CABINET MEMBER FOR ADULT, SOCIAL CARE AND HEALTH

Venue: **Town Hall, Moorgate Street, Rotherham.**

Date: **Monday, 31 March 2008**

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 the Local Government Act 1972.

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

3. Apologies for Absence.

4. Minutes of the previous meeting held on 10th March, 2008 (Pages 1 - 2)

5. CSCI Report (Pages 3 - 22)

6. Commissioning Strategy (Pages 23 - 28)

7. ESCR Report (Pages 29 - 31)

8. Joint Commissioning Strategy (Pages 32 - 98)

9. Adult Services 3rd Quarter (April to December) Performance Report, 2007/08 (Pages 99 - 103)

10. Capital Budget Monitoring Report 2007/08 (Pages 104 - 109)

11. Adult Services Revenue Budget Monitoring Report 2007/08 (Pages 110 - 114)

LATE ITEM

12. Charging for Transport - Consultation Report (Pages 115 - 119)

13. Date and time of next meeting:-
    Monday, 7th April, 2008.

ADULT, SOCIAL CARE AND HEALTH
10th March, 2008

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

101. MINUTES OF PREVIOUS MEETING HELD ON 25TH FEBRUARY, 2008

Resolved:- That the minutes of the previous meeting held on 25th February 2008 be approved as a correct record.

102. ADULT SERVICES REVENUE BUDGET REPORT 2007/08

The Service Accountant (Adult Social Services) submitted a Budget Monitoring Report which provided a financial forecast for the Adult Services Department within the Neighbourhoods and Adult Services Directorate to the end of March 2008 based on actual income and expenditure to the end of January 2008.

During the year there have been a number of budget pressures within the service, mainly in respect of the non-achievement of a number of savings proposals, built into the 2007/08 budget, for reducing service level agreements with voluntary and community sector providers in addition to demand pressures on domiciliary and residential care budgets. These have been reported throughout the year in previous budget monitoring reports. A number of management actions to reduce these pressures were also identified however subsequent to implementing these actions, a significant pressure remained. As part of the Revised Estimates process the Cabinet approved an additional one-off budget allocation of £974k to reduce the projected overspend in 2007/08. The forecast position for the year assuming the remaining management actions are fully implemented is now a balanced budget.

Members welcomed the balanced budget and were provided with information on a number of issues, including the following:-

- Talking Newspaper
- Winter Pressures
- Capitalisation of Direct Payments

Resolved:- That the latest balanced financial projection against budget for the year based on actual income and expenditure to the end of January 2008 for Adult Social Services be noted.

(The Chairman authorised consideration of the following items to enable progress to be made)

103. ROTHERHAM CARERS STRATEGY REFRESH

The Strategic Director submitted a draft of a proposed consultation document for a refreshed Carers Strategy.

Resolved:- That consideration of this matter be deferred and a revised draft be submitted to Members shortly.

104. GREEN LANE CENTRE

The Chairman circulated letters from two volunteers at the Green Lane Centre who sought information on matters relating to the Talking Book Service and the re-imbursement of costs incurred by Volunteers.

Resolved:- That the Strategic Director arrange for the letters to be responded to.

Annual Performance Excellence Plan Progress Update
14th March 2008

Outcome 1 – Improving Health and Emotional Well Being

Enjoying good physical and mental health (including protection from abuse and exploitation). Access to appropriate treatment and support in managing long-term conditions independently. There are opportunities for physical activity.

1) Improve performance on reviews from 45 to 75 – COMPLETE

We have significantly improved our performance on reviews over the past 3 months and are currently achieving **75.17.** This improvement equates to 2000 more service users receiving a review of their needs than in the previous year.

This has been achieved by:

- Establishing a centralised review team.
- Putting in place a support framework for SWIFT input.
- Setting individual and team targets monitored weekly through the use of Performance Clinics.
- Putting in place new managerial arrangements to strengthen the focus and prioritising of reviews.

2) Develop and implement the Single Assessment Process (SAP) – ON TARGET

SAP has been the subject of detailed discussion with the PCT, Foundation Trust and GPs and a way forward to introduce a person held SAP record, in the absence of a national electronic solution has been agreed. It is proposed to introduce Person Held Records that will be kept with the Service User. The record will be multi-agency and will contain assessment and care planning information and will include a SAP summary record.

The Person Held Record and guidance have now been updated through the involvement of both staff and service users. The implementation for this remains on target for December 2008.

3) Progress recommendations of the review of the intermediate care service – OFF TARGET

Progress in ongoing with the implementation of the 26 recommendations that were identified in the review. Below are actions that are in the latter stages of completion, these include:

- New GP contract agreed
- Pooled budget in process of being verified
- New admissions protocol for residential beds being developed

- Ring fence removed for people under 65
- Specialist mental health OT recruitment approved
- Intermediate Care Service Manager post being re-advertised

The Adults Planning Board closely monitors performance and has agreed a Joint Performance Management Framework.

4) Evidence the impact of health initiatives for those who use social care – ON TARGET

A variety of health initiatives have been undertaken. These include:

- The Active Always Programme which encourages older people to attend exercise classes in 7 areas of Rotherham, one area, Kimberworth Park has received "Closing the Gap" funding to expand the range of activities which has proved successful. The popularity of these events has resulted in 3 additional areas receiving these opportunities later this year.

- The training programme for Residential and Nursing homes (OCN accredited Active in Age) is expanding to encourage activity for residents and more staff have been trained across the statutory and independent sector. This has improved services for residents and levels of physical activity in the homes.

- Learning Disabilities have a peer support scheme where a Healthy Trainer provides one to one support to encourage service users to adopt a healthy lifestyle.

- Residents in residential homes have been supported by the smoking cessation service to stop smoking.

All these activities will have a positive impact on the lives of those that take part through improvements to their health, mobility and independence.

Outcome 2 – Improved quality of life

Access to leisure, social activities and life-long learning and to universal, public and commercial services. Security at home, access to transport and confidence in safety outside the home.

1) Support those with a physical disability to enable them to live at home, improving from 3.12 to 4.2, including maintaining the improvements made in the last 6 months on the waiting times for major adaptations – ON TARGET

Waiting time for an adaptation following a referral from an OT continues to improve. Average waiting times were 183 days last year compared to 52 days this year. We anticipate sustaining top band (5 out of 5) for D54 - equipment delivered in 7 days. Weekly Performance clinics focusing on assessments and reviews have been taking place which focus on targets that have been set at individual and team level.

New targets have been set for the physical disability team to focus on new assessments, the team have been provided with resources to enable them to meet their targets.

2) **Increase Support for Carers from 4.28 to 9 – ON TARGET**

We are currently performing at 8.14 against the original target of 9, a stretch target has been set to 12.15. This performance has been achieved by a variety of actions, including:

- Greater awareness of the need to undertake separate carers assessments
- Better identification of the support provided to people to undertake the caring role, separating this from user focussed services.
- Increased data validation and cleansing
- Increased publicity about carers rights to an assessment
- Expanding the training support provided to carers
- Referring carers to support groups and increasing awareness of leisure discounts that are open to them.
- Establishing a Carers Emergency Scheme which has had more than 50 carers expressing an interest in joining the scheme prior to a launch taking place. These assessments are currently being undertaken by a dedicated worker. RotherCare will be utilised as the initial 24/7 response and then Crossroads have been commissioned to provide homecare support for up to 48 hours after an emergency plan has been activated should the situation deem this necessary. Publicity material is now available and is currently being distributed across the borough.

As a result 246 more carers have been supported this year.

3) **Put in place signposting to preventative services for older people and people with a physical disability – ON TARGET**

We are currently in the middle of modernising/streamlining our assessment access process (Assessment Direct) to ensure effective signposting of people towards preventative services. Communication to staff has improved through the drive of the Service Quality Team. An audit of leaflets has been undertaken both internally and externally increasing staff access to information and maximising opportunities for promoting available services. Additionally staff are routinely notified of any new preventative services that are available such as the Poppy Handyman scheme run by the Royal British Legion, through manager briefings and team meeting.

Falls prevention is a key area and referrals are made directly to the falls nurse within our services. However a new multi-disciplinary Falls Group has been established to explore opportunities to develop the service further for the benefit of service users.

4) **Influence further development of third sector provision to ensure services are modernised and preventative services are developed to meet assessed strategic needs – ON TARGET**

The development of the Commissioning strategy will give explicit information on the direction of travel for NAS over the next 15 years. Within the strategy we have addressed the need to tackle the preventative agenda. It is this agenda that will provide the basis for third sector involvement. Commissioning Strategy is now completed the consultation process has commenced with a number of events with all stakeholders are taking place shortly. The strategy will be in finalised by April 2008.

In partnership with Voluntary Action Rotherham (VAR) we are in the process of completing impact assessments for all contracted services. The Development Worker attached to the Adult Services Network is critical to this and the future change agenda, it has been agreed with the PCT that we will jointly fund this post for the next 3 years. Regular meetings are now taking place to ensure open dialogue on a range of issues including the JSNA and Commissioning Strategies ensuring that all developments take into account the views of community and voluntary services.

The Local Area Agreement contains a number of PI's within the Stronger Communities Theme. These relate to maintaining and enhancing the health, vitality and independence of Rotherham's Third Sector. A seminar and performance clinic was held in September and an action plan is being developed by the Council through VAR to ensure these PI are on target.

Mental Health Provider 'capacity building' seminars have commenced to inform and consult on service modernisation and guide on accessing external grants (Future Builders), developing Social Firms, and develop capacity around self-directed budgets. A Provider Framework Agreement is currently being negotiated to assist with implementation.

5) **Develop further systems to establish if those who use services feel safer as a result and if any further measures are needed – ON TARGET**

An extensive review has been completed to identify how we test customer satisfaction and perception. This has resulted in the development of a framework regularly testing customer feedback through a variety of methods such as:

- Face to face surveys following Assessments and Reviews
- Random Telephone surveys
- Strengthened consultation through User Forums

Questions have been developed through the Directorates 'Learning from Customer' Forum. They have identified a number of local performance indicators/measures which focus on improving outcomes for the people of Rotherham. Baselines have been established and customers have defined our targets for 2007/08 and 2008/09.

Current Performance:

- 84% feel that due to the services they receive they feel safe in their home/community
- 78% feel that the service they receive improves their health and emotional well-being
- 74% feel the services they receive improves their quality of life
- 88% feel that services they receive help them to live at home
- 83% feel that the service helps maintain and promote their independence

85% of people report feeling safer in ‘no cold calling’ zones.

Outcome 3 – Making a Positive Contribution

Maintaining involvement in local activities and being involved in policy development and decision-making.

No improvement actions identified in the annual performance assessment, however, Neighbourhoods and Adult Services have been identified as one of the first authorities to receive the Charter Mark Standard Bearers award by the Cabinet Office. This is in recognition of our 'Learning from Customers' approach and the high standards of customer service that has been seen through recent Charter Mark inspections. This was formally be announced on the 10th March at the same time as the launch of the new 'Customer Service Excellence Standard' which replaces the Charter Mark standard. We have already agreed a timetable for a full assessment of all our services. Assessment will take place in June 2008 under the new methodology. We will one of the first organisations to do this.

Outcome 4 – Increased choice and control

Through maximum independence and access to information. Being able to choose and control services and helped to manage risk in personal life.

1) Improve the timeliness of assessments - Particular areas of concern relate to assessments in the mental health and learning disability services – ON TARGET

We have been working closely with the Department of Health CSED Project over the past 4 months and have completed business process re-engineering on all our customer access channels for conducting assessments. This has taken into account how customers access the service through to them receiving an assessment removing duplication, streamlining back office process, and increased accessibility. 'Assessment Direct' will go live on 1st April, this will include:

- Radically changing how we deal with the customer face to face to a 'one stop shop' approach where customers will be given an appointment at the first point of contact.
- Putting in place a 'golden number' telephone access point.
- Putting in place 24/7 emergency out of hours services utilising the 'golden number'.
- Rolling out a further three Customer Service Centres across the borough over the next 12 months.

A number of back office processes have already been streamlined. This has resulted in the complete reduction of all backlogs and performance since 1st January is showing that 100% of all assessments have been seen within 4 weeks of notification, now averaging at 1 week. 331 more assessments have been undertaken so far this year.

2) Improve Carer's Assessments – ON TARGET

Performance on carer's assessments continues to improve and we have almost achieved our target for this year. This has been and will continue to be achieved through:

- New documentation is being implemented consistently across all services, including mental health services.
- New protocols put in place for joint assessment and support for Young Carers with Children and Young People's Service which are in draft format and due for completion by the end of March. This should have a positive impact and improve the process for both young carers and staff.
- Promoting carers right to an assessment through publicity in the Carers Information Centre, carers events and through the carers emergency scheme.
- The new carer emergency assessment officer completing full carers assessment when required which now offers an independent assessment from the operational social work teams.

The carer's assessment is now more holistic. Social work staff now promote additional services that can offer support, advice and information.

3) Ensure people receive a statement of their needs, improving D39 from 83.08 to 95 – ON TARGET

Current performance against this is 93 and is on target to achieve 95. We have set a stretched target of 97 for the year-end. This has been achieved through improving our focus on delivering this for our customer. We have put in place streamlined processes that ensure that more customers receive statements of need immediately following assessments and reviews. So far this year 646 more statement of needs have been completed.

4) Progress planned improvements to the out of hours service – ON TARGET

Following consultation with our customers and staff in March 2008 there will be the launch of a new Adult Social Services 24/7 Emergency Out of Hours Service. The service will primarily function through the already well established RotherCare service which currently operates a 24/7 service. RotherCare will be strengthened through training, improving back office processes and increasing accessibility of support workers to deliver a customer focused 'one-stop-shop' service between 5.30pm and 8.00am (Mon – Thurs) and 5.30pm (Friday) and continuously through the weekend to 8.00am (Monday).

Customers will be able to access the service through one 'Golden Number' which will be publicised by a variety of methods. The service will be supported by a number of back office frameworks to ensure that

customers' needs are fully met and we are providing a seamless service. These include:

- Fast Response Team
- Out of Hours Duty Social Worker and Support Officer
- On Call Senior Management
- Emergency Home Care provision through Care Force.
- Carers Emergency Scheme with provision through Crossroads

5) **Improve Complaints procedures – keeping people informed of progress, further improving satisfaction with the outcome of complaints, and ensuring as far as possible that people would be prepared to use the procedure again, improving satisfaction with complaint outcome from 61% to 65% - ON TARGET**

In July 2007 we strengthened the management arrangements of our complaints service. A robust Performance Management Framework was put in place which focused on improving the complaints service through response, quality and learning from the customer. This included:

- Development of Local Performance Indicators and Targets in conjunction with customers
- Improving information given to customers throughout the process.
- Reporting performance on a monthly basis.
- Tracking mechanisms put in place to ensure prompt response
- Training for all Complaint Investigators
- Routinely testing customer satisfaction with the complaints service
- Learning from Complaint sessions taking place with customer involvement on every complaint with actions for improvement monitored through to implementation.

As a result:

- Performance on response times has improved from 72% (06/07) to 92% (January 2008)
- Satisfaction has improved for overall outcome 56% (06/07) to 66% (Jan 08)
- Satisfaction with handling has improved from 52% (06/07) to 68% (Jan 08)

Outcome 5 – Freedom from discrimination or harassment

Equality of access to services. Not being subject to abuse.

1) **Involve service users and carers in the annual review of eligibility criteria – ON TARGET**

We are currently reviewing our eligibility criteria with service users and carers. This is being carried out in a number of ways:

- Face to face surveys through conducting the Annual Review
- User Forums (Carers Forum, Rotherham Older Peoples Forum etc.)
- A survey of the people who did not meet FACS over the past 12 months.

Findings of this study will be available at the end of March and will be reported to Cabinet Member in April 2008.

2) **Raise awareness of services, the help available for older people from black and minority ethnic groups, and to improve access to services for BME post assessment, achieving targets for E47 and E48 – OFF TARGET**

We are currently benchmarking in the region with authorities that have comparable BME populations in order to help identify possible areas of best practice in encouraging the uptake of social care services. Early findings indicate that comparable authorities are experiencing similar difficulties.

Local initiatives which have been undertaken in partnership with the PCT include:

- Undertaking a BME Health Needs Assessment (a systematic method for reviewing health and social care needs). An initial DRAFT report has been completed (November, 2007) and results presented to the steering group. Further work includes a Family Health questionnaire which has been developed and initially piloted (Health Trainers/Community Researchers will undertake face to face interviews) and agreed consultation plan which includes running focus groups and a large event is planned for 31st March 2008. All work is being reported via the ALIVE Theme Board of Rotherham LSP.

- Delivering Race Equality (DRE) in Mental Health – RPCT has a focused Implementation Site for Delivering Race Equality in local Mental Health services. The Steering Group has developed a final draft action plan and are currently looking at a recruitment strategy (nationally set local targets for employing Community Development Workers) that will help meet the local target. Consultation with BME communities identified initial areas of priority work, which include C&YP, Older People and Working Age. Work is progressing on an audit of need and draft report produced on BME Older People's - A Health Needs Assessment.

In order to improve the take up of social care service a specific initiative, jointly working with the Rotherham Hospital Foundation Trust will engage with BME communities at the point of patient admission. It will gather qualitative information to identify client/patient levels of service awareness and their intentions on accessing follow-up service should they require them. The current pilot and timescale (a two-week period) has been extended to 6 months due to the small numbers of throughput of BME older people. Officer time has been made available to carry out patient interviews.

3) **Establish how many self funding people access services without an assessment to judge whether there is a need to further promote the availability of assessments – ON TARGET**

A comprehensive survey has been completed across all residential and

nursing care services has been completed. This discovered that there are 320 self funders paying for this provision which equates to 21%. After further investigation only 118 of the self funders (37%) accessed service after an assessment had taken place.

A review of the accessibility and quality of current advice and information provision to prospective service users is currently being undertaken and will include verbal advice by staff, provision of written documentation i.e. leaflets and Internet provision.

Local recommendations derived from the report ‘A Fairer Contract for Older People’ report are being implemented, these include ensuring there is a reference to contract terms and conditions for older people entering residential care.

This information has also been included in the JSNA and has been taken into account during the development of the Commissioning Strategy.

Outcome 6 – Economic Well being

Access to income and resources sufficient for a good diet, accommodation and participation in family and community life. Ability to meet costs arising from specific individual needs.

1) <u>Support the employment of carers – ON TARGET</u>

The employment status of carers that we are aware of has improved both from the implementation of the new assessment for and also the changes to the Carers Register which identifies their employment status and desires which provides us a targeted audience to consult with around the development of carer sensitive employment policies. However these are still very few in number.

Social care staff offer carers support through:

- Improving day, respite and home care services to fit in with their work patterns.
- Increasing access to Direct Payments as a method of enabling the carer to arrange their own care around their employment commitments.
- Promoting the availability and benefits of flexible working arrangements that enables the carer to request a change of hours they work, a change to the times they are required to work or to work from home there are policies now in place in the 3 largest employers in the borough the Council, PCT and the Acute Trust. These policies include Carers being able to take a reasonable period of unpaid leave to deal with emergencies involving a dependent. For example if the cared for falls ill, becomes injured or there is breakdown in care arrangements. It is expected that carers take annual leave.
- Encouraging and referring those carers wanting to return to work to Phoenix Enterprises and the Stepping Stones projects which involve the Rotherham Transitional Labour Market, offering support and assistance.
- Promoting the Carers Emergency Scheme which is a new service for carers that has just commenced which is concerned about what would happen to the person they care for if they are taken ill or have to deal with an emergency. Social care services will assist the carer in making arrangements for emergency cover. This also includes temporary homecare provision if the carer's employment is at risk due to their caring duties.

A review of the impact of these existing initiatives will be undertaken as part of the development of a new Carers Strategy in line with the National guidance that is due for release later this year.

Outcome 7 – Maintaining personal dignity and respect

Keeping clean and comfortable. Enjoying a clean and orderly environment. Availability of appropriate personal care.

1) Promote basic adult protection awareness training in the independent sector – ON TARGET

Regular planning meetings are being held between Safeguarding Manager and Learning and Development (L&D) Manager to identify potential training providers.

Additional sector specific, basic training has been agreed by the Safeguarding Manager and L&D Manager and a schedule of training courses produced and distributed to providers for 2008/09.

Sixteen independent sector specific off-site training courses have been organised, these commenced on 6th December and will end on 28th March 2008. 82 staff have been trained from December to January and a further 190 staff are booked onto the remaining courses, further bookings are still being received. Additionally a small number of staff are choosing to attended the Directorate's in-house staff training course.

Training course flyers have been produced and distributed; additional promotion has taken place at the provider forums. The L&D Team continue to contact providers to seek additional course bookings and weekly monitoring of bookings is taking place and being reported. On-site training courses have also been offered and arranged for larger organisation who felt they would benefit from this.

An L&D team member now attends the independent sector forum meetings to promote the opportunities that are available and work with providers to identify their training needs and advise on possible solutions.

