

The groups are structured, each having Terms of Reference, Risk Log and Action Plan. The Risk Logs and Action Plans have been formulated into a single overall plan for Rotherham.

ADASS have requested the completion of two stocktakes, to date. The one completed in the Summer indicated that Rotherham had some risk areas. However these have been addressed and the Autumn stocktake summarised our progress as Green in 5 domains and Amber in 4. This places us in the top third of Local Authorities, and indicates that there are no concerns with progress.

There is a regional Care Act Group, led by Pete Lenahan, an ADASS project lead. RMBC is an active participant in this group.

The final guidance, which forms part of the legislative framework, was issued in late October, and now means that the pace of change has to significantly increase.

One of the sub-groups focuses on Policy Development and will ensure that all key decisions are supported with an effective framework of consultation, research, legal advice, equalities assessment and implementation plan.

There are other areas which will require the delivery of key information, such as finance, and it is proposed to produce a series of briefings to ensure key

people are kept informed of what will be a complex, intensive and broad piece of work. The attached briefing on finance provides an example.

8 **Risks**

- Key element of the ADASS Stocktake is information, ensuring stakeholders and decision makers are kept informed. This process reduces the risk of lack of information.

- Current Corporate Governance Inspection – resources are allocated to supporting this process.

- Information overload – that people receive too much information. Every effort will be made to ensure briefings are accessible/easy read and can be placed on the website to inform customers and others.

9 **Policy and Performance Agenda Implications**

The Care Bill Tracker will ensure that all elements of Part 1 of the Act are addressed. In addition, Part 2, which relates to CQC activity, Part 3 relating to Health Education England, and parts 4 and 5 which relate to integration and general orders will be reviewed to ensure that any related links to Adult Social Care and Public Health Services are known and addressed.

The Customer Engagement Sub Group will ensure that all changes are co-produced, ensuring that customers are kept at the heart of the process.

An Impact Assessment is being produced.

This process results in significant changes to Council Policy – both in terms of amendment to existing and new policy. Consideration is being given to the way in which these changes can be managed efficiently in respect of Council decision making and approval processes, including consultation with members, and Cabinet timetables.

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ROTHERHAM BOROUGH COUNCIL – REPORT TO MEMBERS

1	**Meeting:**	**Cabinet Member for Adult Social Care and Health**
2	**Date:**	**Monday 26th January 2015**
3	**Title:**	**Adult Services Revenue Budget Monitoring Report 2014/15**
4	**Directorate :**	**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 November 2014.

The latest forecast for the financial year 2014/15 shows an overall overspend of £468k against an approved net revenue budget of £69.751m, this represents a reduction of £268k 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	1,645	-165	-9.12
Older People	28,261	28,337	+76	+0.27
Learning Disabilities	22,179	22,806	+627	+2.83
Mental Health	4,759	4,548	-211	-4.43
Physical & Sensory Disabilities	5,390	5,585	+195	+3.62
Safeguarding	686	712	+26	+3.94
Supporting People	6,666	6,586	-80	-1.20
Total Adult Services	**69,751**	**70,219**	**+468**	**+0.67**

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 (-£165k)

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.

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Older People (+£76k)

- Recurrent budget pressure on Direct Payments over budget (+£367k). Client numbers have increased (+82) since April together with an increase in the average cost of care packages.
- Forecast under spend on Enabling Care and sitting service (-£88k) based on current level of service together with an overspend within Independent sector home care (+£50k), which has experienced a slight reduction in demand (-35 clients) since April.
- An over spend on independent residential and nursing care (+£621k) due to delays in achieving the savings target for additional Continuing healthcare income. Additional income from property charges is reducing the overall overspend.
- Underspend within In house Residential care and Day Care services due to vacancies pending restructure, additional income from self- funders together with winter Pressures funding (-£217k).
- Planned delay's on recruitment to vacant posts within Assessment & Care Management plus additional income from Health is resulting in an overall underspend (-£479k).
- Overall under spend on Rothercare (-£145k) 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 (-£33k).

Learning Disabilities (+£627k)

- Independent sector residential care budget is forecasting a underspend of (-£172k). Realisation of continued work reviewing all CHC applications and high cost placements as part of budget savings target.
- Forecast overspend within Day Care Services (+£130k) 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 (+£71k) 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 (-£101k).
- 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 (+£430k).
- Staff turnover lower than forecast within In House Residential Care (+£97k) reduced by saving on RDASH administration support (-£27k).

Mental Health (-£211k)

- A projected under spend on residential care budget (-£154k) due to a reduction of 5 placements since April plus additional Public Health funding for substance misuse.
- Reduced Pressures on employee budgets due to lower than expected staff turnover plus review of night cover arrangements (-£11k) offset by underspend on Community Support and Direct Payments (-£46k) due to a review of a number of care packages plus additional Public Health funding.