2) Raise awareness of adult protection in the mental health sector – ON TARGET

There has been an increase in adult protection referrals from Mental Health teams, in 2006/7 3 safeguarding investigations took place and to date this year this has increased to 7. This has been achieved through:

- Training and awareness raising commenced and ongoing
- New procedures launched in November 2007.
- Distribution of leaflets, posters & mini-guides.
- Staff briefings delivered to NAS/ Safeguarding Committee Members/ Voluntary Sector/ Independent Providers/ Supporting People.

Promotion will continue and further briefings are planned for Area Assemblies, Warden Service, Mental Health Service

3) Finalise the policy in development regarding inter-personal relationships – ON TARGET

This policy is being developed by learning disability services. It is nearing completion, at draft stage and will be out for consultation soon. Service users and carers have been involved in its development, and it is being developed jointly with Public Health Services in the PCT.

4) Secure partnership funding for the Adult Protection Committees and progressing the safeguarding agenda – ON TARGET

Directors within the PCT have agreed to jointly fund the Adult Protection Committee; this is awaiting ratification from the PCT Board.

New South Yorkshire wide procedures have been produced and launched in November 2007, this included a sub-set of local procedure as a appendices. In addition to the leaflets, posters & mini-guides have also been distributed. The awareness of these new procedures has been raised through staff briefings which have been delivered to social work teams, the Safeguarding Committee Members, voluntary sector organisations, independent providers, supporting people staff. Further briefings planned for Area Assemblies, the Warden Service and Mental Health Service.

This launch and issuing of the new procedures and publicity material has raised profile of adult protection and resulted in an increase in referrals (including whistle blowing incidents).

Additionally Case Conference training including how to investigate cases and chair meetings has been undertaken by a variety of safe across different agencies. A Support Officer is due to commence next month who will facilitate the Case Conference process.

Leadership

The CASSR has corporate arrangements and capacity to achieve consistent, sustainable and effective improvement in Adult Social Service. In addition to meeting the requirements for a grade 3 the following criteria are met in delivering excellent leadership.

1) Strengthen links with the independent sector to ensure relevant occupational and professional standards across all adult social services – ON TARGET

As part of the restructure, a Learning & Development Officer post specifically for the independent sector has been established and appointed. The role will:

- Conduct training needs analysis and prepare training programme specifications according to sector requirements.
- Commission and coordinate a range of training programmes to meet the identified needs of the workforce.
- Commission core training programmes to support and meet National Minimum Care Standards training requirements, and vocational and professional awards.

The new L&D Officer has now been introduced to the providers and job role explained. Drop-in sessions were held in January 08 as well as on-site visits which included providing support and guidance on the submission of workforce development funding applications.

In order to improve communication channels the Quality Care Partnership (QCP) Manager attends the L&D Group and has regular meetings with the L&D Manger to discuss independent sector learning needs and links with their Skills for Care projects in this region.

An action plan to increase learning and development support to the independent sector has been completed and implemented. This document will be continually revised, responding to the changing needs that are identified during the training needs analysis which will be completed shortly. This will then provide a clear summary of the future needs to drive improvement in the quality of service provided in this sector which will be demonstrated in improving their customer satisfaction levels which are monitored by our officers as put of the compliance review.

2) Put in place training opportunities for the independent sector – ON TARGET

The Learning & Development team have been increasingly proactive during 2007/8 and have arranged for:

- A series of workshops promoting the portfolio of training opportunities offered with a specific focus on common induction standards have taken place and been well attended. The impact of these workshops has been a noticeable increase in the number of

staff nominated to attend training events.

- A comprehensive training programme to be available to independent sector staff covering a range of programmes such as movement and handling, first aid, tissue viability, adult protection, Mental Capacity Act Awareness Sessions, as well as supporting the registration on distance learning programmes.

- Funds to be made available to the independent sector for improving learning and development. In December 2007 a Panel considered 22 applications from a range of providers and approved grants totalling £99,000. The funding will enable providers to support induction training and support training programmes including Certificate in Mental Health awards, and NVQ's in Health and Social Care. Other funded applications included learning programmes on 'what it means to be person-centred', 'providing a quality nail cutting service', 'reminiscence techniques', 'practice assessor training course', 'introduction to mentoring', and achieving the 'MATRIX quality standard'. Clear monitoring systems and quality assurance measure are in place and an evaluation process will be conducted in April demonstrating the impact to both providers and customers.

- Eight independent sector staff to commence the Level 3 Certificate in Mental Health in January 2008.

With the appointment of a dedicated worker for the independent sector relationships are becoming stronger. This will undoubtedly have a positive impact on the skills of independent sector staff and the quality and range of services they provided to their customers in the future.

3) Improve Performance Assessment Framework Indicators (PAF PIs) – ON TARGET

6 indicators were identified for improvement by CSCI in Rotherham's 2007 Performance Assessment. Performance on 3 of these of these has been covered in previous sections.

The remaining indicators are;

- C32 Older people helped to live at home
- C29 Physical disabilities helped to live at home
- C72 Admissions to residential care

Weekly performance clinics are being held with social work managers with team and individual targets in place. 16 clinics have taken place since December. The results of these actions are that;

- Number of assessments has doubled,
- Number of has reviews trebled,
- Backlog of new assessments from historical level of 300 has been removed

- 374 more older people to live at home this year compared to last year.
- 47 less admissions to residential and nursing care
- Management changes have been made in poor performing teams,

We are very clear what our areas for improvement will be over the next 12 months and are confident that we can continue to improve performance and include Occupational Therapy assessments and preventative services.

4) <u>Implement electronic social care records – OFF TARGET</u>

The implementation of ESCR (Electronic Social Care Records) in Rotherham has progressed significantly since last November. On 18th March the start of a 'go-live' pilot commenced which involves the social work team in the south of the borough inputting records using the new system. To assist this process scanners have been set up following work with RBT and staff will be able to comment on the new system.

A weekly appraisal of the Project plan has been complemented by several workshops attended by staff. Again during these sessions staff were able to contribute their thoughts to the development of the process. These events have allowed all concerned to have valuable insight into the complexity, skills and resources necessary for the official 'go-live' date to be achieved and a success in its delivery.

Swift has been upgraded in order to ensure the best possible environment for the launch and the social work team involved are excited about being the first group to scan in ESCR information. The pilot will mark the culmination of work between the Council and partners to deliver solutions that are focused on delivering a better service to our customers.

Full implementation will be November 2008.

5) <u>Improve the availability of data from the mental health service – ON TARGET</u>

We are now able to access mental health data to plan services, project performance and agree action plans. Current performance on mental health users helped to live at home (C31) is projected to improve from 4.5 to 5.1.

Commissioning

The CASSR commissions and delivers services to clear standards of both quality and cost, by the most effective, economic and efficient means available. In addition to meeting the requirements for a grade 3 the following criteria are met in delivering excellent commissioning and use of resources.

1) **With the Director of Public Health, complete the detailed analysis of needs for the population and strategic commissioning plan - COMPLETE**

The multi-agency task group has completed the the joint strategic needs assessment after detailed consultation and evidence gathering across all agencies and sectors in Rotherham. A summary document now has been compiled and has been circulated to all stakeholders.

The impact of the document has and will continue to shape both the Joint and NAS commissioning strategies. The first consultation event which pulls together all these agendas took place on the 22nd February.

2) **Continue to modernise the in-house domiciliary care service to ensure it offers an enabling service – ON TARGET**

Decision reached by Cabinet Member on 10.12.07 to significantly shift the focus and balance of domiciliary care services. Following careful analysis of current unit costs, performance and outcomes achieved, it was agreed to shift the balance of services from 60% in-house, 40% independent sector (HHI September 2007 baseline) and to develop the remaining in-house service as an enabling/reabling service, based on national examples of good practice but focussing specifically on Rotherham's needs. There is a steering group in place to deliver this challenging agenda, and several workstreams are in place to deliver on the following:

- developing a Rotherham Vision for reablement,
- developing a workforce plan , revising job descriptions and terms and conditions to create a well-trained, supported an informed work force.
- The Turnaround Team is undertaking a BPR exercise and seeking to create more efficiency in the current and future service.
- The Commissioning Team is focused on the development of quality independent services
- a communication team to ensure that everyone including staff, service users, carers, trades unions and the wider service are being kept informed.

Initially there will be a minimal impact from the above actions. However a greater impact will be evident over the coming months as the balance moves towards the independent sector and re-investment can be utilised into re-ablement and preventative agendas that will recognised as a positive change by our customers.

ROTHERHAM BOROUGH COUNCIL – REPORT TO MEMBERS

1.	Meeting:	Cabinet Member for Adult Social Care and Health
2.	Date:	31 March 2008
3.	Title:	Adult Services Performance Assessment Excellence Plan All Wards Affected
4.	Programme Area:	Neighbourhoods and Adult Services

5. Summary

This report outlines the progress being made to improve on the areas of weakness identified by the Commission for Social Care Inspectorate (CSCI) in the 2007 Annual Performance Assessment of registered Adult Services.

6. Recommendations

That Cabinet Member is asked to note the progress made against the excellence plan.

7. Proposals and Details

The 2007 social care Annual Performance Assessment (APA) identified that Rotherham is a ‘2 Star’ (Good) Authority with ‘Promising Prospects for Improvement’. The report identified 60 areas of strength, which far outweigh the 29 areas of weakness. This meant that we had a platform on which to improve services and raise the standard of services towards excellent next year.

The Neighbourhoods and Adult Services Performance Assessment Excellence Plan (Appendix A) captures each of the identified areas of weakness made by CSCI into an action plan. This plan provides the Directorate with a focus on addressing the areas which will contribute to achieving a ‘3 Star’ (Excellent) rating. Each weakness has been assigned to a Director with clear timescales for delivery including milestones to measure progress. Progress is performance managed through the Directorate Management Team and reported quarterly to Members.

The is the first progress report since the plan was presented to the Cabinet Member for Adult Social Care and Health on 10 December 2007 and the Adult Services and Health Scrutiny Panel on 10 January 2008.

Of the 29 actions that are contained within the excellence plan, 26 (90%) are rated ‘complete’ or ‘on target’ and 3 (10%) are rated ‘off target’.

The following actions are rated ‘off target’:

- **Progress recommendations of the review of the intermediate care service.**
  A remedial action plan is in place performance managed through the Directorate Management Team to address areas of slippage;
- **Raise awareness of services, the help available for older people from black and minority ethnic groups, and to improve access to services for BME post assessment, achieving targets for E47 and E48**
  The hospital study of BME take up of service has now commenced and findings will be reported in April 2008
- **Implement electronic social care records**
  Delays have been due to problems with IT interfaces which are being addressed area by area. A successful ESCR pilot was run in Maltby on 17th March. A programme is place to ensure that over the next 8 months ESCR will be implemented across Rotherham.

The plan also identifies recent improvements to services. Key achievements to date are:

- **Health & Wellbeing**,
  We have increased level of reviews from 45% to 75%
- **Improved Quality of Life,**
  We have undertaken 331 more assessments**,** we have reduced the back log of assessments from 300 to 0, we have helped 374 more older people to live at home this year compared to last year and we have reduced waiting times for major adaptations from 183 days to 52 days.

- **Making a Positive Contribution**
  We have become Standard Bearers for Cabinet Office Customer Service Excellence Standard.
- **Increased Choice and Control**
  We have reduced assessment times from 11 weeks to 1 week we have increased statement of need from 83 to 93.
- **Economic Wellbeing**
  We have supported 246 more carers.

8. Finance

The costs associated with this improvement plan have been incorporated into the budget recently agreed by Members.

9. Risks and Uncertainties

The main risk is that we fail to deliver on our promises made to Members, Customers and CSCI that we would make improvements to the Adult Social Care service. This is being mitigated through the implementation of this excellence plan. The leadership team that is now in place will be able to demonstrate an ability to follow through on promises by delivering against this plan. This has been viewed as a weakness in the past both internally and externally.

10. Policy and Performance Agenda Implications

The ability to deliver continuous improvement and better outcomes for residents is crucial to achieving good inspection ratings. Our performance is regularly assessed by the CSCI throughout the year. This assessment is based on a Self Assessment Survey which is submitted in May, supplementary evidence requested by CSCI and culminating in the Annual Review Meeting (ARM) in July. The inspection framework covers two judgements; how well we are ‘delivering outcomes’ for local people our ‘capacity for Improvement’. The excellence plan is shaped around our desire to deliver better outcomes for local people. This year’s results will be announced in November 2008.

11. Background Papers and Consultation

The Annual Performance Report from CSCI has been discussed with the Cabinet, the Cabinet Member, Scrutiny Panel, Customers and Staff.

The excellence plan is attached.

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Agenda Item 6

ROTHERHAM BOROUGH COUNCIL – REPORT TO DMT

1.	**Meeting:**	**Adult Social Care and Health Cabinet Member**
2.	**Date:**	**31st March, 2008**
3.	**Title:**	**Commissioning Strategy**
4.	**Directorate:**	**Neighbourhoods and Adult Services**

5. **Summary**

5.1 The Directorate set out in its 2007/08 Service Plan the intention to '*deliver quality, innovative, efficient, value for money services to our customers through Commissioning by the year 2010'.* This is the beginning of a process of change in the way services are commissioned and provided. As part of this process there is a commitment to have in place a 15 year Commissioning Strategy for Adult Social Care in Rotherham. This report gives an overview of the strategy and outlines the plans for commissioning services to meet the needs of the local population.

6. **Recommendations**

6.1 That Members note the progress that has been achieved in the continued development of the Commissioning Strategy.

6.2 That Members endorse the strategy.

6.3 That members agree to accept update reports on a quarterly basis as the strategy continues to develop in response to national and local drivers.

7. Proposals and Details

7.1 Background

7.1.1 Strategic Commissioning is the process of specifying, securing and monitoring services at a strategic level, to meet people's needs. This applies to all services, whether they are provided by the Local Authority, NHS, other public agencies, or by the private and voluntary sectors (Audit Commission 2003).

7.1.2 The White Paper '**Our Health, Our Care, and Our Say: A New Direction for Community Services '(2006)** [1] places the emphasis on effective commissioning to deliver improved outcomes for service users. There is a requirement to move towards commissioning to promote health and wellbeing and develop preventative approaches.

7.1.3 The Local Authority Circular 'Transforming Social Care' (LAC(DH) (2008) 1) sets out the information required to support the transformation of social care as previously highlighted in the Department of Health's Green Paper, ***Independence, Wellbeing and Choice*** **(2005)** and reinforced in the White Paper, ***Our Health, our care, our say: A New Direction for Community Services*** **(2006)**. The direction of travel is clearly towards the personalisation of services with a strategic shift towards early intervention and prevention.

7.1.4 Such a change in the way services are commissioned cannot be achieved immediately. The commissioning strategy will look at the long term needs of the population and begin to reshape services to meet those needs. There may be some opportunities to change things quickly but in the longer term a radical shift in the current approach to commissioning will be required.

7.2 Joint Strategic Needs Assessment

7.2.1 The Joint Strategic Needs Assessment (JSNA) has been completed with the Primary Care Trust to identify local needs. Its findings have informed both the Commissioning Strategy and Joint Commissioning Strategy. The JSNA will be continually updated and revised to give the most accurate demographic information gathered which will be used to inform the future commissioning and planning of services.

7.2.2 The Joint Strategic Needs Assessment shows us that the increasing numbers of dependent people will place significant pressure on our budgets in the short, medium and longer term. We will not be able to continue with our current pattern of purchasing and must redesign and reconfigure services to meet the growing need.

7.3 **The Commissioning Strategy**

7.3.1 The strategy provides a framework for the strategic commissioning of adult social care services for the next 15 years to 2023 and beyond. The current draft contains an action plan for the next three years. It relates to adults over the age of 18. There will be separate and specific arrangements for the commissioning for those services that are provided on an integrated basis with health partners. These include services for adults with a learning disability and for adults with a mental health problem.

7.3.2 Consultation on the strategy so far has indicated that:

- Historical approaches to providing activities for people such as bingo will no longer be acceptable or appropriate.

- Access to a variety of activities such as exercise and lifelong learning has been highlighted as a priority.

- People want access to good quality information to enable them look after their health and wellbeing.

- Traditional service provision will need to be complemented by alternatives to meet the needs of the diverse local population.

- Effective means of transport are essential to enable people to participate in activities.

The strategy will provide guidance to reshape commissioning activity to best meet the needs of local people, encouraging innovation and good practice.

7.3.3 The overall strategic direction is to strengthen the Council's commissioning activity in line with the new National Commissioning Framework. The emphasis will be on enabling people to do things for themselves. There will also be a move from direct provision to commissioning from the Independent and 3rd Sector. In addition there will be a continuation in the development of partnerships with all stakeholders to facilitate the improved delivery of services at a local level.

7.3.4 The Commissioning Strategy also takes action to implement the Member's decision taken on 10th December, 2007, to move towards a 65/35 split in domiciliary care provision both in independent and in-house sectors.

7.3.5 The Commissioning Strategy is designed to embed a service user focus to commissioning and make sure that people who use services and their carers have access to a choice of good quality services which are responsive to their needs and preferences. This will include the development of specialised support services to enable more people to stay closer to home rather than be placed in out of district specialist services.

7.3.6 The Commissioning Strategy provides a framework for the actions needed to achieve change. An annual implementation plan and three yearly refresh of the strategy will keep targets and objectives relevant and achievable.

8. **Finance**

8.1 There are no specific financial issues associated with this report but the creation of new services in the future will require funding and this will need to be identified.

8.2 The Commissioning Strategy is intended to deliver improved value for money for current and future need.

9. **Risks and Uncertainties**

9.1 Current service provision is inadequate and the costs of services compare poorly with other providers and Authorities. The Commissioning Strategy seeks to improve this position by commissioning more from the independent sector. There are risks associated with this which will be managed through the action plan.

10. **Policy and Performance Agenda Implications**

10.1 This strategy will assist the Local Authority to meet key objectives set out in the Outcomes Framework:

Outcome 2 Improved Quality of Life - 'Services promote independence and support people to live a fulfilled life making the most of their capacity and potential .In order to meet the excellent grade, the Council needs to demonstrate that it 'commissions or provides a good range of preventative services, which have directly contributed to reductions in people needing higher level support'. The move towards a preventative approach is highlighted in the Commissioning Strategy.

Outcome 9 Commissioning and use of Resources - Adult Social Care commission and deliver services to clear standards of both quality and cost, by the most effective, economic and efficient means available. To achieve the excellent grade, the Council must meet the requirement that ' working with the primary care trust's director of public health has a detailed analysis of need of the whole population with comprehensive gap analysis and strategic commissioning plan that links to investment activity over time.' The Joint Strategic Needs Assessment Provides such an analysis and has supported the development of the Commissioning Strategy.

It will also contribute to the NAS Service Plan Strategic Objective 4: 'Deliver quality, innovative, efficient, value for money services to our customers through Commissioning by the year 2010'.

11. **Background Papers and Consultation**

11.1 Commissioning Framework for Health and Wellbeing (DH 06.03.07)
11.2 Department of Health White Paper – Our Health, Our Care, Our Say
11.3 Social Care Outcomes Framework

Consultation

Consultation is currently taking place with all stakeholders and the wider public. A series of meetings and events has been arranged - see timetable (Appendix 1). Feedback to date has been positive with a high level of engagement with service users, carers, partner agencies and providers. The consultation period is ongoing and all comments to date have been incorporated into the strategy. On completion of this period of consultation it is planned to finalise the strategy and present to elected members for their agreement.

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APPENDIX 1

Commissioning Strategy Consultation Programme

Event	Date	Venue/Time
Voluntary Sector Forum	13th February	Unity Centre 2 p.m. 4 p.m.
VAR Adult Services Consortium	19th February	Talbot Lane Methodist Church 10 a.m. – 12 noon
Domiciliary Care Forum	20th February	Unity Centre 10 a.m. – 12 noon
Contracting for Care forum	20th February	Town Hall 1 p.m. - 2.30 p.m.
Public Consultation Events	22nd February 25th February	Silverwood Miners Welfare 9.30 p.m. -1.30 p.m. RAIN Building Drop-in 10 a.m. 10 a.m. -12 noon 2 p.m. - 4 p.m. 5.30 p.m. -7.30 p.m.
Scrutiny	28th Feb	Town Hall 9.30 a.m.
NAS Commissioning Group	29th February	Oak House 10 a.m. -11 a.m.
Older Peoples Planning Group	7th March	Oak House 10 a.m. – 12 noon
Residential Care Forum	12th March	Unity Centre 10 a.m. -12 noon
ROPES Meeting	14th March	RAIN Building 10 a.m. – 12 noon
Long Term Conditions Planning Group	18th March	Oak House 2.15 p.m. - 4.15 p.m.
Older People Mental Health Steering Group	19th March	RDGH 10 a.m. – 12 noon

Agenda Item 7

ROTHERHAM BOROUGH COUNCIL – REPORT TO MEMBERS

1.	Meeting:	Adult Social Care and Health Cabinet Member
2.	Date:	31st March 2008
3.	Title	Electronic Social Care Records (ESCR)
4.	Programme Area:	Neighbourhoods and Adult Services and Children and Young People's Services

5. Summary

5.1 This report provides an update on the implementation of Electronic Social Care Records in Adult Social Care Services.

5.2 Phase One of the Project has now been completed. This has included the full installation and configuration of the system, resulting in a fully working Electronic Document and Record Management System linked to SWIFT.

5.3 Full evaluation and detailed testing of the system will take place from April onwards with the first teams going 'live' on the system from July 2008.

5.4 A successful 'live' pilot was held between 14th and 18th March, 2008 within the Maltby Social Work Team. This will be one of the first teams to go 'live' in July 2008 in the Maltby Customer Service Centre.

6. Recommendations

(a) That Members receive this report as an update on ESCR implementation.

(b) That a further update be provided to a future meeting in September 2008.

7. Proposals and Details

7.1 The implementation of Electronic Social Care Records will mean that customer case records will no longer be held on paper, enabling greater agile working by Social Workers and other Staff providing services to Adults and Older People.

7.2 Customers will benefit from a more responsive service resulting from a more effective and timely sharing of information across the service. Once implemented staff will be able to access a customers full social care record from any location.

7.3 A number of workshops have been held focusing on business processes, and the structure of the electronic file. The production of an electronic document library via the intranet enables staff to quickly and easily find and complete the forms they require and save them within the customers electronic file.

7.4 The solution will also include the deployment of scanners to capture incoming correspondence and to route these documents electronically to the most appropriate member of staff.

7.5 Phase 2 Implementation:

April 2008	User Acceptance testing and process review.
May 2008	Local office PC set up and resolve issues list.
June 2008	Develop training materials and train the trainers.
July 2008	Commence end user training and first teams go live.
Aug – Nov 2008	Review and roll out to remainder of services.

8. Finance

8.1 Capital funding of £761,000 has been allocated and the majority utilised for software, hardware and professional services to implement ESCR across both Neighbourhoods and Adult Services and Children and Young People's Services.

8.2 An element of this, approximately £100,000 has been earmarked for the scanning solution and further work is required with RBT to achieve best value for money.

9. Risk and Uncertainties

9.1 ESCR is being monitored through the corporate RISGEN risk management tool.

10. Policy and Performance Agenda Implications

10.1 The implementation of ESCR continues to be monitored by the Self Assessment Survey. It is also incorporated in the RMBC Year Ahead statement and the Service Plan.

10.2 The system will promote improved joint working within and across services through better information sharing and more timely access to information. This will specifically contribute to the "Improved Health" and "Improved Quality of Life" outcomes as a result of more efficient decision making and timely provision of services.

10.3 As part of the Councils ICT Strategy, the introduction of an electronic document and record management system is one of the key work streams. In this respect, the implementation of ESCR across Neighbourhoods and Adults Services and Children and Young People's Service will form the pilot and platform for the rest of the Council.

11. Background and Consultation

11.1 The Electronic Social Care Record is a Department of Health initiative and part of the modernising social services agenda. The consultation, guidance and specification for ESCR were developed by the DoH, Information for Social Care Policy Unit.

References:

Defining the Electronic Social Care Record: DoH 2003
Social Services Cabinet Paper, 26th November 2004
Social Services Cabinet Member, 18th March 2006
Adult Social Care & Health Cabinet Member, 24th October 2005
Adult Social Care & Health Cabinet Member, 12th December 2005
Adult Social Care & Health Cabinet Member, 23rd October 2006
Adult Social Care & Health Cabinet Member, 15th January 2007
RMBC Cabinet, 2nd May 2007
Adult Social Care & Health Cabinet Member, 11th June 2007

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ROTHERHAM BOROUGH COUNCIL – REPORT TO MEMBERS

1.	**Meeting:**	Adult Social Care and Health Cabinet Member
2.	**Date:**	31st March, 2008
3.	**Title:**	Joint Commissioning Strategy
4.	**Directorate:**	Neighbourhoods and Adult Services

5. Summary

5.1 The Joint Commissioning Strategy sets out the commissioning intentions and the presents an analysis of local need, describes services that currently exists and highlights gaps in provision. It identifies those service areas where a joint approach would be most effective and sets out proposals on joint commissioning arrangements, service reconfiguration and resource allocation.

5.2 The Joint Commissioning Strategy replaces the current joint strategies for Long Term Conditions, Intermediate Care and Older People's Mental Health.

6. Recommendations

It is recommended that the Cabinet Member for Adult Social Care and Health:-

- **Endorses the Joint Commissioning Strategy.**

- **Receives a progress report on implementation in September 2008.**

7. Proposals and Details

7.1 The Joint Commissioning Strategy sets out a joint vision for health and adult social care in Rotherham to deliver a personalised health and social care service, which is seamless and of the highest quality. This vision will be delivered through joint commissioning, effective joint working and integrated health and adult social care provision.

7.2 The strategy has been subject to a comprehensive consultation programme, which has taken account of the views of service users, stakeholders and members of the public. Key events are summarised below:-

Public consultation event	22nd February 2008
Presentation to the Older People's Planning Group	7th March 2008
Citizens Juries on Long Term Conditions	10th October 2007
Citizens Jury on Older Peoples Mental Health OPMH)	14th June 2007
Presentation to the OPMH Steering Group	16th January2008
Presentation to Adults Board	7th February 2008

7.3 Service users and partners have all endorsed the direction of travel set by the strategy. There is strong support for identifying specific priorities and building the joint planning framework around these. The consultation process has highlighted gaps in coverage of the strategy, specifically in relation to mental health and learning disability. The Adults Board intends to update the strategy over the next year to include these communities of interest.

7.4 The overarching vision of the Joint Commissioning Strategy is to:-

- Maintain people in independence for as long as possible.
- Develop community-based services, which provide choice and improve quality of life.
- Make sure that health and social care services are working closely together.
- Maintain mental well-being well into later life.

7.5 The Joint Commissioning Strategy proposes that, over the next three years, Rotherham MBC and Rotherham PCT will work together to:-

- Improve the quality of health and social care services to people who have a long term condition.
- Develop effective rehabilitation and support services to ensure people can maintain their independence.
- Make significant improvements to services which focus on the mental health needs of older people.
- Reduce hospital admissions and admissions to residential or nursing care by helping people to stay at home for longer.

7.6 Over the next fifteen years Rotherham MBC and Rotherham PCT will:-

- Develop fully integrated health and social care services in the community for people with long term conditions.
- Develop a fully integrated specialist service for older people with mental health problems, which is co-located within a purpose-built unit and incorporates relevant inpatient and community-based services.
- Develop a new service structure based on enablement rather than delivery of direct care.
- Fully integrate the commissioning function for community based health and social care services.

7.7 The priorities identified within the Joint Commissioning Strategy reflect the current work streams of the Adults Board. They focus on services which are strategically relevant to both RPCT and RMBC and they incorporate priorities identified within national and local strategic documents.

Priority 1: Meeting the needs of people with long term conditions
Priority 2: Effective, jointly commissioned Intermediate Care services
Priority 3: Older People's Mental Health (OPMH)
Priority 4: Reducing admissions to institutional care
Priority 5: Effective joint governance arrangements

8. Finance

8.1 The intention is that the Joint Commissioning Strategy will be supported by a range of Directorate and PCT budgets and outcomes will be agreed for delivery within funding that is available.

9. Risk and Uncertainties

9.1 There are a number of risks associated with non-implementation of the strategy:-

- The development of a Joint Commissioning Strategy is part of the Council's Year Ahead Plan and is scheduled for completion in March 2008. Failure to endorse the strategy will compromise the target set in the Year Ahead Plan.

- A recent CSCI inspection raised concerns about the Intermediate Care service. Intermediate Care one of the joint commissioning priorities so a delay in approving the strategy will delay remedial action planned to improve performance.

- The reconfiguration of OPMH services, identification of High Intensity Users, preventing A&E admissions from residential care and the review of CRT are all waiting on endorsement of the strategy.

- Failure to endorse the strategy will delay the required joint response to demographic changes that are likely to place the existing service model under considerable pressure

9.2 The Adults Board will closely monitor the progress of the Joint Commissioning Strategy. The strategy is a vehicle for managing continuous improvement of performance across both organisations for the benefits of adults in Rotherham.

9.3 Should risks be identified where the desired improvements will not be achieved, which would therefore impact on inspection ratings and customer satisfaction remedial actions will be taken and closely monitored.

10. Policy and Performance Agenda Implications

10.1 This Joint Commissioning Strategy contributes to the Rotherham Proud and Alive Themes as well as the Leadership and Commissioning and Use of Resources outcomes set out in the Social Care outcomes Framework in that the services that we jointly provide are commissioned and delivered to clear standards of both quality and cost. Additionally the strategy's effective implementation will make a significant contribution to Improved Quality of Life and Increased Choice and Control outcomes.

10.2 The Joint Commissioning Strategy will address all the key lines of assessment standards of performance identified in CSCI's Outcome Performance Framework for Performance assessment of Adult Social Care. The greatest impact will be on the following standards:-

- *Improving health and emotional well-being*

  It demonstrates well-developed and consistent joint working with health partners. Health and social care needs will be effectively supported to prevent admission and support discharge. It will assist the council in developing clear and successful mechanisms with partners to ensure quality response to need.

- *Improved quality of life*

  The intermediate care priority will promote independence actively and consistently, minimising the impact of any disabilities. The new commissioning arrangements will ensure that a good range of preventive services are available, which have a direct impact the number of people with higher level support.

- *Commissioning and use of resources*

  The OPMH priority on will ensure that expenditure on social care services reflects national and local priorities. It complies with the principles set out in "Everybody's Business" and "Our Health Our care Our Say". It will deliver a robust commissioning partnership in relation to OPMH services and makes optimum use of joint commissioning.

11. Background and Consultation

Joint Commissioning Strategy
Neighbourhoods and Adult Services Service Plan for 2007 - 2010

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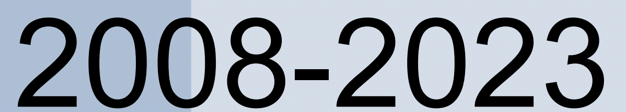
March 2008 – Final Draft

JOINT COMMISSIONING STRATEGY

Adult Services

ROTHERHAM



2008-2023

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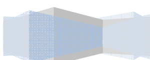

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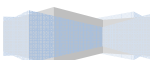


EXECUTIVE SUMARY

This document sets out the commissioning intentions of Rotherham Metropolitan Borough Council (RMBC) and Rotherham Primary Care Trust (RPCT) for the next 15 years. It sets priorities for joint commissioning and joint working during the next three years, details priorities that focus on service integration, improving quality and strengthening the joint commissioning framework. Figure 1 shows a summary of the main priorities.

Summary of key objectives and outcomes

The vision for health and adult social care in Rotherham is to deliver a personalised health and social care service, which is seamless and of the highest quality. This vision will be delivered through joint commissioning, effective joint working and integrated health and adult social care provision.

Our overarching vision is to;

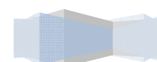
- Maintain people in independence for as long as possible
- Develop community-based services, which provide choice and improve quality of life
- Make sure that health and social care services are working closely together
- Maintain mental well-being well into later life

Over the next three years we will;

- Improve the quality of health and social care services to people who have a long term condition
- Develop effective rehabilitation and support services to ensure people can maintain their independence
- Make significant improvements to services which focus on the mental health needs of older people
- Reduce hospital admissions and admissions to residential or nursing care by helping people to stay at home for longer

Over the next fifteen years we will;

- Develop fully integrated health and social care services in the community for people with ong term conditions
- Develop a fully integrated specialist service for older people with mental health problems, which is co-located within a purpose-built unit and incorporates relevant inpatient and community-based services
- Develop a new service structure based on enablement rather than delivery of direct care
- Fully integrate the commissioning function for community based health and social care services



The five priorities

Figure 1 summarises the five priorities of the Joint Commissioning Strategy.

Figure 1: Summary of Joint Commissioning Strategy Priorities

Priority 1: Meeting the needs of people with long term conditions

This priority focuses on the development of appropriate health and social care packages for people with long term conditions who are living in their own homes. It responds to the anticipated increase in the numbers of people with a long term condition during the next 15 years.

RMBC and RPCT will identify high intensity users (HIUs) and those at risk of admission to hospital care. We will develop a case management approach to HIUs, which will deliver integrated packages of care and support. For the purposes of this strategy an HIU is someone who has a long term condition and is receiving a combination of health and social care services. For example, somebody living at home who is suffering from a combination of diabetes and cardiovascular disease and who has a community matron and an intensive package of home care support.

The Adults Board will explore the potential for co-location and then integration of the assessment and case management function of both organisations. We will establish a common definition of case management across health and social care. We will introduce a Common Assessment Framework for people with HIUs. We will review the community matron service, ensuring that it complies with national guidance on case management and enabling it to work across health and social care boundaries. Finally, we will recommission the Expert Patient Programme, opening out opportunities for the third sector to deliver jointly commissioned services.

Priority 2: Effective, jointly commissioned Intermediate Care Services

This priority focuses on the delivery of support and rehabilitation services that facilitate hospital discharge and reduce the risk of admission to institutional care. The main aim of this priority will

be to keep people as independent as possible and maximise their rehabilitation potential. It builds on the recent review of Intermediate Care Services which developed new joint commissioning arrangements and extended the remit of the service to act as a vehicle for community based re-ablement.

The Adults Board will explore the potential for jointly commissioning an Intermediate Care Service, which incorporates nurse-led step-up and step down services, providing alternative care pathways out of hospital and reducing admissions to hospital and residential care. We will remove all age restrictions on the Intermediate Care Residential Service. We will reconfigure the Community Rehabilitation Service, exploring the potential for co-location. We will review admission protocols so that they prevent inappropriate admissions to the service and target those who gain most benefit. We will develop mechanisms monitoring the long-term impact on service users. We will improve performance of the Community Rehabilitation Service by increasing the capacity of home care enablers. We will develop a joint performance management framework for the service. Finally, we will explore the potential for extending the Community Rehabilitation Service so that it incorporates a specialist falls prevention service.

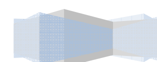
Priority 3: Older People's Mental Health (OPMH)

This priority addresses the impact of the ageing population on specialist OPMH services. It looks at whether the current service complies with national guidance. Finally it aims to develop a new service structure that is community based, focusing on preventing illness and promoting independence.

RMBC and RPCT will develop future investment plans for specialist OPMH services taking into account the change in demographics, the likely increase in demand and current under investment. We will develop a new service model for specialist OPMH services, which complies with the recommendations of the OPMH Review. We will explore the potential for joint commissioning and pooled budget arrangements for OPMH specialist services. We will commission an extended Memory Service, which acts as a multidisciplinary hub for delivering dementia care and we examine the potential for developing a specialist Discharge Liaison Scheme and a Home Care Enabling Service for OPMH. We will develop services and strategies aimed at supporting carers. We will adopt a Care Management Approach which incorporates the six strategies for promoting independence identified within NICE guidance. Finally, we will commission a fully integrated day care service, which combines the functions of social and rehabilitative day care.

Priority 4: Maintaining independence and reducing admissions

This priority considers the impact of the ageing population on the numbers of people entering hospital, residential or nursing care. It examines the current service model for community based health and social care services and how this might be realigned to prevent illness rather than promote dependence.

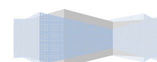


RMBC and RPCT will reduce the number of people entering hospital from residential and nursing care by providing better support in care homes. We will promote the use of assistive technology so that people can remain at home safely for longer. Finally we will develop a care-enabling ethos across all primary health and social care services, focusing first of all on the domiciliary care providers.

Priority 5: Effective joint governance arrangements

This priority considers the reconfiguration of joint governance arrangements so that they are able to deliver the objectives set out in the Joint Commissioning Strategy. It sets out arrangements for decision making, planning and service user engagement.

The Adults Board will commission all activity funded through Health Act Flexibilities through the Joint Commissioning Framework. We will delegate responsibility for implementation of the Joint Commissioning Strategy to the Chief Executive of RPCT and the Strategic Director of Neighbourhoods and Adults Services at RMBC. We will reconfigure the planning groups to reflect the priorities in the Joint Commissioning Strategy. We will develop recruitment and support strategies for service users and carers who are involved in joint planning. We will establish an annual programme of Citizens Juries and service user participation events aimed at improving and facilitating involvement. Finally, we will review the structure and resource requirements of the Joint Commissioning Team so that it is able to co-ordinate the implementation of the Joint Commissioning Strategy.



1 INTRODUCTION

1.1 Purpose of Joint Commissioning Strategy

This document sets out the commissioning intentions and the joint working priorities of RMBC and RPCT in relation to adult services. The strategy presents an analysis of local need, describes services that currently exists and highlights gaps in provision. It identifies those service areas where a joint approach would be most effective and sets out proposals on joint commissioning arrangements, service reconfiguration and resource allocation.

This is a 15 year strategy. It sets the direction of travel for the health and social care community by identifying long term objectives for the Adults Board. It specifically sets out actions that will be carried out within the next three years, working towards the longer term objectives of the strategy.

The Joint Commissioning Strategy replaces the current joint strategies for Long Term Conditions, Intermediate Care and Older People's Mental Health. Further work still needs to be done on priorities relating to learning disability and mental health for adults of working age. The Joint Commissioning Strategy will be revised this year to include these key work areas.

1.2 What is joint commissioning?

Joint commissioning is the process in which two or more commissioning agents act together to co-ordinate their commissioning activity, taking joint responsibility for the translation of strategy into action. It incorporates a number of activities which are set out in figure 1 as a cycle. Key features of Joint Commissioning are:

- Pooled budgets: the ability for partners to contribute agreed funds to a single pot, to be spent on agreed projects for designated services
- Lead commissioning - where partners can agree to delegate commissioning of a service to one lead organisation
- Integrated provision - where partners can bring together staff, resources, and management structures to integrate the provision of a service from managerial level to the front line

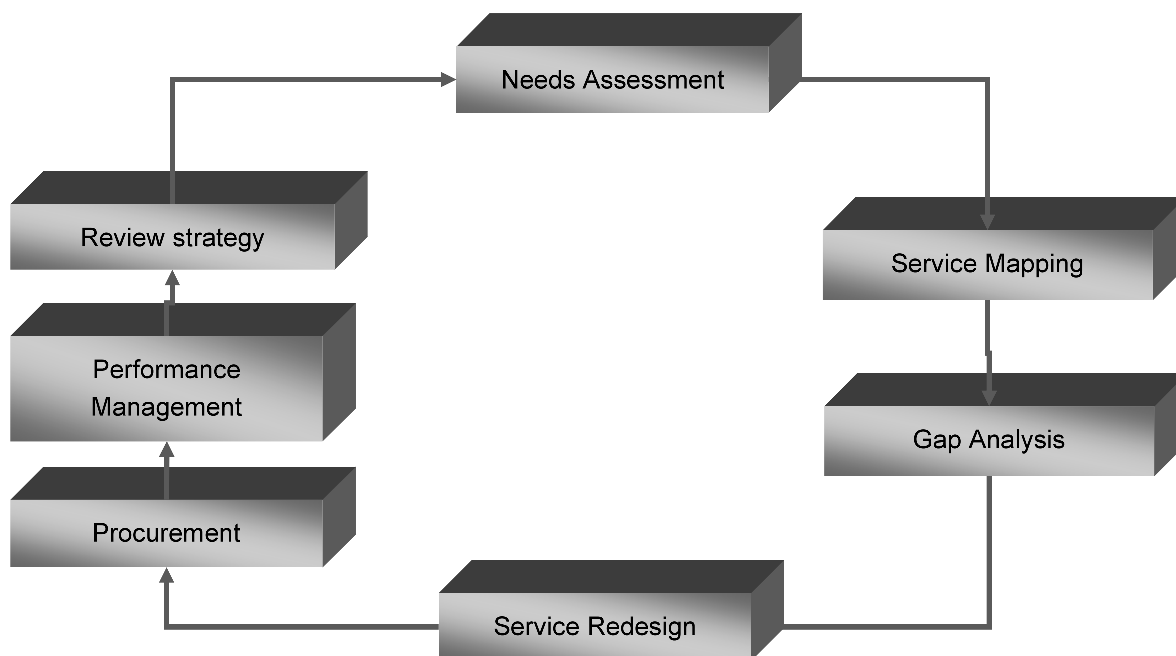
Joint Commissioning between health and social care agencies is supported by arrangements under flexibilities introduced by the Health Act Flexibilities which empowers health and local authority partners to transfer funding across organisations.

The aim of Joint Commissioning is to enable partners to work together to design and deliver services around the needs of users, rather than worrying about the boundaries of their

organisations. These arrangements help eliminate unnecessary gaps and duplications between services.

The joint commissioning governance arrangements for Rotherham are contained within the Joint Commissioning Framework "Joining Up Services". This documents sets out the powers of the Adults Board, and explains how the RPCT and RMBC jointly commission services. The framework also explains how service users and providers contribute to the commissioning process.

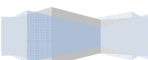
Figure 2 – The Joint Commissioning Cycle



1.3 Setting priorities

The priorities identified within the Joint Commissioning Strategy reflect the current work streams of the Adults Planning Board. They focus on services which are strategically relevant to both RPCT and RMBC and they incorporate priorities identified within national and local strategic documents.