Physical & Sensory Disabilities (+£195k)

- Further increase in demand for Direct Payments (+41 clients since April) in addition to a recurrent budget pressure is forecasting an overspend (+£347k).
- Efficiency savings on contracts for advice and information (-£18k).
- Independent sector Residential care is now forecasting an underspend (-£64k) as one client is now supported by another authority.
- Underspend on Independent sector homecare (-£55K) as clients migrate to direct payments scheme.
- Slight underspends on independent day care, therapy and equipment support (-£15k).

Safeguarding (+£26k)

- The increase in demand for assessments under Deprivation of Liberty Safeguards (154 completed 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 (-£80k)

- 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 November 2014 was £130,961 (no off contract), this is a significant reduction compared with actual expenditure of £254,082 (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 November 2014 was £132,130 compared with £273,472 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 30 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 (16th 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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ROTHERHAM BOROUGH COUNCIL – REPORT TO MEMBERS - EXEMPT

1.	**Meeting:**	**Cabinet Member for Adult Social Care and Health**
2.	**Date:**	**Monday 26th January 2015**
3	**Title:**	**Setting In House Residential Accommodation Charges 2015/16**
4	**Directorate:**	**Adult Services**

5. Summary

5.1 The Council has a statutory duty to set a maximum charge for residential accommodation provided in Local Authority Homes. This charge has to reflect the costs of providing residential care which includes expenditure such as running costs and management overheads.

5.2 This report details the proposals for increasing the charge to service users for the provision of in-house residential care for the 2015/16 financial year to take account of inflation.

6. Recommendations

- **That the charges set out Appendix 1 are agreed with effect from April 2015.**

7. Proposals and Details

7.1 General

7.1.1 In accordance with its statutory duty, the Council is required to set a maximum charge for residential accommodation it provides in Local Authority Homes for:

- Those service users who refuse to provide details of their financial circumstances.
- Those service users who have been financially assessed according to their ability to pay and as a result are required to pay the maximum charge i.e. have savings/assets of more than £23,250. Currently this affects 17 people.
- Those service users who are placed and financially supported by another Local Authority. Currently this affects 1 person.

7.1.2 All other service users with savings of less than £23,250 will be financially assessed according to the income they receive which is generally made up of retirement pension and/or other welfare benefits. Their charges will increase in line with welfare benefits increases of 2.5%. The average charge is currently around £247 per week.

7.2 Homes for Older People

7.2.1 It is proposed that the maximum charge for all local authority residential care homes is increased by 2.5% in line with the increase in welfare benefits.

7.2.2 As Members will note from the attached appendix 1, the proposed charge based on this approach will be £550 per week. This is an increase on the current charge of £13.00 per week (2.5%). For information the maximum charge for residential care in the independent sector from April 2015 is likely to be £401per week.

7.2.3 Currently 18 people are required to pay the maximum charge. The proposal to increase the maximum charge by 2.5% is to align the percentage increase with the increase applied to service users in receipt of welfare benefits.

7.3 Homes for Other Service User Groups

7.3.1 The proposed revised charges for other service user groups has limited immediate impact as there is currently only 1 client paying the full cost. Attached at Appendix 1 are details of the proposed revised charges. These charges reflect the actual unit costs of providing the services.

8. Finance

8.1 The Directorate is required to review its fees and charges as part of the annual budget setting process. The proposed increase of 2.5% is in line with the increase in welfare benefits which is based on CPI inflation as at September 2014, with a minimum guarantee of 2.5%.

8.2 This would mean an increase in charge of £13 per week from £537 to £550 from April 2015 for In House Elderly Residential care. This would generate additional income of £12,170 in a full year.

9. Risks and Uncertainties

9.1 In accordance with established practice, all the charges are based on estimated cost and occupancy levels, so that residents can be advised of the revised charges as near to the date they become effective as possible. Members should note that the actual full costs may be higher than those proposed due to further reductions in occupancy levels or due to a change in the number of service users paying full cost.

10. Policy and Performance Agenda Implications

10.1 These recommendations are consistent with the Commissioning and Use of Resources outcome contained in the Social Care Outcomes Framework in that services are commissioned and delivered to clear standards of both quality and cost, by the most effective, economic and efficient means available and so demonstrate value for money.

11. Background Papers and Consultation

11.1 This report has been discussed with the Director of Adult Social Services.

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Neighbourhoods and Adult Services

IN HOUSE RESIDENTIAL ACCOMMODATION CHARGES – 2015/2016

1.1 Maximum Charge for People Accommodated in residential care homes

SERVICE	Budgeted Occupancy Levels	Charges 2014/2015	Charges 2015/2016	Change in Maximum Charge from 2014/15
	%	£	£	£
Homes for the Elderly	**96**	**537.00**	**550.00**	**+13.00**
Non Elderly :-				
Parkhill Lodge	**98**	**638.01**	**672.17**	**+34.16**
Quarryhill Road	**95**	**1493.41**	**1453.57**	**-39.84**
Treefield Close	**95**	**1493.41**	**1453.57**	**-39.84**

NB. The maximum charges for Non elderly homes are based on the economic costs of providing the service.

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