Priority 1: Meeting the needs of people with long term conditions



In Rotherham there is likely to be a significant growth in the number of people with long term conditions over the next 15 years. The ageing population, higher levels of deprivation and the

legacy of a local economy based on heavy industry have all contributed to a disproportionately high incidence of long term illness.

For this reason meeting the needs of people with a long term condition has been a transformational priority of RPCT since 2006. This priority is based on the premise that there is a significant cohort of people with long term conditions who are receiving both health and social care services. The challenge is to develop a system of identification, case management and service delivery which will address the needs of this group of people.

The key challenges within this priority include;

- Identification of high intensity service users (HIUs)
- Developing a case management approach to managing long term conditions
- Integration community based health and social care teams
- Developing local ways to support self care

Priority 2: Effective Intermediate Care Services

In Rotherham we have had an Intermediate Care Service for 10 years. The model of provision has not changed during that time and it is now necessary to reconfigure the service so that it meets the demographic challenges. The Wanless Social Care Review on Social Care for Older People refreshes the definition and objectives of Intermediate Care Services. This Priority aims to bring the local service into line with this new vision.

The key challenges within this priority include;

- Commissioning an effective Intermediate Care pathway which fulfils the three functions identified in the *Wanless Social Care Review of Older People's Services*
- Reviewing the Community Rehabilitation Service and Millennium Day Service
- The development of nurse led step-up and step-down provision as part of the Intermediate Care pathway
- Exploring the potential for a single point of entry into Intermediate Care Services

Priority 3: Older People's Mental Health

In Rotherham the population of older people is predicted to grow 40% by 2025. The corresponding growth in older people with mental health problems will require more resources and a new approach to service delivery.

There is a need for additional investment and to realign services so that they promote independence, maintain cognitive function and prevent deterioration. By focusing on prevention and early intervention for those with mental health problems, health and social care agencies can reduce the costs of institutional care and offset some of the increased demand arising from the impact of an ageing population.

The key challenges within this priority include;

- Future investment in specialist OPMH services responding to change in demographics
- Development of a new service model for specialist OPMH services
- Exploring the potential for joint commissioning and pooled budget arrangements
- Developing a better balance between community, residential and inpatient care
- The development of new, innovative services targeted at those with mild/moderate dementia
- The development of a Care Management Approach, focusing on prevention

Priority 4: Maintaining independence and reducing admissions

In Rotherham there has been significant progress in reducing delayed transfers from hospital, but this has not been matched by reductions in avoidable admissions to hospital and long term care. Overall, there is potential to move care out of hospital and into the community but simply re-directing resources without clear evidence that community-based services have an impact on admissions could be counter-productive. For the NHS the strategic relevance of reduced hospital admissions is clear. Hospital admission reduction strategies can; ease waiting list pressures, indirectly reduce delayed discharges and allow more focus on preventive work.

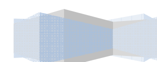
The key challenges for this priority will be to;

- Reduce the number of A&E attendances from residential and nursing care
- Promote an enabling an approach to service delivery, which will reduce dependence
- Utilise assistive technology so that it increases independence and reduces risk

Priority 5: Effective governance

In Rotherham has recently redefined the role of the Adults Board, pooling the delegated powers of the Chief Executive of RPCT and the Strategic Director for Neighbourhood & Adult Services. It introduces new planning groups, which act as the interface between service users, providers and commissioners.

There are however significant barriers to integrated commissioning. RPCT and RMBC have different planning mechanisms, their budget cycles do not synchronise and they operate within different legislative frameworks. Both organisations have their own systems of performance management, separate lines of accountability and a range of cultural disparities which impact on the way commissioners operate. The Commissioning Framework for Health and Social Care moves health and social care partnerships from being optional to mandatory. While partnership may be the preferred language, integrated commissioning is the expected outcome. We need to respond to this expectation by building on the current strong partnership arrangements.



The key challenges within this priority include;

- Redefining the role of the Adults Board

- Identification of service areas where a lead commissioner role is appropriate
- Increasing the degree of integration on commissioning
- Ensuring that service users and providers can influence the commissioning process

1.4 Limitations of the Joint Commissioning Strategy

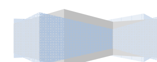
The Joint Commissioning Strategy focuses on older people and people with long term conditions. This is not currently a strategy which sets out a work programme for people with learning disabilities or adults of working age with mental health problems.

The Valuing People White Paper published by the DH in 2001 is the template for the development of joint working on learning disability. This White Paper established Learning Disability Partnership Boards to oversee the implementation of health act flexibilities, and incorporates a range of targets on person centred planning, health, housing, employment and carer support.

A recent revision of Valuing People reasserts the primary role of the local authority as the lead commissioner for learning disability services and states that communities that have not already put in place robust joint arrangements and pooled budgets for learning disability services should arrange to transfer funding for social care services, still resting with PCTs, to the local authority during 2009/10.

The Mental Health National Service Framework (1999) and NSF Five Years on (Dec 2004) propose an ambitious programme of reform of mental health services across health and social care. The new Framework promotes the use of the Health Act Flexibilities to commission integrated services for people with Mental Health problems.

The ‘Five Years On’ document (DH 2004) focuses on social inclusion, iimproving services for people from Black and Ethnic Minorities, improving choice, the development of psychological (talking) therapies and improving care for those with long-term mental health needs. The document recognises the need for health and social care to work in partnership.



PRIORITY 1: MANAGEMENT OF LONG TERM CONDITIONS

2.1 Strategic Relevance

Our Health, Our Care, Our Say[3] identifies the management of long-term conditions as a priority. It recognises that currently many people with a chronic condition are not aware of support or treatment options. They do not have a clear plan, which explains how they can manage their own condition better. The White Paper supports an integrated approach to developing health and social care plans, integrated teams and carer support.

The *NHS Operating Framework*[2] expects PCTs to improve care for people with long-term conditions and to ensure there is more choice for these patients. PCTs are now required to develop a model of care for long-term conditions, which focuses on effective care planning.

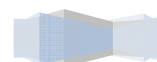
The *Wanless Social Care Review of Older People's Services*[1] highlights the link between the ageing population and increased prevalence of long-term conditions. The review predicts an increase in the numbers of older people with a long-term condition where there is an impact on cognitive function and/or on the ability to carry out activities of daily living. It draws a direct correlation between the growth in this population and future service demand. However, the review also explains that future increases in demand can be controlled if health and social care agencies work together to achieve overall improvements in population health and if new treatments or technologies are effective at reducing levels of disability.

Finally, the new *National Indicators for Local Authorities and Local Authority Partnerships*[12] include one indicator on the number of people with a long-term condition supported to be independent and in control of their condition. This is a new indicator for which there will be a joint responsibility on delivery.

2.2 Current workstreams

The Joint Commissioning Team is currently reviewing the Community Matron Service, which is responsible for the case management and clinical nursing care of people with long term conditions who have complex needs.

RPCT is also in the process of commissioning a local study on case management, which will make proposals on the identification of HIUs, the assessment of people's needs, the process of case management and how it should change the way services are delivered to people with long term conditions.



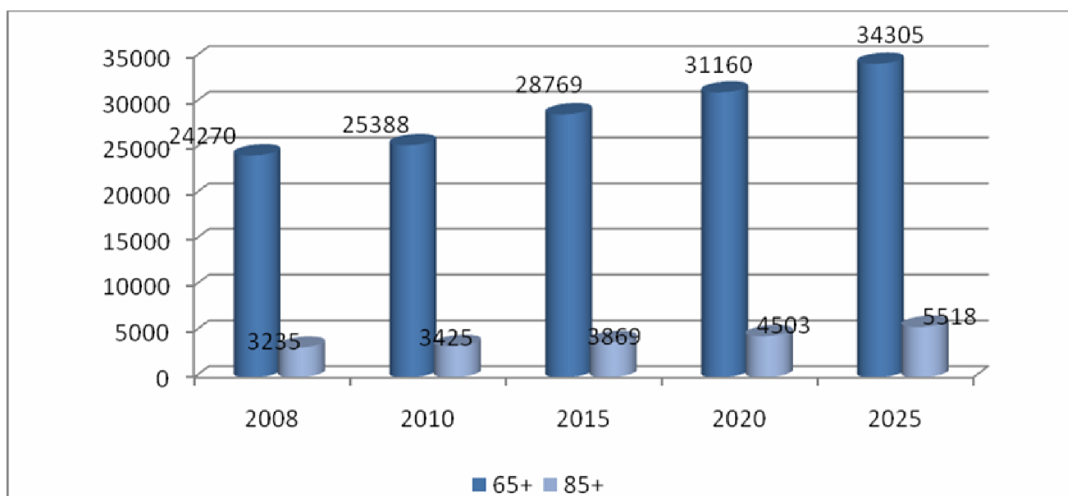
Finally the Joint Commissioning Team is currently re-commissioning the Expert Patient Programme. This will be the first time that a jointly commissioned service is opened out to a broad range of providers, providing the third sector with an opportunity to deliver a core strategic service.

2.3 Needs Assessment

The needs assessment focuses on the needs of people over 65 years with a limiting long-term condition. This is because national guidance documents only produce predictive data for older people.

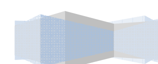
Figure 3 estimates the projected increase in numbers of people over 65 years old who have a limiting long term condition. Figures are taken from the Joint Strategic Needs Assessment[17]. The projections are calculated by applying percentages of people with a long term condition in 2001 to projected population figures.

Figure 3 - People over 65 with a long term condition in Rotherham



The ONS predicts an increase of 4.6% in the number of older people with a long term condition by 2010, accelerating to 18% by 2015.

The *Wanless Social Care Review of Older People's Services*[1-p35] builds on these by incorporating predictions on healthy life expectancy. When assessing the impact of the ageing population it is important to establish whether people are living longer because of later onset of disease or whether they are living longer after developing a long term condition. If longevity is due to late onset of disease then the burden on health & social care services correlates to population growth. However if people are living longer after they have



developed a long-term condition there will be a disproportionate rise in the number of people with a disability compared to population profiles.

Wanless concludes that increases in healthy life expectancy are not keeping pace with improvements in life expectancy. As life expectancy increases a smaller proportion of that time will be disability-free. This is likely to lead to a greater reliance on community based health & social care services than would normally be expected from population growth profiles.

The introduction of new medical technologies and public health campaigns aimed at adjusting lifestyle could have an impact on the numbers of older people with long term conditions in the future. Wanless recognises this and identifies three scenarios which could affect healthy life expectancy and therefore the proportion of older people who are unable to carry out one ADL.

Scenario 1: No change to population health

Public health strategies have no impact on the prevalence of long term conditions. New treatments only offset the negative influences of obesity and other lifestyle issues. The incidence of and recovery rates from dependency remain the same. Life expectancy continues to rise in line with ONS projections.

This scenario shows that if rates of disease and other factors stayed as they were in 2005 Rotherham's disabled population would grow by 78% by 2025.

Scenario 2: Poorer population health

Obesity trends continue, increasing the proportion of the population with associated long term conditions. This increases the prevalence of arthritis, stroke, coronary heart disease and vascular dementia. The emergence of ethnic minorities in the older population increases the prevalence of stroke and coronary heart disease. Public health strategies fail to offset these pressures, increasing prevalence long term conditions. Medical intervention continues to focus on reducing mortality from diseases rather than reducing the disabling effects.

This scenario shows that if rates of disease and other factors stayed as they were in 2005 Rotherham's disabled population would grow by 80% by 2025.

Scenario 3: Improving population health

Public health campaigns are successfully change behaviour and there is a decline in risk factors associated with lifestyle. The health service redirects technology and resources to focus on disease prevention for a much broader population.

This scenario shows that if rates of disease and other factors stayed as they were in 2005 Rotherham's disabled population would grow by 65% by 2025.

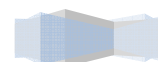
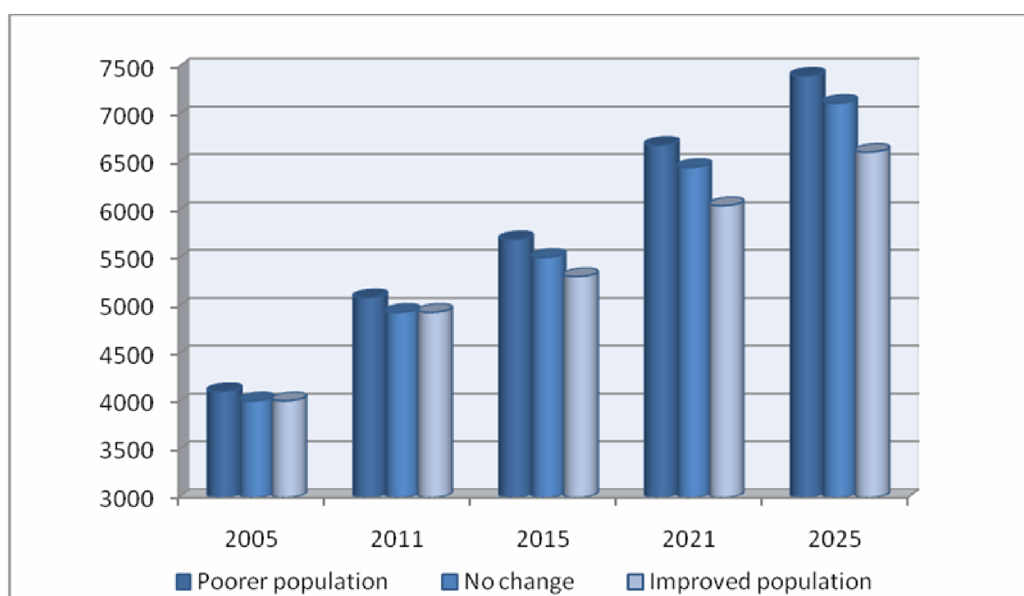


Figure 4 predicts the numbers of people over 65 who have a long term condition which prevents them from carrying out one Activity of Daily Living (washing, going to bed , going to the toilet.). This is the group most likely to require health and social care support.

For the purposes of this strategy we have assumed that *Scenario 3 (Improving Health Population)* applies. Wanless predicts an increase of 23% in the number of older people with a long term condition who are unable to carry out one ADL, from 4,012 to 4,936 between 2005 and 2011. This grows to 5310(32%) and 6609(65%) by 2015 in 2025 respectively.

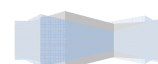
Figure 4 - People over 65 with a long term condition & who can not carry out one Activity of Daily Living



The limitations on these predictions are set out below;

- Assumes moderate improvements are made in reducing levels of obesity and other lifestyle issues
- Assumes new treatments or technologies are effective at reducing consequences of disability
- Only considers increase in prevalence of long term conditions in older population

Even with a relatively optimistic scenario the evidence is that there will be an increase in the prevalence of older people with long term conditions who are unable to carry out at least one ADL. In each of the scenarios ‘no change’, ‘poorer health’ and ‘improved health’, the increases are significant.



This indicates that there will be a growing population of people whose care will be complex and difficult for the current health and social care system to manage. For the purpose of this

document these service users are referred to as High Intensity Users (HIUs). HIUs have a mixture of health and social care needs accompanied by increased vulnerability and a high-risk of unplanned institutional care.

The NHS and Social Care Model for Long Term Conditions[7-p2] sets out how health and social care can work together to identify those with long-term and how their needs can be met. It identifies the key elements of a health and social care model which best meets the challenges presented by a growing population of people with long term needs. In particular the model emphasises

- The identification of people with a long term condition who are high intensity users
- The stratification of need so that people can receive care according to their needs,
- The use of community matrons to provide case management,
- The establishment of multi-disciplinary teams in the community
- The development of local ways to support self care

Identification & Stratification of High Intensity Users

The NHS and Social Care Model for Long Term Conditions[7-p2] emphasises the importance of identifying those people at highest risk of hospital admission. It offers an opportunity to help design, commission and implement care pathways for people according to their level of need. Identification and stratification is also essential for effective long term conditions management. It ensures that people with a chronic condition are put on the correct care pathway at the appropriate time, saving time and money further down the line.

There are a number of tools currently available to health and social care agencies which help identify people at high risk of admission to hospital. They use a combination of hospital admission data, trigger conditions and primary care data to identify people who are at risk and therefore likely to be have a complex range of needs.

Fig 5 shows how one of these tools, *The Combined Predictive Tool* stratifies level of risk, expected emergency admission rates and the relative proportions of the Rotherham population. The diagram also aligns the expected risk with anticipated need as set out in the South Yorkshire Model for Management of Long Term Conditions.

A key question for this strategy is whether HIUs (high intensity users of health and social care services) are those at greatest risk of hospital admission. This strategy assumes that those people using a combination of community-based health and social care services are more likely to be at risk of hospital admission. It also assumes that people with a combination of long term conditions are more likely to require combined health and social care packages. However it is recognised that further work is needed to establish the extent to which these assumptions are accurate. There is a need to identify the cohort of people with a long term condition who receive community-based health and social care packages. This will enable RPCT and RMBC to develop targeted strategies aimed at reducing hospital and residential care admissions.

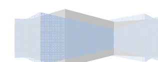
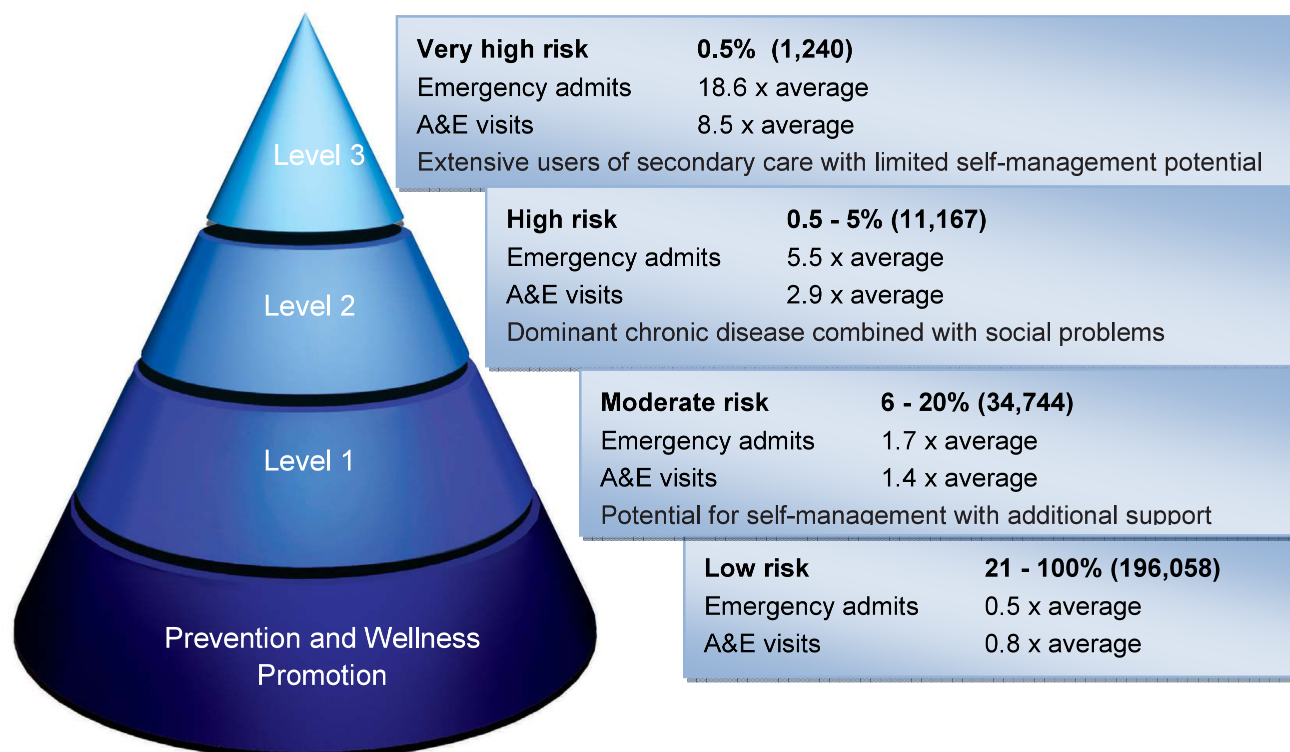


Fig 5 Segmentation of Rotherham population using Combined Model

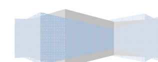


Developing care pathways for people with Long Term Conditions

Our NHS, Our Future[4] promotes the designing of services in terms of care pathways. Professor Dazi, the author of this report, believes that this approach is more likely to deliver quality of care, reducing the obstructive effect of organisational boundaries. A pathway approach to service design requires collective accountability for outcomes at each point. In joint commissioning terms this requires a strong relationship between RMBC and RPCT.

In order to develop an effective care pathway for High Intensity Users, the following key elements are required

- Adopting a case management approach, coordinating care packages for those at highest risk. i.e. those in level 2 or 3 of the risk pyramid.
- Integration of assessment and care management across health and social care
- Integration of service delivery across health & social care
- Access to a single or clear point of entry into services



Adopting a case management approach

There is a range of evidence which supports the development of an integrated case management approach when working with HIUs.

The NHS Case Management Competences Framework[14] states that;

"Though each individual's combination of conditions is different, they have a common requirement for all of their needs to be brought together in a co-ordinated manner. Case management is considered the best vehicle for bringing together all of the care and treatments needed by many people with complex long term conditions[14-p1]."

The *Wanless Review of Social Care for Older People*[1] highlights the importance of good case management, seeing these as the cornerstone of high quality care.

Also Our Health, Our Care Our Say[3] advocates the development of joint health and social care teams with dedicated case management through a single expert case manager[3-p120]. The Department of Health has introduced a National Public Service Agreement target to improve outcomes for people with long term conditions. This agreement calls for a personalised care plan for vulnerable people most at risk, and incorporates targets on the reduction of emergency bed days.

What is case management?

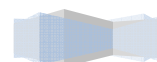
For the purpose of this strategy the definition of case management complies with that set out in the Case Management Competences Framework[14]. At the heart of this framework is the need to be proactive and co-ordinated in identifying those people with the most complex need and then co-ordinating and managing their care effectively.

The Case Management Competences Framework explains that effective case management should incorporate the following key elements;

- A personalised and integrated care plan based on needs, preference, choices and aspirations
- A focus on those who carry the highest burden of disease
- Co-ordination of the journey through all parts of the health and social care system

The Framework defines the role of case manager and explains the difference between this role and that of a Community Matron. A case manager is a qualified nurse, social worker or allied health professional who works with people who have a dominant complex single condition but with intensive needs that require a properly co-ordinated care plan. A case manager works as part of an integrated team and is responsible for planning, co-ordinating and reviewing formal care input from both health and social care agencies.

A community matron is a nurse who combines the case management role with advanced clinical nursing care. They target those people at the top of the risk pyramid (Fig 5). A



community matron will work with people who have multiple long term conditions that put them at high risk of unplanned hospital admission. A typical service user will have a combination of pharmacy, social, medical and nursing needs, which can be met at home if risks are appropriately managed.

The establishment of multi-disciplinary teams in the community

Our Health, Our Care, Our Say[1-p57] states that access to high-quality primary healthcare has a vital role in helping people to live longer and healthier lives. Integration of these services with other community and social care services helps to ensure better co-ordinated support and care for each individual, better management of chronic disease, and reduced need for costly and avoidable hospital care.

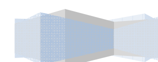
Similarly *The Commissioning Framework for Health & Well Being*[15] recognises that integration of health, social care and other service providers is likely to help people stay healthy and independent.

However the *Wanless Review of Social Care for Older People*[1-p211] sets out the strongest argument for integration of the case management function, explaining the potential benefits for the management of long term conditions. Wanless highlights the needs for better integration of assessment across the health and social care. This will lead to the development of shared care plans forming part of an integrated health and social care record. Wanless regards integrated care for people with complex long-term needs as a particular challenge. He encourages the creation of multidisciplinary teams between PCTs and local authorities, the co-location of key services and the increased use of Health Act Flexibilities.

2.4 Gap Analysis & Future Vision

The first challenge for the local health and social care community is to reduce the number of people who have a long term condition and increase healthy life expectancy. The needs assessment assumes a 65% growth in the number of people with a long term condition who will require service intervention by 2025. This however assumes that population health will improve. If public health campaigns are unsuccessful and unable to address risk factors associated with lifestyle, the percentage increase could be even greater. If the health service fails to redirect technology and resources to focus on disease prevention for a much broader population, Wanless predicts that the growth in the population of older people with a disabling long term condition could be as high as 80%.

To address this The Adults Board will develop a 5 year Public Health Strategy specifically aimed at increasing healthy life expectancy and introducing specific targets on reducing the numbers of people with long term chronic conditions.



In Rotherham there is currently no system of identification of people with long term conditions who are high intensity users of health & social care services (HIUs). The community matron service does have access to the PARR predictive toolkit but this does not act as a central source of information when identifying those who require a case management approach. Also the PARR toolkit only uses hospital admission data, which is restrictive and does not predict high intensity service usage for people managing their condition in the community.

The Adults Board will develop an appropriate system for identification of HIUs and stratification of risk. We will adopt an integrated case management approach to this cohort of service users.

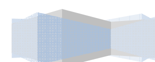
There are significant obstacles which prevent community matrons and specialist case managers from acting as effective case managers. Caseloads are not established with reference to an appropriate predictive risk toolkit but are mainly controlled by local GPs who make judgments about the most appropriate patients. This can lead to service inconsistency and inequalities. Community matrons do not have the authority to co-ordinate social care packages. They do not have direct access to social care resources and do not have access to appropriate Multi-Disciplinary Teams.

RPCT will recommission the community matrons service, ensuring that it complies with national guidance on case management and that it works across health and social care boundaries. The Adults Board will explore the potential of developing Multi-Disciplinary Teams which are responsible for the case management of HIUs.

For those people who present a lower risk it is important that appropriate services are in place, which focus on self care and prevention. RPCT currently coordinates an Expert Patient Programme which provides advice and guidance on self management of long term conditions. The Adults Board will recommission this service, opening opportunities for voluntary and independent sector service providers to deliver this strategically relevant service.

There are a wide range of activities and programmes which help people who have a long term condition self manage. Some of these are condition specific (Diabetes management) and some are generic (Expert Patient Programme). The Adults Board will carry out an audit of self management activity across partner organisations. It will identify gaps and develop a strategy for promoting self management.

In the longer term the Adults Board intends to commission integrated care pathways, which will remove organisational boundaries and deliver a seamless service for people with long term conditions. The Adults Board will also build on the development of Multi-Disciplinary Teams by developing fully integrated community based health and social care teams. Starting with assessment and care management, this process of integration will move on to direct services and further integration of the commissioning process.



2.5 Summary of Action Plan

Short term actions 3 years

A1 Develop a 5 year Public Health Strategy specifically aimed at increasing healthy life expectancy and introducing specific targets on reducing the numbers of people with long term chronic conditions.

A2 Develop a system of identification for high intensity users of health and social care services (HIUs)

A3 Recommission the community matron service, ensuring that it complies with national guidance on case management and works across health & social care boundaries

A4 Develop Multi-Disciplinary Teams, which are responsible for the case management of HIUs

A5 Carry out an audit of self management activity and develop a Self Care Strategy

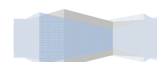
A6 Recommission and expand the Expert Patient Programme

Long term actions objectives

L1 Commission integrated care pathways for people with a long term condition who can not carry out activities of daily living

L2 Develop fully integrated case management teams for adults with long term conditions living in the community

L3 Develop a system of identification for all people with a long term condition, enabling early intervention and the delivery of preventive services.



PRIORITY 2: INTERMEDIATE CARE

3.1 Strategic Relevance

Our Health, Our Care, Our Say[3] explains that investment in Intermediate Care since 2001 has already resulted in a significant reduction in delayed discharge from hospital. The White Paper advocates greater use of Intermediate Care Services to enable more people to be cared for in the community. It states that strengthened Intermediate Care Services will provide safe and effective alternatives to acute hospital admission for many people.

The *Wanless Social Care Review of Older People's Services*[1] highlights the potential of Intermediate Care as a vehicle for maintaining physical function preventing deterioration of long term conditions. The review identifies three key functions of an Intermediate Care Service[1-p172];

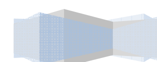
1. To provide a service option for people with long-term conditions who experience an acute exacerbation, which does not need to be managed in a hospital.

2. To provide a short-term solution for people ready to be discharged from hospital in order for their long-term care options to be assessed and arranged.

3. To rehabilitate people on discharge from hospital so that they can readjust to life back in the community.

Wanless recognises that clarity is needed on what should be the key objectives of an Intermediate Care Service. If cost savings are the main aim, then admission avoidance should receive more emphasis. The review recommends more emphasis on non-residential Intermediate Care schemes, greater flexibility on the 6 week time limit and the development of Intermediate Care Services targeted at specific conditions.

Intermediate Care Services are also strategically relevant for RPCT. *Our Future Health Secured; A Review of NHS Funding & Performance*[9] identifies Intermediate Care Services as having made a significant contribution to the reduction in delayed discharges from hospital. Standard 3 of The National Service Framework for older people sets out the responsibilities of the NHS in relation to Intermediate Care. It places a responsibility on PCTs to develop enhanced rehabilitation services which will prevent unnecessary hospital admission and enable early discharge from hospital.



3.2 Current workstreams

The Joint Commissioning Team recently completed a review of the Intermediate Care Service in Rotherham. It made recommendations on the development of new joint commissioning arrangements for the service and set out proposals for service reconfiguration which would improve the performance of the residential service.

Much progress has been made on developing the Intermediate Care pathway. A jointly funded service manager's post has been agreed to lead the service. There is a new joint performance management framework which sets targets on bed occupancy and length of stay. The service has also been reconfigured so that the residential service is opened up to community based referrals or referrals from residential care.

3.3 Definition of Intermediate Care

For the purpose of this strategy an Intermediate Care Service is one which;

- Is targeted at people who would otherwise face prolonged hospital stays or inappropriate admission to acute inpatient care or long term residential/nursing care
- Is provided on the basis of a comprehensive assessment, resulting in a structured individual care plan that involves active therapy, treatment or opportunity for recovery
- Has a planned outcome of maximising independence, enabling users stay at home
- Is time-limited, normally no longer than six weeks and frequently as little as 1-2 weeks
- Involves cross-professional working, with a single assessment framework

3.4 Service & Resource Map

The Intermediate Care Service in Rotherham is made up of three key service areas. These services fit the current definition of Intermediate Care and are included in the relevant joint commissioning and pooled budget arrangements.

The *Intermediate Care Residential Service (ICAB)* provides rehabilitation for people who are considered unsafe to remain in or return to their own homes but who would have the capacity to live at home if provided with suitable rehabilitation services. Table 1 shows where these beds are currently located;

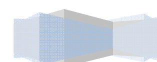


Table 1 Distribution of Intermediate Care Beds

Name of home	No. of beds	Status	Nursing /Residential
Netherfield Court	21	Local Authority	Residential
Broom Lane	8	Independent	Dual registered
Rothwel Grange	12	Local Authority	Residential

The Community Rehabilitation Team (CRT) is a multi-disciplinary team which brings together occupational therapists, physiotherapists and home care enablers to deliver rehabilitative support to people in their own homes. The service currently focuses on reducing home care packages by increasing levels of independence. The service is generally available for up to six weeks, although this is flexible depending on individual need.

CRT co-ordinates individual care plans following a joint assessment by a physiotherapist and occupational therapist. Care plans are aimed at enhancing daily living skills, mobility, confidence and social skills.

Finally *The Millennium Day Rehabilitation Unit* provides rehabilitation in a day care setting to improve safety, function and independence. The service is available for people for up to six weeks, although this is flexible depending on individual need. The multidisciplinary team consists of an occupational therapist, physiotherapist, rehabilitation support workers and rehabilitation assistants.

Each of the above services are supported by a specialist Mental Health Occupational Therapy Service. This carries out assessments of need and signposts people to relevant specialist services. The Mental Health OT Service is currently managed by DASH.

3.5 Gap analysis & Action Plan

The Adults Board endorsed the review of Intermediate Care Services in September 2007[19]. The purpose of the review was to map current provision, develop joint commissioning arrangements, ensuring appropriate service levels agreements and pooled budgets were in place. It also put forward proposals on the reconfiguration of the residential service so that it addressed the strategic objectives of the RPCT and RMBC. The review incorporated 26 recommendations. The key outcomes from the review are set out below[19] with proposals for future action.

Joint Commissioning Arrangements

The review recommended that from 2008/09 funding for all Intermediate Care Services should be transferred to a pooled budget and this has been agreed by The Adults Board. The incorporation of services into one pooled budget will clarify the commissioning and financial

arrangements for Intermediate Care. It will place the service in a position where it can be jointly commissioned. It will enable the development of co-ordinated care pathways from residential rehabilitation services to community and day care provision. Finally it will facilitate the delivery of integrated teams, case management and single assessment.

In order to establish a clear split between commissioning and service provision RMBC and RPCT have agreed that responsibility for commissioning the Intermediate Care Service is transferred to the Joint Commissioning Team, acting on behalf of The Adults Board. The Adults Board has developed a service level agreement and joint performance management framework to support this arrangement. The Joint Commissioning Team (JCT) will, from April 2008, lead on commissioning activity relating to Intermediate Care. It is responsible for preparing needs analyses, mapping service provision, gap analyses, strategic development, contracting and performance management. The service is commissioned as part of the Joint Commissioning Framework.

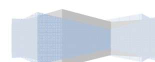
Provider responsibility for the service is held by RMBC. As provider, the Council holds the pooled budget and is responsible for overall performance of the service. Underpinning this overarching contract between the Adults Board and RMBC is a separate block contract between RMBC and RPCT Provider Services to deliver therapy services within Intermediate Care.

Developing an effective service model

The current residential Intermediate Care Service is successful in facilitating timely, effective and safe discharge from hospital. It is also helping to prevent unnecessary admission to long term care. In 2006 over 70% of service users returned home after receiving the Intermediate Care Residential Service, with only 4% having to move on to long term residential care. This indicates that the service is able to facilitate hospital discharge and help people to adjust to life back in the community.

However the service does not currently provide a service option for people with long term conditions who experience and exacerbation and it does not provide a short-term solution for people in hospital who are waiting for long-term care options to be assessed. The service does not prevent unnecessary admission to hospital or provide appropriate access to community based pathways of care. This is evidenced by the admissions profile for the residential service in 2006 which indicates that the service is almost exclusively being used to facilitate timely hospital discharge.

The Adults Board intends to commission an Intermediate Care Service which fulfils all the functions set out in *The Wanless Social Care Review of Older People's Services*[1-p172]. The new service will provide alternative care pathways out of hospital and reduce admissions to hospital and residential care. In addition to the current residential service rehabilitation service the Adults Board intends to explore the potential for developing nurse-led residential provision targeted at people who are;



- Fit to leave hospital but do not have appropriate care packages in place to return home
- Fit to leave hospital but require a short period of convalescence before returning home
- Awaiting assessment and/or transfer to residential/nursing care from hospital
- Temporarily at high risk of hospital admission because of exacerbation of a long term condition

There is evidence that nurse-led Intermediate Care units have longer lengths of stay than in secondary care but that post-discharge resource use is lower because people are discharged with a higher level of functionality. Also, discharge into institutional care is considerably lower, as are hospital re-admission rates. There is substantial evidence of improved functionality on discharge from Intermediate Care but it is unclear whether these improvements are sustainable. The overall reduction in post-discharge costs relies on sustained health improvement after discharge from Intermediate Care. The current evidence indicates if the appropriate model of nurse-led Intermediate Care is commissioned, this could have a significant impact on levels of dependency on secondary and community based health and social care services in the future.

Service integration and leadership

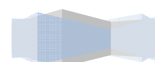
The Intermediate Care Review[19] considered the current management structure for the service. It recognised the strong relationship between front-line health and social care staff. However there was an unnecessary separation between health & social care professionals and between the Community Rehabilitation and Residential services. The review highlighted a lack of cross-over between these services during times of high activity in the residential service.

The review set out a structure for the Intermediate Care Service which clarifies the relationship between the RMBC and RPCT provider services. The Adults Board has agreed to a subcontract agreement between RMBC and RPCT Provider Services to deliver the therapy element of the Intermediate Care Service. Under the new service structure RMBC will recruit an Intermediate Care Service Manager who is has operational responsibility for social care staff, acts a contract manager for the therapy contract and is the accountable officer for the Intermediate Care Service Level Agreement.

Over the next three years The Adults Board intends to move forward on integration and explore the potential for a fully integrated Intermediate Care Service.

Performance management arrangements

The New Performance Framework for Local Authorities and Local Partnerships[12] recognises the significance of Intermediate Care in relation to reducing hospital stay, maximising independence and promoting active recovery for people with long term conditions. The new framework incorporates two indicators for which there will be shared performance targets. Indicator 1 measures the benefit to individuals from Intermediate Care and rehabilitation following a hospital episode. The indicator covers older people who on discharge from hospital:



- Would otherwise face an unnecessarily prolonged stay in institutional care
- Would otherwise be permanently admitted to institutional care
- Have a planned outcome of maximising independence, whilst living at home
- Require a support package which includes active therapy or treatment
- Require a short-term intervention, no longer than 6 weeks

Indicator 2 measures the proportion of older people discharged from hospital and benefiting from Intermediate Care and who are still living at home three months after discharge as a proportion of all older people discharged from hospital and receiving Intermediate Care.

This new performance management framework recently developed for the Intermediate Care Service will directly measure progress on these key indicators. The Adults Board has developed reporting mechanisms, identified accountable officers and developed proceses for addressing poor performance.

Age restrictions on current care pathway

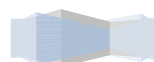
The Intermediate Care Residential Service is currently restricted to people over 65 years. CSCI registration procedures make it difficult to develop integrated provision for all adults. Residential facilities require separate registration for older people and working-age adults. Current service utilisation data indicates low demand from working-age adults but this is likely to change as care pathways are opened up into the service.

The Adults Board will remove all age restrictions on the residential service, opening up the service to working-age adults who are managing a long term condition in the community or who require rehabilitation support after hospital discharge.

Reconfiguration of the Community Rehabilitation Service

The Intermediate Care Review highlighted a number of issues which impact on the performance and strategic relevance of the Community Rehabilitation Service. Therapy staff are currently located at 3 separate sites. There is a significant degree of disaggregation between health and social care staff and a loss of service identity caused by the spread of service locations.

There is an anticipated improvement in the performance of the residential service over the next three years and this is likely to have a significant impact on the Community Rehabilitation Service. In 2006 15% of people discharged from the residential service were referred for further support from The Community Rehabilitation Service. If the service were to continue to work with the same proportion of residential discharges demand would increase significantly.



There is a greater need for follow-up support and monitoring from the residential service and the Community Rehabilitation Service should be meeting this need. Realigning the Community Rehabilitation Service within the Intermediate Care Pathway so that it follows up a higher

proportion of discharges from the residential service will streamline the care pathway, although it will also have an impact on demand for the service.

The Adults Board intends to commission a Community Rehabilitation Service which is fully integrated into the Intermediate Care Pathway. The service will be extended so that it can incorporate follow-up work from the residential care service and so that it can deliver a falls prevention service.

Falls prevention services

There is a significant gap in service provision in relation to falls prevention. There is a lack of proactive case finding and an under-usage of the Falls Risk Assessment Tool (FRAT) by community based health and social care professional. There is no clear care pathway for people who have fallen or who have been identified as a high falls risk.

Currently there is no falls prevention service ins Rotherham and therefore a lack of capacity and focus for preventive and rehabilitative work. Consequently there is no follow-up available when people have been identified by A&E, GP practices, Intermediate Care or the Community Matron Service.

RPCT will commission a Falls Prevention Service and explore how this can be integrated into or work alongside the Community Rehabilitation Service.

3.6 Summary of Action Plan

A7 Commission an Intermediate Care Service which fulfils the three functions identified in the *Wanless Social Care Review of Older People's Services*[1]

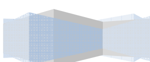
A8 Develop a fully integrated Intermediate Care Service

A9 Develop joint commissioning arrangements, service level agreements, pooled budget arrangements and a joint performance management framework

A10 Remove all age restrictions on the Intermediate Care Residential Service

A11 Review and reconfigure the Community Rehabilitation Service

A12 Improve performance of the Intermediate Care Service



PRIORITY 3: OLDER PEOPLE'S MENTAL HEALTH

4.1 Needs Assessment

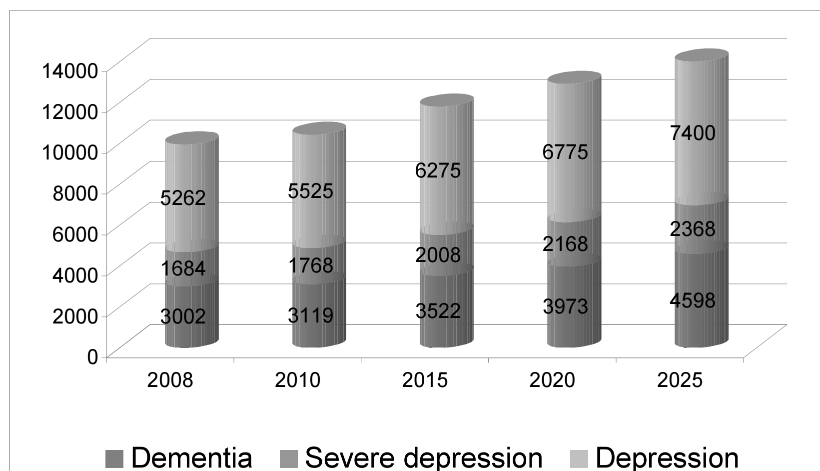
Demographics of depression & dementia

Figure 6 shows the predicted population profile for depression and dementia amongst older people in Rotherham. ONS estimates show that between 10–15% of older people suffer from depression and that 3-5% have severe depression. Average prevalence rates are applied to population projections for older people.

It is estimated that the number of older people with depression will increase by 19% between 2008 and 2015. Prevalence rates for dementia are calculated using the Medical Research Council's Cognitive Function and Ageing Study. It is possible that improvements in treatment of cardiovascular diseases could reduce the prevalence rates of people with vascular dementia. This would result in a slight deviance in age specific dementia rates.

Applying these prevalence rates to ONS population projections gives estimated numbers of people predicted to have dementia to 2025. It is estimated that the number of older people with dementia will increase by 17% between 2008 and 2015. This rate increases to 20% for people over 85 years. For this age group there is a rise from 1284 to 1540 over the next 7 years. Most of the overall rise in prevalence takes place in this age group which is significant as it is the group most likely to present with co-morbidities.

Figure 6 - Population profile for dementia/depression: 2008 – 2025[16]



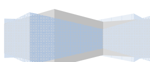
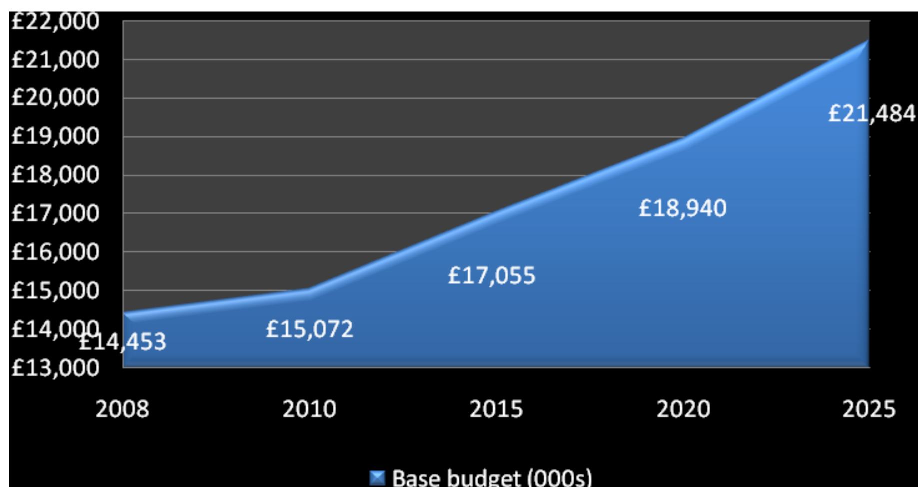


Figure 7 sets out the potential impact that these demographic changes could have on service costs. The baseline costs are taken from the supply mapping exercise completed in March 2007. This identifies all specialist services for older people with mental health problems. It identifies budgets for 2006/07. A 2% uplift has been assumed to align costs with the demographic data.

Figure 7 – Predicted service costs: 2008 - 2025



The service costs included in this prediction include; community mental health services, specialist residential care services, Hawthorne Day Hospital, specialist social day care, inpatient care, Intermediate Care and outpatient services. It does not include any service costs for; primary care, elderly inpatient care, home care, mainstream Intermediate Care, generic residential and day care services or social work. It is likely that there will be substantial additional costs in these areas as well.

4.2 Evidence to support investment in preventive services

The financial burden resulting from the increase in population of older people with mental health problems will be unsustainable unless service structures change and/or extra investment is found.

For dementia there is evidence that services aimed at supporting independence can delay admission to nursing care and reduce the cost of health and social care packages[16-p15]. There is a correlation between level of cognitive function and cost of care. There is also a correlation

between the level of cognitive function and susceptibility to secondary conditions and illnesses, which will accelerate progression towards high-cost community care.

There is evidence that addressing risk factors such as physical disability and illness, sensory impairment and social isolation can reduce the cost of health and social care. Targeting older people at times of risk can prevent depression as can responding to the effects of life-changing events such as illness and bereavement. Emotional support and counselling following such events can reduce levels of depression and anxiety.

4.3 Key components of a preventive mental health service

The Joint Commissioning Team has recently completed a review of OPMH Specialist Services[16]. It identifies the following key components of a high quality mental health service, which will promote independence, prevent illness and reduce costs of hospital/residential care.

Detection & diagnosis

For dementia there is evidence that early diagnosis acts as a gateway to support services and enables those with dementia to prepare for the future. Early recognition helps reduce anxiety relating to changes in memory, mood or behaviour. Detection and active therapy at the point of diagnosis can delay the subsequent need for nursing home care.

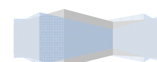
Memory Services are able to deliver a range of services such as diagnostics, psychosocial intervention, provision of information and pharmacological support. There is evidence that these services improve outcomes for people with dementia and their families.

Assessment & care planning

Older people with mental health problems need a case management approach, which minimises duplication and incorporates the needs of carers. Older people with mental health problems may receive assessments under the Care Management Approach (CMA) or the Single Assessment Process (SAP). The CMA is a joint assessment and planning framework for people in need of specialist mental health services. SAP is a joint planning tool for older people, which incorporates four different levels of assessment (contact, overview, specialist and comprehensive).

There is evidence that CMA improves outcomes and that it reduces the likelihood of admission to residential care. A CMA which incorporates the maintenance of general health and well being of both service users and carers also reduces the likelihood of institutionalisation.

The National Institute for Clinical Excellence identifies 6 strategies for promoting independence, maintaining cognitive function and preventing illness when co-ordinating care plans;



Communication	Setting out strategies for promoting and maintaining communication skills
ADL* training	Primarily aimed at maintaining independence in personal care tasks
Activity planning	Identifying a range of activities that the person should be involved in
Assistive technology	Use of technology to promote independence and maintain function
Physical activity	Targeted exercise programmes to improve physical function
Rehabilitation	Adapting programmes to compensate for loss of cognitive function.

*Activities of Daily Living

Support for carers

Carers for people with dementia are among the most vulnerable. They often suffer from high levels of stress, feelings of guilt, depression and other psychological problems. Carers can often neglect their own health needs and as a consequence are more likely to suffer poor physical health.

NICE recommends the development of multi-component interventions which combine psychological support, skills training and support groups. Care plans for carers should involve a range of interventions including; psycho-educational support, peer-support, information ervices, training courses, respite/daycare/transport, sitting services and psychological therapy

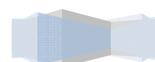
Community Mental Health Teams

Community Mental Health Teams (CMHTs) have lead responsibility for assessment and care planning. Their main function is to support the individual, carers and families through the care pathway. This care pathway cuts across the boundaries of health & social care and primary & secondary care

Fully integrated CMHTs are able to commission social care services, including home care. They carry out social care assessments using fair access to care criteria and have direct control over both health and social care resources when co-ordinating care plans. CMHTs carry out regular social care reviews as part of an integrated health and social care review process.

Day care services

Good quality day care services provide multi disciplinary assessment and rehabilitation services for people so that they can maintain an optimum level of functioning whilst being supported by family or informal carers. Day care should alleviate or reduce psychological and emotional distress of mental illness by providing support, coping strategies, information and education.



Good day care services are often an important part of a care package which reduces the need for hospital/residential care admission and assists in rehabilitation after hospital discharge. Day care services should promote social activity, mobility, physical health and cognitive function through therapeutic group work and individual care plans

Community support and specialist home care services

The development of specialist home care and community support services is essential to the delivery of care and support packages for older people with mental health problems. These services can have a direct impact on levels of independence, social interaction and isolation. They can prevent the development of depression, maintain cognitive function and reduce the risk of physical co-morbidities. As part of a care package community support and specialist home care can assist with carrying out ADL programmes, activity plans and physical exercise schedules. They can also benefit carers, reducing levels of stress and the risk of developing mental health problems.

There is a strong argument for the development of specialist home care services, ring fenced for use by Community Mental Health Teams and specifically trained to meet the needs of older people with mental health problems.

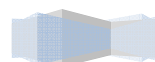
Memory services

Memory services provide a range of assessment, diagnostic, therapeutic and rehabilitation services for people with dementia. They support the detection of dementia in primary care across the whole spectrum of the disease and provide prompt assessment and diagnosis. They deliver diagnostic assessments which are comprehensive and avoid duplication with other elements of the care pathway.

Memory services can provide a range of drug treatments aimed at improving cognitive ability and increasing independence. They are able to monitor and evaluate the effectiveness of anti-dementia drugs. They are also able to provide appropriate psychological therapies for patients and carers.

Psychological intervention

For people with dementia there is evidence that cognitive function can be maintained or improved through psychological intervention. This improvement in function increases independence reduces the incidence of behavioural problems and has a long term impact on the cost of care.



Psychological support is an obvious intervention for older people with depression. It is particularly important because the outcomes for older people with depression in the community

are so poor. After the age of 65 there is an increased risk of major life events associated with depression. These include loss of employment, loss of spouse and change of social situation. Alongside these older people are more likely to experience social isolation and deterioration in health. Depression can significantly affect the ability to cope with physical conditions.

NICE recommends that the full range of psychological interventions should be made available to older adults with depression.

Supported housing

There are a number of supported housing models which are relevant to older people with mental health problems.

Floating support services are low level housing related support services delivered in an individual's own home. They can be reactive, acting as a response service to community alarms or they can deliver regular support as part of an integrated care plan.

Sheltered housing schemes can provide low level support services to people with early/moderate stage dementia. On-site support services are available to individuals and their carers.

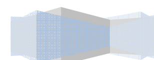
Extra Care Housing focuses on people with moderate/ severe dementia, delivering intensive home care and support services to individuals and their carers in their own home for 24 hours/day. These types of service often act as alternatives to residential care, delivering intensive support while maintaining independence.

Service integration

Older people with mental health problems require support from both health and social care agencies. There is a strong degree of cross-over between services, which reinforces the need for integration and co-ordination. There are strong arguments to support service integration

- It reduces the number of professionals working with an individual
- It removes the need for assessment repetition
- It enables better decisions on service provision
- Response from referral to diagnosis is quicker [5 - p117]

Integration can take a number of forms. Teams from across health and social care can co-locate, improving co-operation and communication between different professionals. Integration can involve developing common records and assessment frameworks. Finally integration can involve the merging of service structures and budgets, creating one streamlined service with one line of accountability.



There is evidence that improved outcomes are only achieved where there is a significant degree of integration at each level in a service. It is difficult to measure the impact of service structures on outcomes for individuals and there is recognition that further research is required in this area but there is a consensus that integration improves service quality.

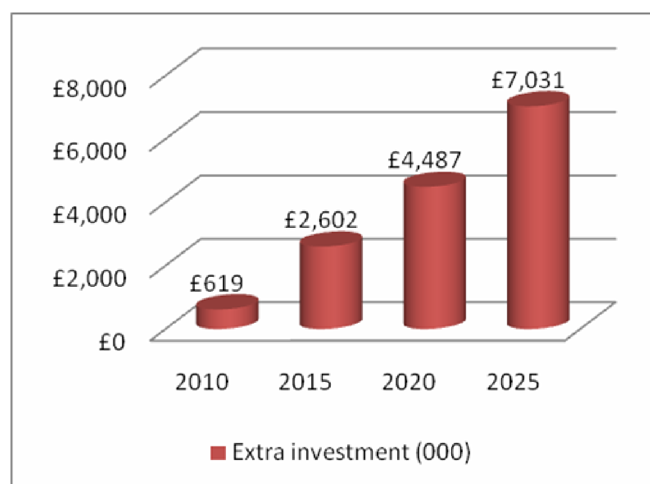
4.4 Gap Analysis

Addressing the demographics

The OPMH Review[16] concluded that community based specialist OPMH services are significantly under-resourced and that the gap between service requirement and capacity is likely to grow further. The review makes comparisons with typical service profiles set out in the Royal College of Psychiatry's (RCP) report *Raising the Standard*[17]. The RCP makes recommendations on service composition. Applying this to the local service profile it indicates that there are shortages in psychological services, occupational therapy and Community Psychiatric Nurse (CPN) support.

The lack of community based services is exacerbated by the impact of an ageing population. From the needs assessment it can be seen that, in order to maintain current levels of service an additional £619,000 investment is required in real terms by 2010 for specialist OPMH services. The impact on service cost accelerates after 2010 with an additional 2.6 million required to stand still. Figure 8 identifies the estimated additional investment that will be required to maintain current levels of service.

Figure 8 Estimated additional investment to maintain current service



The changes in population profile present a significant challenge to health and social care services over the next 10 years. Failing to respond will lead to service deterioration, greater

vulnerability for older people, increased burden on carers and acceleration into institutionalised care.

There is a strong argument for investment in OPMH services. The demographic changes and current under investment in community services can not be addressed by service reconfiguration alone. It is important that RPCT and RMBC try to pre-empt the impact of demographic changes by developing appropriate financial plans aimed at increasing investment in line with the growth in population of older people with mental health problems.

To address these issues The Adults Board will prepare plans for future investment in specialist OPMH services taking account of the change in demographics, current investment profiles and the likely increase in demand.

Developing an appropriate service model

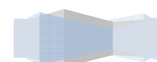
The current service model for OPMH Specialist Services does not comply with NICE guidance for dementia or depression. Neither does it comply with any of the national guidance documents relating to older people's mental health. Most relevant policies and guidelines recommend a focus on promoting independence and preventing deterioration. The current service model focuses on those with acute needs and is unable to address this preventive agenda.

Those service areas that could have the greatest impact on maintaining independence and preventing illness are the ones which receive the least investment. Only 19% of investment into OPMH specialist services is dedicated to community based services. This low level of investment in community mental health services increases the risk of early entry into institutional care.

The lack of a comprehensive memory service, a care home support team and a discharge liaison team should be addressed in any service reconfiguration. These services are all currently established in neighbouring authorities and the indications are that they have been successful in delaying or preventing admissions to residential and hospital care.

Currently only 0.2% of investment in OPMH specialist services goes into psychological support. There is accumulating evidence that talking therapies can have a significant impact on maintaining independence for those with dementia and that these services can help deal with major life events in old age.

It is important to develop a role for the third sector in delivering preventive services. There is potential for creating partnerships between voluntary sector organisations and lead providers. There are benefits to be gained from developing preventive services which are delivered by voluntary sector partners and incorporated into formal care pathways.



There is a heavy reliance on informal carers when meeting the needs of older people with mental health problems. Very few carers receive needs assessments and even fewer numbers

receive support specific to their need. The service profile set out in the OPMH Review indicates that Rotherham is under-resourced in relation to carer support services compared to neighbouring authorities. NICE recommends the development of new systems of support for carers including; psychological intervention, skills training, and respite.

To address these issues The Joint Commissioning Team will work with RDASH to develop a new service model which focuses on promoting independence and preventing illness and reflects the recommendations contained in the OPMH Review.

The shift from a service model based on institutional care to one which is community based will be achieved by an initial injection of resources into community-based services followed by disinvestment in inpatient and/or residential care.

Early intervention, assessment & care planning

Current estimates indicate that in Rotherham there are 3002 people with dementia and between 1263 – 2105 with severe depression. Currently there are 1152 people on GP dementia registers. This indicates low levels of detection and intervention in primary care for people with dementia.

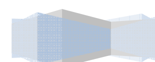
There are significant problems relating to social care assessments. The local authority is operating eligibility criteria, which prevent access to social care services by those with mild-moderate dementia or depression. Last year RMBC carried out just 69 social care assessments, where the client category was mental health. Of these only 49 were offered a service.

There is a strong argument for developing a specialist OPMH care enabling service which is not subject to the local authority's Fair Access to Care eligibility criteria and which can be offered to people with low-level dementia/depression.

The Adults Board will explore the potential for developing a specialist OPMH home care enabling service, targeted at those with mild/moderate dementia and focusing on promoting independence. As part of the commissioning arrangements with RDASH there will be a requirement to deliver a Care Management Approach based on the six strategies for promoting independence identified by NICE. Finally The Adults Board will set local targets on early diagnosis, assessments and reviews which are incorporated into a joint performance management framework.

A new approach to commissioning

Currently OPMH specialist services in Rotherham are subject to single agency commissioning arrangements. Inpatient care and parts of the community mental health & day care services are commissioned by RPCT. RDASH delivers these services as part of a broader adult mental



health contract. RMBC commission specialist residential/nursing care services and some direct community services.

These commissioning arrangements make it difficult to develop an integrated and efficient service model. The service is not subject to a joint performance management framework and there is no funding cross-over. Lines of accountability are unclear for services that are not directly line managed by RDASH.

The Adults Board will therefore explore the potential for joint commissioning and pooled budget arrangements for OPMH Specialist Services. This will be underpinned by appropriate service level agreements and a joint performance management framework.

Day care services

RDASH and RMBC have recently conducted a review of specialist day care services. The review highlighted a number of key issues.

A number of service users are accessing different elements of the day care provision, with some attending both specialist and generic services. There are no clear eligibility criteria for the service. Once the service has been accessed there is no formal review process. There are no overarching standards for delivery of day care services and there is a lack of flexibility in terms of opening hours.

To address these issues the Adults Board will explore the potential for commissioning a specialist day care service, which brings together all existing day care provision under one jointly commissioned arrangement. The new service will work alongside case managers and focus on the six strategies for promoting independence identified in NICE guidance. The Adults Board will develop clear eligibility criteria for the service. The service will be realigned so that it provides specific provision for different levels of need

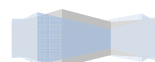
4.5 Summary of Action Plan

Short terms objectives 3 years

A13 Develop future investment plans for specialist OPMH services taking into account the change in demographics, the likely increase in demand and current under investment

A14 Develop a new service model specialist OPMH services, which complies with the recommendations of the OPMH Review.

A15 Develop a fully integrated Community Mental Health Team for Older People



A16 Explore potential for joint commissioning and pooled budget arrangements for OPMH Specialist services, including a joint performance management framework

A17 Commission an extended Memory Service, which acts as a multidisciplinary hub for delivering dementia care

A18 Commission a specialist Discharge Liaison Service and a Home Care Enabling Service for OPMH

A19 Develop services and strategies aimed at supporting carers

A20 Adopt a Care Management Approach which incorporates the six strategies for promoting independence identified within NICE guidance.

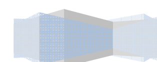
A21 Commission a fully integrated day care service, which forms a central part of the Care Management Approach

Longer term objectives

In the longer term it is the intention of The Adults Board to develop a fully integrated OPMH service, which is co-located within a purpose-built unit. This new modern service will not only act as a hub for service delivery but will also be a centre of excellence for the treatment and care of older people with mental health needs.

L4 Develop a fully integrated service, which is co-located within a purpose-built unit and incorporates relevant inpatient and community-based services for older people with mental health needs

L5 Develop hospital based rehabilitation and assessment services aimed at reducing length of stay and improving outcomes



PRIORITY 4: MAINTAINING INDEPENDENCE AND REDUCING ADMISSIONS

5.1 Strategic relevance

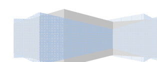
The financial burden resulting from the ageing population and increases in levels of chronic disease will be unsustainable unless service structures change. Future investment in health and social care systems needs to prioritise prevention of illness, promote independence and encouraging self-care.

Developing a service model which promotes independence and prevents illness should reduce costs of care and support further down the line. Community based services are best placed to promote independence and prevent illness. It is these services which will have to face the challenge of reducing the number of people requiring hospital or residential care. They will have to help extend the period of independence for people with so that they enter residential & nursing care at a later age. Community services will also have to facilitate early discharge from hospital care. They must do all this and at the same time avoid over-dependence on their own services.

This is a huge challenge which can only be met if there are opportunities and resources available for early, community-based intervention. Shifting resources from residential or secondary care budgets to community-based services which target people who have a lower level of need is difficult to justify. The demographics tell us that there could be increased demand for institutional care even if community-based services were extended. Disinvestment in secondary/residential care therefore is a significant risk. Also, the evidence to support the cost-effectiveness of early intervention is not conclusive. Delivering support at the point of diagnosis for people suffering from dementia probably has an impact on care costs later on but it is not clear whether this offsets the additional costs of early intervention.

5.2 Current Workstreams

The Adults Board is currently overseeing work on hospital admissions from residential and nursing care. It has already developed some good strategies aimed at reducing rates of admission to hospital and attendance at A&E for homes that are high users of hospital services. RPCT and RMBC are working closely on the development of assistive technology. Central government grants have provided an opportunity to develop projects on community equipment. Telehealth and Telecare.

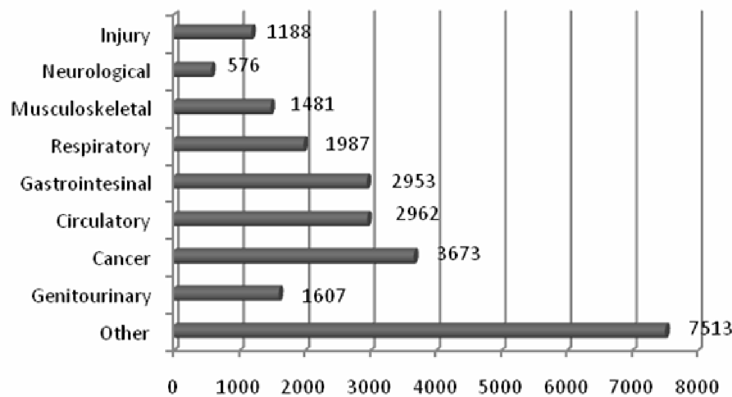


5.3 Needs Assessment

Hospital Admissions

Figure 9 shows a breakdown of hospital admissions for people over 65 years from September 2006 to August 2007. There were 29,717 admissions during this period.

Figure 9: Hospital admissions for people over 65 years. Sept 06 – Aug 07[22]



Of these admissions 10,695 were emergency admissions. Also, 11,310 people were readmitted during the year. Emergency admissions and readmissions should be the main focus for the Joint Commissioning Strategy. Figure 10 shows a breakdown of A&E attendances for people over 65 years for the same period.

From September 2006 to August 2007 there were an estimated 13,546 A&E attendances for people over 65 years. Of these 3,811 (31%) were readmissions. The most common reasons for attendance were cardiac problems, physical injury or musculoskeletal problems. 63% of attendances were by emergency services and the busiest months for attendances were December and January. Age distribution for this population was even with all 5-year age bands constituting around 20% of the overall population. The most common referral period was between 10.00amd and 12.00pm.

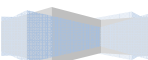
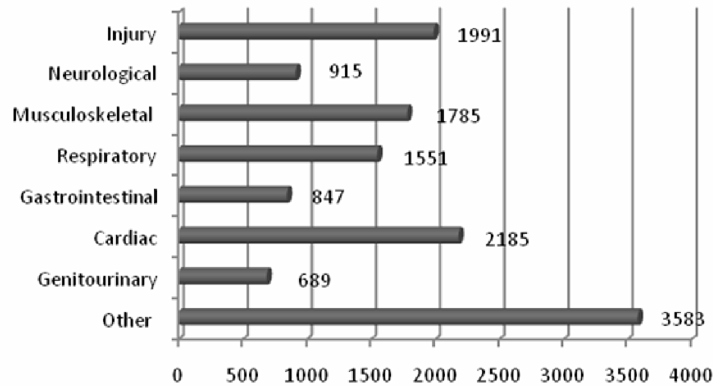


Figure 10: A&E attendances for people over 65 years. Sept 06 – Aug 07[23]

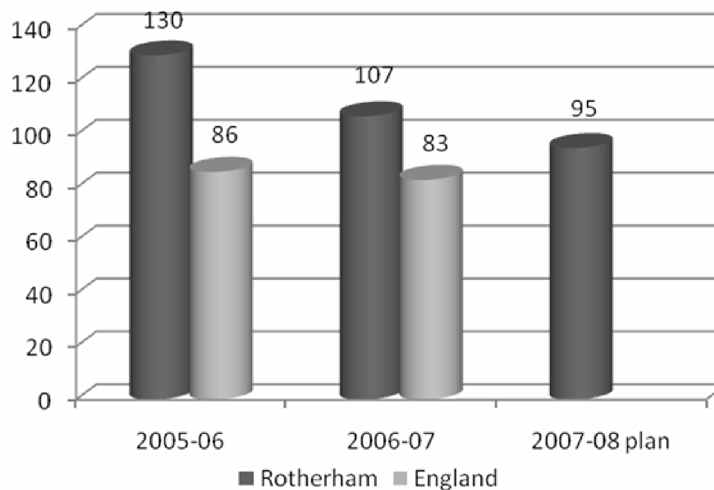


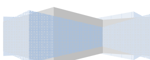
Residential/Nursing Care

The Wanless Review on Social Care suggests that more can be done to prevent admission to residential care[1-pxxi]. It is recognised that older people prefer to receive care in their own homes, yet local authority spending on care home placements has risen at a faster rate than that on home care. In 2004/5, almost 60% of local authority expenditure on older people's social care went on residential and nursing home placements.

There is evidence that rates of admission and numbers of people in residential care is high in Rotherham compared to the national average. Figure 11 shows the rates of admission to residential or nursing care per 10,000 of the population aged 65 and over.

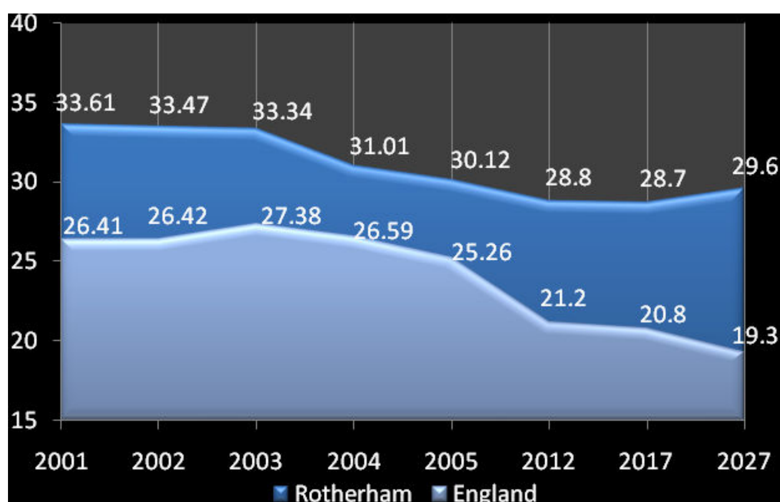
Figure 11: Admission to residential/nursing care per 10,000 older population[23]





This shows a gradual reduction in admissions but there is still a significant gap compared to the national average. Figure 12 shows the total population of older people in residential and nursing care as a proportion of the older population. It combines historical data from the local authority SAS submission with the recent *Strategic Needs Assessment of Long Term Social Care for Older People* [25]. This also shows a reduction in overall numbers in residential/nursing care but a predicted increase in the gap between Rotherham's residential care population and the rest of England. The *Strategic Needs Assessment* predicts an actual growth in the residential care population over the next 20 years, while provision in the rest of the country contracts.

Figure 12: Long stay residents in residential/nursing care per 1,000 older population

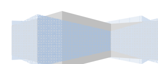


5.4 Gap Analysis and Action Plan

There are a number of ways in which RPCT and RMBC can work together to reduce the risk of admission to hospital, residential and nursing care. Some of these workstreams are already underway but lie outside the joint commissioning framework. Some workstreams currently form part of looser arrangements between partner organisations. The Adults Board will formally bring these together under the Joint Commissioning Framework and set out clear objectives for the future.

A&E admissions from residential and nursing homes

The Residential care Network has looked at referral data for A&E attendances from residential nursing care from Sept 2006 to Aug 2007. There were 1,731 attendances from care homes, 14% of all attendances for people over 65 years. There are 67 residential and nursing homes in Rotherham, 9 of which made 40% of the referrals to A&E. 50% of all attendances resulted in



admission to hospital. The most common reason for attendance, 41% of all attendances, was a falls related injury.

The OPMH Review also highlighted the issue of mental health support for residents. Targeted support in care homes aimed at maintaining cognitive and physical function could have a significant impact on admissions to general and specialist wards. There is evidence that the maintenance of mental health is not given the same emphasis as physical health even though there is a clear link between the two.

There is evidence that inpatient and residential care volumes for OPMH[16] could be reduced if community support services were extended. Rotherham has significantly higher numbers of inpatient and residential beds compared to neighbouring authorities. Currently these two service areas take up 81% of the combined specialist OPMH budget. Reducing inpatient and residential capacity to levels nearer those of neighbouring areas could release substantial investment for community support services and redress the balance between community support and institutional care.

The Adults Board will develop strategies for residential and nursing homes where there are high levels of A&E referral. It will liaise with these homes to establish the reasons for the relatively high referral rates and put in place action plans to control the numbers of older people being set to A&E. The Adults Board will commission a care home liaison service, which will provide support to residential and nursing homes on how to meet the health needs of residents. This multi-disciplinary service will incorporate the following functions;

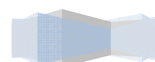
- Ensuring that the mental health needs of residents are addressed
- Reducing the number of A&E attendances and hospital admissions
- Delivering a falls prevention service within care homes
- Providing advice and guidance on how to meet the health needs of residents

The service will be jointly commissioned and performance managed against a common outcome framework.

The Adults Board will also ensure that residential and nursing home contracts are effectively monitored in relation to health-related activity. It will develop a system of contract monitoring which ensures that there is compliance on health elements of residential and nursing home contracts.

Telecare and related technology

The *Wanless Social Care Review of Older People's Services*[1-p155] describes telecare as any service which brings health and social care directly to a user, generally in their own homes, supported by information and communication technology. Existing basic telecare units include fall alarms, safety sensors for risks such as gas leaks and bath floods, and 'wander' monitors for people with dementia. More advanced 'intelligent' systems such as telehealth are designed to



remotely monitor vital signs such as temperature and blood pressure. This data can then be used by medical professionals to support patients in their self-care, and as a preventative tool against exacerbations in their condition.

There is evidence that this type of assistive technology can increase independence and choice by helping older people remain in their own homes longer. It can also assist carers, giving them reassurance and greater flexibility. The main objectives of this type of technology are to;

- Avoid or defer admissions to a care home or hospital
- Reduction or replacement of some routine inputs needed from carers
- Facilitate early discharge from hospital
- Maintain a healthier lifestyle
- Reduce costs of community based health and social care services

Rotherham has received the Department of Health's 'Preventative Technology Grant, which is aimed at utlilising assistive technology to reduce avoidable admissions to hospital and residential care. The Adults Board will, through use of this grant and other funding, develop strategies for utlilising this type of technology. It will also engage with the Supporting People programme to ensure that their strategy on assistive technology addresses the issue of admissions to residential and hospital care.

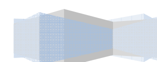
Telecare, telehealth, other assistive technology will be reviewed on a routine basis, to ensure that new and innovative technologies are explored, whilst ensuring that existing technologies already in use in Rotherham, such as community equipment, are maximised in supporting the independence of older people.

In Rotherham there is a need to review the local Community Equipment Service to ensure that it is effective in maintaining people's independence and reducing admissions to residential/hospital care. In particular work still needs to be done on community equipment in residential and nursing homes and what the demarcation in responsibility is between the Community Equipment Service and a residential/nursing home.

Occupational Therapy

The Rotherham Occupational Therapy Service is one of the vehicles for maintaining people in their own homes. It is a joint service where there has been a recent decision to develop joint commissioning arrangements. The service has experienced difficulties with backlogs and remedial action is being taken by The Adults Board to rectify this.

The Adults Board will develop joint commissioning arrangements for this service, ensuring that it connects it other community-based health and social care services. It will introduce a joint performance management framework, and pooled budget arrangements.



Home care enabling

There is evidence that the development of a home care service which focuses on enablement is more effective at preventing residential and hospital admissions than the current model, which focuses on direct care provision[6]. There is a powerful argument for developing a service model which reduces dependency. The *Strategic Needs Assessment of Long Term Social Care for Older People* [25-p35] predicts a 24% increase in the cost of residential care and home care by 2017. It anticipates that the number of older people potentially in need of formal care will rise from 15,660 to19,400 between 2007 and 2017.

It is important that we address this potential growth in demand for services by adopting a service model that does not accelerate the journey into institutional care. There are significant difficulties involved in restructuring home care services so that they promote an ethos of enabling. RMBC is currently operating eligibility criteria for home care which restricts eligibility to those who have a substantial or critical need. There is evidence that a care-enabling approach will have an impact on health and social care costs further down the care pathway but the initial investment is higher because it takes longer to enable someone to carry out a task than it does to do it for them.

As a first step The Adults Board will develop a discrete home care enabling service, linked with Intermediate Care, which focuses on hospital discharge. The service will facilitate early discharge and reduce the number of readmissions to hospital. Currently 48% of admissions for older people are readmitted within the same year. Access to a home care enabling service, supported by high quality Intermediate Care should have a significant impact on the number of readmissions. This home care enabling service will be in addition to that planned for older people with mental health needs.

5.5 Summary of Action Plan

A22 Develop a strategy for reducing A&E attendance rates from residential and nursing care

A23 Develop a care home liaison service which focuses on reducing hospital admissions and meeting mental health needs

A24 Develop contract monitoring procedures for health-elements of residential/nursing care contract

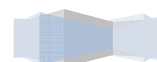
A25 Develop joint assistive technology strategy

A26 Review the Community Equipment Service

A27 Develop a specialist home care enabling service for hospital discharges

A28 Develop joint commissioning arrangements for the Occupational Therapy Service

L6 Develop a home care service which adopts a care-enabling approach



PRIORITY 5: EFFECTIVE GOVERNANCE

6.1 Background

RMBC and RPCT have a history of successful joint working. In 2005 the Council's Social Care services for elderly people were inspected by CSCI and reported that commissioning reflected the Department's strategic aims and objectives. Partners were involved in commissioning and there was close partnership working with the PCT. It was recommended that the Council and PCT should further formalise their commissioning arrangements. The planning groups, joint planning arrangements and structures have been reviewed and new arrangements are being put in place.

The Corporate Performance Assessment (CPA) carried out in 2007 by the Audit Commission acknowledged the partnership arrangements between the Council and the PCT.

"RMBC "has developed major strategic partnerships which are improving services to customers and citizens and achieving financial savings"

The CPA highlighted the jointly produced public health strategy which links the health inequalities agenda to poverty and economic well-being. The CPA highlighted the potential for joint commissioning and shared service provision and integrated performance management. It encouraged the extended use of pooled budgets emphasising the importance of linking investment in housing with health outcomes. It recognised the need to build on current arrangements by enhancing shared governance.

Joint Commissioning in Rotherham is being achieved within the context of the Rotherham Partnership. Rotherham's Community Strategy sets out a long term vision for the year 2020 of a borough where everyone feels proud to live and work, where every citizen and business can realise their potential. There are five strategic and two cross cutting themes. The Council's vision for the borough is a vision that looks forward to a Rotherham that is Learning, Achieving, Alive, Safe and Proud, and is underpinned by principles of Sustainable Development and Fairness. The provision of health and social care is embedded within these key themes.

6.2 The Joint Commissioning Framework

The Joint Commissioning Framework complies with the Commissioning Framework for Health & Well Being[15]. It describes how the Council and PCT pool their resources and act together to implement a common strategy.

The framework addresses the eight steps set out in the joint commissioning framework by;

- Putting people at the centre of commissioning
- Understanding the needs of populations and individuals
- Sharing and using information more effectively
- Assuring high quality providers for all services
- Recognising the interdependence between work and health
- Developing incentives for commissioning for health and well-being
- Developing local accountability
- Developing capability and leadership

The Framework reflects the closer working of the Strategic Director of Neighbourhoods and Adult Services and the Director of Public Health, including the shift towards preventative services based on regular joint strategic needs assessments. It is informed by systematic consultation with users and carers and service providers.

Each organisation will commission services separately and this strategy sits within the broader commissioning strategies of both the PCT and Council. It is recognised that this may change over time and what may be singly commissioned now may be joint in the longer term.

6.3 Gap Analysis & Action Plan

The current Joint Commissioning Framework is a significant step towards the development of a fully integrated health and social care commissioning framework. It incorporates a commitment to adopt a staged approach to embedding and extending joint commissioning. The key features of the vision for joint commissioning are to;

- Strengthen current joint working relationships through joint planning and joint performance targets
- Develop integrated health and social care teams
- Integrate planning, procurement and performance management where there are common areas of interest
- Establish and manage a range of pooled budgets for specific service areas
- Develop integrated personal health and social care by 2008

There is recognition within the JCF that it will be necessary to enhance the governance arrangements as joint commissioning and services integration develop. There are some key areas where these changes are now required.

Use of Health Act Flexibilities

This expectation of integrated commissioning is underpinned by a legal framework, which allows joint funding and the establishment of pooled budgets. Section 31 Health Act Flexibilities is the main vehicle for funding transfer from health to social care. This ability to move resources enables commissioners to develop care pathways, which deliver a unified package of care and avoid the transaction costs associated with separate accounting systems.

Where there is use of Health Act Flexibilities and there is delegation of functions then accountability for statutory responsibilities (for integrated working) does not change. However it is important that the use of funding transferred by Health Act Flexibilities is subject to service level agreements, an outcome based performance framework and financial reporting systems. These arrangements do not currently exist for funding transferred in this way.

The new Joint Commissioning Framework will act as the vehicle for all commissioning activity relating to Health Act Flexibilities. The Adults Board will be responsible for commissioning services, care pathways or outcomes for all of this funding. It will, through the Joint Commissioning Team, develop appropriate service level agreements and performance management arrangements.

Role of The Adults Board

The Adults Board is the joint decision making body with overall responsibility for joint commissioning activity. It has significant decision making powers;

- Endorsement of joint strategies subject to ratification by Neighbourhood & Adult Services Cabinet Member and the RPCT Board
- Commissioning services which are subject to pooled budget arrangements
- Making decisions on areas of common interest where the Chief Executive of the PCT and Strategic Director of Neighbourhoods & Adult Services have delegated powers.

The Adults Board has the capacity to make decisions on issues where the Strategic Director of Neighbourhood & Adult Services and the Chief Executive of RPCT have delegated powers. All issues that fall outside delegated powers require further approval by the RMBC Cabinet Member and the RPCT Board. The Board will be chaired by the Chief Executive of RPCT.

Membership of the Adult Board includes formal statutory partners, Council Members and service users. The Board is subject to a rotating chair, with the PCT Chief Executive and NAS Strategic Director taking alternate years.

The Adults Board has been more effective since its remit was revised in 2007. The responsiveness of The Adults Board will be enhanced by further delegation of powers from RMBC Cabinet Member and RPCT Board. RMBC and RPCT will delegate responsibility for implementation of The Joint Commissioning Strategy to the Strategic Director of NAS and the

Chief Executive of the PCT respectively. These delegated powers can only be used in accordance with the terms of reference of The Adults Board i.e. with the full consent of the other executive officer.

Role of The Planning Groups

The current Joint Commissioning Framework is divided into two distinct layers. The Adults Board brings together commissioners from health and social care. All other planning and task groups will incorporate provider representation. These groups act as the interface between service users, providers and commissioners. This ensures that the expertise of providers and service users and their knowledge of delivery can inform the commissioning process.

These planning groups will be reconfigured to reflect the priorities in the Joint Commissioning Strategy. The Planning Boards for Mental Health and Learning Disability will remain in place but those for Older People and Long Term Conditions will be revised. A diagrammatic representation of the new framework, excluding learning disability and mental health is set out in Figure 13

Service User Engagement

Service users and carers are currently engaged in the Joint Planning Framework in a number of different ways. They are represented at all levels of the commissioning framework, including the Adult Planning Board. The Joint Commissioning Framework includes a service user & carer group, which brings together representatives from all planning groups so that they can share information and consider specific issues in detail.

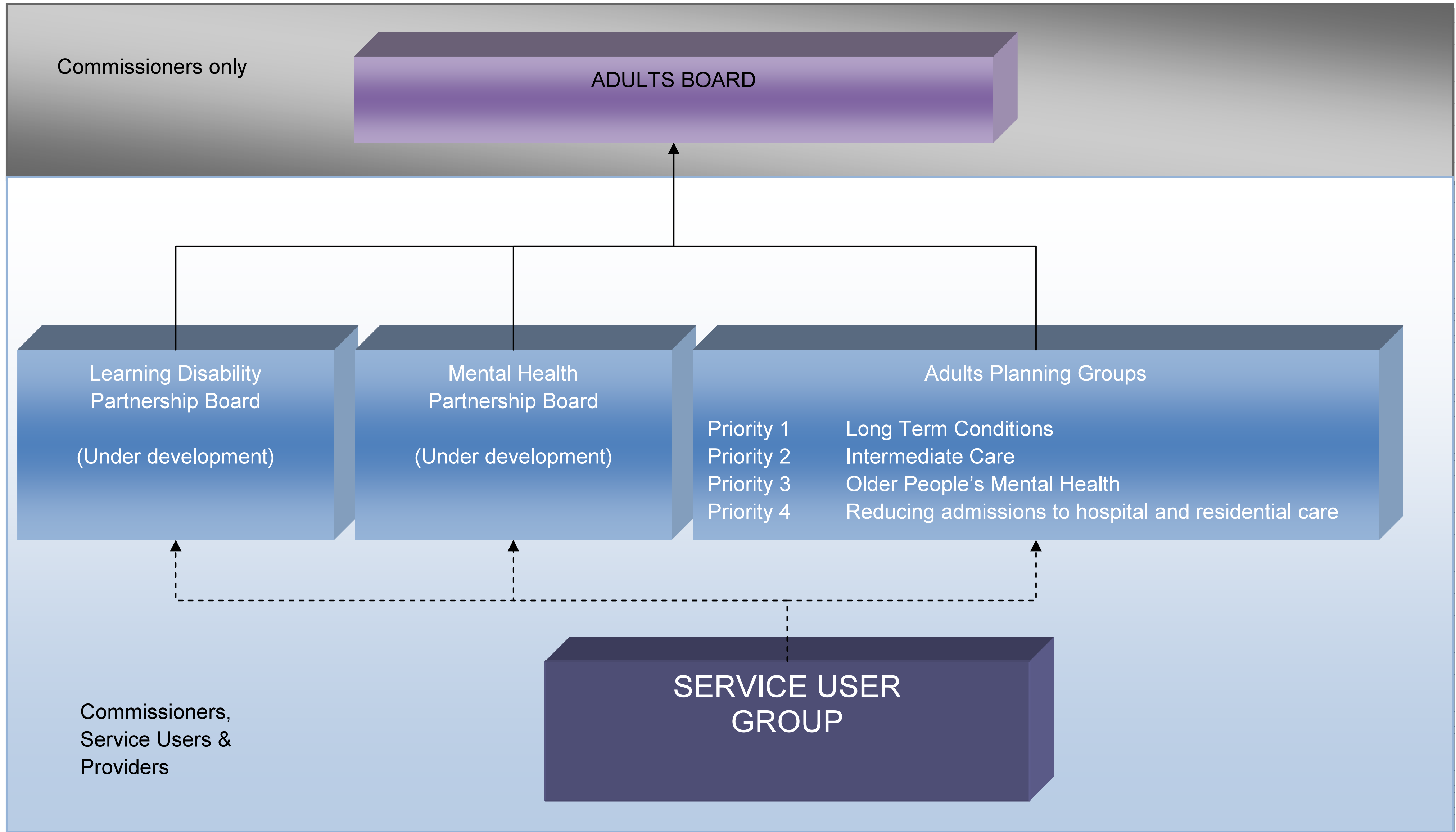
The service user and carer group is responsible for identifying appropriate representation on the planning groups and identifying where there are gaps in representation.

Service user engagement has been enhanced by the use of Citizens Juries, which have been used to inform and influence the planning process.

The Adults Board will prioritise the recruitment of service users and carers on the new planning groups. It will develop recruitment and support strategies for service users and carers who are involved in joint planning.

The Adults Board will continue to use Citizens Juries as a vehicle for service user engagement. It will develop an annual programme of Juries specifically targeted at services where there is an intention to reconfigure. The Adults Board will ensure that recommendations from Citizens Juries are reported direct to the Board and considered as part of any service reconfiguration process.

Figure 13: New Joint Commissioning Framework



Role of the Joint Commissioning Team

The Joint Commissioning Team (JCT) is responsible for co-ordinating the work of the Adults Board, Joint Commissioning Group and Adult Planning Groups. The team is jointly funded, located in the PCT and managed by its Strategic Director.

The JCT leads on needs analyses, supply mapping, gap analyses, service reviews and PMF development. Its focus is on services which

- Have a shared strategic interest for both the Council and the PCT
- Require joint working between health and social care staff
- Have been agreed by both agencies as coming within the Joint Commissioning Framework

It is possible that the implementation of the Joint Commissioning Strategy will have implications for the way in which the JCT is structured and resourced. In order to ensure that the JCT is can maintain its co-ordination role The Adults Board will review the structure and size of the team, ensuring that it is properly positioned to deliver the priorities set out in the strategy.

Performance Management Framework

The Joint Commissioning Framework incorporates a joint performance management framework (PMF) which is split into three levels. The PMF identifies those national indicators which can best be achieved through joint working. Table 1 sets out the these strategic indicators, which are derived from the following national performance frameworks;

- National Performance Management Framework for Local Partnerships
- Local Area Agreement Stretch Targets
- Local Area Agreement: “35 designated priorities”
- NHS Operating Framework Vital Signs

Table 2 sets out the performance indicator suite for the Joint Commissioning Strategy. It identifies three key indicators which will indicate successful implementation of the strategy and have a significant impact on the joint commissioning strategic indicators.

In addition to these two indicator suites the Adults Board will ensure that all jointly commissioned services have their own PMF, which measures performance and impact on strategic objectives.

8.4 Summary of Action Plan

Short terms objectives 3 years

A29 Commission all activity funded through Health Act Flexibilities through the Joint Commissioning Framework

A30 Delegate responsibility for implementation of the Joint Commissioning Strategy to the Chief Executive of RPCT and the Strategic Director of RMBC

A31 Reconfigure the planning groups to reflect the priorities in the Joint Commissioning Strategy

A32 Develop recruitment and support strategies for service users and carers who are involved in joint planning

A33 Establish an annual programme of Citizens Juries and service user participation events aimed at enhancing involvement

A34 Review the structure and resource requirements of the Joint Commissioning Team so that it able to co-ordinate implementation of the Joint Commissioning Strategy

A35 Adopt the tiered performance indicator suite set out within the new Performance Management Framework

Long terms objectives

L7 Full integration of the commissioning function for community based services where there is a common interest

Table 2: Performance Framework Indicator Set – Strategic Indicators

No.	Description	NPMF	LAA Stretch	LAA 35	Vital Signs
1	People with a long-term condition supported to be independent and in control of their condition	✔			✔
2	Achieving independence for older people through rehabilitation & Intermediate Care	✔			✔
3	Delayed transfers of care from hospitals	✔			
4	Timeliness of social care assessment	✔			✔
5	Timeliness of social care packages	✔			✔
6	The number of emergency bed days per head of weighted population	✔			
7	The extent to which older people receive the support they need to live independently at home	✔			✔
8	Healthy life expectancy	✔			✔
9	Older People's Mental Health: Assessments of needs	✔			

No.	Description	NPMF	LAA Stretch	LAA 35	Vital Signs
10	Equipment delivered within 7 days				

Table 3: Performance Framework Indicator Set – Joint Commissioning Priorities

Description	Strategic Targets Addressed
Priority 1: Management of Long Term Conditions	
No. of people with a long term condition who are high intensity users of services	1,8
No. of hospital admissions prevented by case managers	1,6
No. of high intensity users and are helped to remain at home	1,7
Priority 2: Intermediate Care	
No. of admissions to hospital and residential care prevented	2,6,7,8
No. of hospital discharges facilitated	2,3,7,8
No. of people readmitted to hospital within 6 months of discharge from residential service	2,6,7,8
Priority 3: Older People's Mental Health	

Description	Strategic Targets Addressed
No. of people with a diagnosis of dementia	9
No. of older people with mental health problems who have had an assessment of need	1,2,7,9
No. of older people with mental health problems who are supported to live independently	1,2,7
Priority 4: Reducing admission to hospital and residential care	
No. of people over 65 years admitted to hospital	6
No. of people over 65 years admitted to residential/nursing care	6
No. of people admitted to A&E from residential care	6

JOINT COMMISSIONING STRATEGY – ACTION PLAN (3 years)

	ACTION	LEAD OFFICER
Priority 1:	Meeting the needs of people with long term, conditions	
1	Develop a 5 year Public Health Strategy specifically aimed at increasing healthy life expectancy and introducing specific targets on reducing the numbers of people with long term chronic conditions	
2	Develop a system of identification for high intensity user of health and social care services (HIUs)	
3	Recommission the community matron service, ensuring that it complies with national guidance on case management and works across health & social care boundaries	
4	Develop multi-disciplinary teams which are responsible for the case management of HIUs	
5	Carry out an audit of self management activity across health and social care and develop a strategy for self management of long term conditions	
6	Recommission and expand the Expert Patient Programme	
Priority 2:	Effective Intermediate Care Services	
7	Commission an Intermediate Care pathway, which fulfils the three functions identified in The Wanless Social Care Review of Older People's Services	
8	Develop a full integrated Intermediate Care Service	
9	Develop joint commissioning arrangements, service level agreements, pooled budget arrangements and a joint	

	ACTION	LEAD OFFICER
	performance management framework	
10	Remove all age restrictions on the Intermediate Care Residential Service	
11	Review and reconfigure the Community Rehabilitation Service	
12	Improve the performance of the Intermediate Care Service	
Priority 3:	Older People's Mental Health	
13	Develop future investment plans for specialist OPMH services taking into account the change in demographics, the likely increase in demand and current under investment	
14	Develop a new service model specialist OPMH services, which complies with the recommendations of the OPMH Review	
15	Develop a fully integrated Community Mental Health Team for Older People	
16	Explore potential for joint commissioning, pooled budget arrangements and a joint performance management framework	
17	Commission an extended Memory Service, which act as a multidisciplinary hub for delivering dementia care	
18	Commission a specialist Discharge Liaison Scheme and a Home Care Enabling Service for OPMH	
19	Develop services and strategies aimed at supporting carers	
20	Adopt a Care Management Approach which incorporates the six strategies for promoting independence identified within NICE guidance.	

	ACTION	LEAD OFFICER
21	Commission a fully integrated day care service, which forms a central part of the Care Management Approach	
Priority 4:	Reducing admissions to hospital and residential care	
22	Develop a strategy for reducing A&E attendance rates from residential and nursing care	
23	Develop a care home liaison service which focuses on reducing hospital admissions and meeting mental health needs	
24	Develop contract monitoring procedures for health elements of residential/nursing care contracts	
25	Develop a Joint Assistive Technology Strategy	
26	Review the Community Equipment Service	
27	Develop a specialist home care enabling service for hospital discharges	
28	Develop joint commissioning arrangements for the Occupational Therapy Service	
Priority 5:	Effective governance	
29	Commission all activity funded through Health Act Flexibilities through the Joint Commissioning Framework	
30	Delegate responsibility for implementation of the Joint Commissioning Strategy to the Chief Executive of RPCT and the Strategic Director of RMBC	
31	Reconfigure the planning groups to reflect the priorities in the Joint Commissioning Strategy	

	ACTION	LEAD OFFICER
32	Develop recruitment and support strategies for service users and carers who are involved in joint planning	
33	Establish an annual programme of Citizens Juries and service user participation events aimed at enhancing involvement	
34	Review the structure and resource requirements of the Joint Commissioning Team so that it able to co-ordinate implementation of the Joint Commissioning Strategy	
35	Adopt the three tiered performance indicator suite set out within the new Performance Management Framework	
Long Term Objectives		
1	Commission fully integrated care pathways for people with a long term condition	
2	Develop a fully integrated service, which is co-located within a purpose-built unit and incorporates relevant inpatient and community-based services for older people with mental health needs	
3	Develop hospital based rehabilitation and assessment services aimed at reducing length of stay and improving outcomes	
4	Recommission specialist OPMH services, opening out opportunities to service providers in the voluntary and independent sector	
5	Develop a home care service which adopts a care-enabling approach ated case management teams for adults with long term conditions living in the community	
6	Full integration of the commissioning function for community based services where there is a common interest	

ROTHERHAM BOROUGH COUNCIL – REPORT TO MEMBERS

1.	Meeting:	Cabinet Member for Adult Social Care and Health
2.	Date:	31 March 2008
3.	Title:	Adult Services 3rd Quarter (April to December) Performance Report, 2007/08 All Wards Affected
4.	Programme Area:	Neighbourhoods and Adult Services

5. Summary

This report outlines the 2007/08 key performance indicator 3rd quarter results for the Adult Services elements of the Directorate.

6. Recommendations

That Cabinet Member is asked to note the results and the remedial actions in place to improve performance.

7. Proposals and Details

At the end of the quarter, 17 (68%) key performance indicators are currently on track to achieve their year end targets and improve upon their position last year. 7 indicators are rated ‘off target’, which again is an improvement from the last quarter when 9 indicators were rated ‘off target’.

Currently we are projecting that 4 areas of the service will have delivered ‘step change’ improvement by the end of the year. These relate to doubling the number of reviews that we have undertaken (D40), increasing the help we give to carers (C62), improving the number of people that are given a statement of how their needs will be met (D39) and the reduction in the time people now have to wait for an assessment from 12 weeks to 1 week (D55).

There are 7 indicators that are rated ‘off’ target, and are shown as a red triangle alert in Appendix A.

Exceptions

D40 - Reviews completed of those on service

Weekly performance clinics are being held with social work managers. 6 clinics took place since December. The sessions hold social work team managers accountable for their team’s performance and ensure that managers prioritise workloads so that we help more people. This has helped bring performance back on target and on track to deliver our stretch target within the Local Area Agreement a year early. We anticipate that 2,000 more people will received a review by the end of the year compared to last year.

C28 - Intensive Home Care

This indicator is based on a sample week in September where we survey the number of people receiving intensive home care. Although the number of people receiving intensive care increased from 568 to 569 this year, Rotherham’s over 65 population increased by 205. This means that performance on the proportion of people that we provide intensive home care packages for has dropped slightly.

C62 - Services for carers

Performance remains well ahead of target profile and is set to exceed the target of 9% with a current projection of over 12%. This improvement is up there with the best in the Country when it was one of the worst services compared to the national position just only two years ago.

C32/C29 - Older people and those with physical disabilities helped to live at home

Weekly performance clinics are being held with social work managers. 6 clinics have taken place since December. The number of assessments that we have completed has doubled (from 50 to 100 assessments per week) in this time and we have completed eradicated the historic backlog of new assessments. People now wait just one week for an assessment instead of 12 weeks last year.

As a consequence of us dramatically increasing the number of reviews, we have identified significant numbers of people who have been inaccurately counted as receiving a service. There errors are being corrected and has resulted in a deterioration in performance.

D54 - Equipment delivered in 7 days

We have improved the timeliness of the delivery of certain items of equipment and 2010 Rotherham in particular have improved their performance. However, we have looked into the detail of the recording system and have found that equipment previously reported as being delivered within 7 days was incorrect. We are working closely with the PCT and REWS to improve equipment delivery times.

C72 - Permanent admissions of older people to residential /nursing care.

A corporate performance clinic was held on 18th October. Performance is now improving but the target of 95 will not be met. A new Continuing Care protocol has been in place since October, meaning that some admissions are accessing more PCT funding and will therefore not be included within the indicator if funded above certain levels. The Director of Assessment and Care Management is attending all panel hearings and is scrutinising all admissions and we believe that the outcome of current actions will improve the indicator from last year's position. However, the number of people we admit to residential and nursing care is high compared to other Councils.

E82 - Adults (over 18's) assessments leading to a provision of service

The indicator has improved slightly and is better than last year. Our ability to quickly assess every person that requests our help has been critical to improving this indicator.

E47 Ethnicity of older people receiving an assessment

Since our last report, performance on this indicator has remained the same. Work is taking place with our Equalities Officer to identify actions that are needed to develop a better and diverse range of services that are sensitive to age, culture, religion, sex and gender.

LPI 102 - Number of protection plans in place

This local indicator remains on track to achieve the stretch target of a 60% increase in performance from last year. This demonstrates that the Directorate is responding well to reported concerns involving vulnerable adults.

8. Finance

Local Area Agreement (LAA) 'pump priming' monies of £180k is available for improving performance on reviews, direct payments and helped to live at home services. £129k has been committed but £60k worth of direct payments investment has not been identified for expenditure as the target is on track to be achieved.

9. Risks and Uncertainties

Compliance with the Performance Assessment Framework is a statutory requirement. Adult Social Services view the arrangements as a means towards managing continuous improvement of performance across a wide range of activities and programmes. There is a risk that the desired improvement rate will not be achieved and therefore there would be an impact on inspection ratings and customer satisfaction. Where an indicator is rated 'off target' a remedial action plan is in place and is closely monitored by the Performance Team.

10. Policy and Performance Agenda Implications

Members should be aware that routine monitoring by CSCI will remain an essential component of the wider performance assessment process, and of its potential implications for Adult Social Services. CSCI have advised that Adults Social Care must improve performance on 6 specific indicators. These have been prioritised for further action at individual team level within the Directorate's Performance Assessment Excellence Plan. Failure to improve against the 6 critical indicators will prevent us from achieving the aims for a 3 star Adult Social Care service by December 2008. The critical indicators are:-

- C29 – Adults with Physical Disabilities Helped to Live at Home
- C32 – Older People Helped to Live at Home
- C62 – Services for Carers
- C72 – Admissions to Residential and Nursing Care
- D39 – % of People receiving a Statement of Need
- D40 – % of Adults and Older People receiving a Review

11. Background Papers and Consultation

The report has been discussed with Neighbourhoods and Adult Services Directorate Management Team. The December performance results for Adult Services are attached (Appendix A) and are compiled using the Corporate 'Performance Plus' management software. The indicators rated 'on target' are shown as a green star and those that are rated off' target are shown as a red triangle alert.

Best Value Performance Indicators for 2007/08 guidance documents.
http://www.audit-commission.gov.uk/performance/guidance.asp

CSCI Performance Assessment Handbook
http://www.csci.org.uk/professional/for_councils.aspx

Rotherham Local Area Agreement (LAA) 2006-09
http://www.rotherham.gov.uk/NR/rdonlyres/48DDD350-6AA3-4900-B568-6A7DF7BA5853/0/LAAFinalAmmendedSubmissionMay2006.pdf

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Appendix A: Neighbourhoods and Adult Services - Performance Indicator Outturns for December 2007

Line No.	YTD	Measure	Good performance & Measure type description	Baseline 06-07 & Paf Band	Qtr 1 June 07	Qtr 2 September 07	Qtr 3 December 07	DoT 06-07v Dec07	07/08 Target	Dec Q3 & [Y/End projected] PAF Banding or/All England Quartile Rating	Responsible Director
Outcomes Framework 1: Improving Health and Emotional Well-being											
1		AS LPI PAF D40 Adult and Older clients receiving a review as a percentage of adult clients receiving a service (KT)	Bigger is better, 100 is best % Percentage	45.66 2 of 3	14.74	26.41	44.32		75 LAA	Band 3 [4] of 4	Brian Doughty
2		AS LPI PAF D41 Number or Delayed Transfers of care per 100,000 population aged 65 and over	Within range 0<20.12 is best Rate calculation	9 rounded 5 of 5	12.31	13.86	15.21		<20.12	Band 5 [5] of 5	Brian Doughty
3		AS LPI PAF D41 (RMBC) Number of delayed transfers of care per 100,000 population aged 65+	Zero is best Number Count	0.00	0.00	0.00	0.00		0.00	Not PAF / banded	Brian Doughty
Outcomes Framework 2: Improved Quality of Life											
4		BV053 (PAF C28) Intensive home care per 1000 65+	Bigger is better, 16+ is best Rate calculation	13.99 4 of 5	15.1 Estimate	14.8 Estimate	13.94 Actual		16.00	Band 4 [4] of 5 Top Q17.02 R= 3rd	Brian Doughty
5		BV054 (PAF C32) Older People helped to live at home	Bigger is better, 100+ is best Rate calculation	79.79 2 of 5	72.39Rev (77.61)	70.95Rev (72.29)	71.17		102 LAA	Band 2 [5] of 5 Top Q100.54 R= 1st	Brian Doughty
6		BV056.03 (PAF D54) %Equipment <£1000 in 7 days (KT)	Bigger is better, 100 is best % Percentage	90.67 5 of 5	82.93	88.51	87.59		95.00	Band 5 [5] of 5 Top Q93 R= 2nd	Brian Doughty
7		AS LPI PAF C29 Adults with physical disabilities helped to live at home	Bigger is better, 5+ is best Rate calculation	3.05 2 of 5	3	2.9	2.6		4.2	Band 2 [4] of 5	Brian Doughty
8		AS LPI PAF C30 Adults with learning disabilities helped to live at home	Bigger is better, 3+ is best Rate calculation	3.13 5 of 5	3.04	2.98	3.02		3.20	Band 5 [5] of 5	Shona McFarlane
9		AS LPI PAF C31 Adults with mental health problems helped to live at home	Bigger is better, 2.3+ is best Rate calculation	4.5 5 of 5	n/a	n/a	n/a		4.8	Band 5 [5] of 5	Kim Curry
10		AS LPI PAF C62 Services for Carers	Bigger is better, 12+ is best % Percentage	4.28 2 of 5	1.06 Excl MH	6.15	7.80		9.00	Band 3 [5] of 5	Brian Doughty
11		AS LPI 102 Number of protection plans in place	Bigger is better Number count	25	8	Accum' 19 Proj'd 44	Accum' 30 Proj'd 42		40	Not PAF / banded	Brian Doughty
Outcomes Framework 4: Increased Choice and Control											
12		BV195 (PAF D55) Acceptable waiting times for assessment (KT)	Bigger is better, 100 is best % Percentage	75.94 2 of 5	77.85	82.58	84.13		85	Band 3 [4] of 5 Top Q88.35 R= 3rd	Brian Doughty
13		BV196 (PAF D56) Acceptable wait for care packages (KT)	Bigger is better, 100 is best % Percentage	96.74 5 of 5	95.11	95.67	95.32		98.00	Band 5 [5] of 5 Top Q92.69 R= 4th	Brian Doughty
14		BV201 (PAF C51) Adults receiving direct payments (KT)	Bigger is better, 150+ is best Rate calculation	137 4 of 5	150	140	154		150 LAA	Band 5 [5] of 5 Top Q126.56 R= 4th	Kim Curry
15		AS LPI (PAF C72) Number of admissions of supported residents aged 65+ to residential and nursing care	Lower is better, 0<90 is best Rate calculation	106.36 3 of 5	120.44	120.82	112.73 Best est = 98.51		95	Band 2 [4] of 5	Brian Doughty
16		AS LPI (PAF D39) % of people receiving a statement of their needs and how they will be met	Bigger is better, 100 is best % Percentage	85.02 2 of 5	86.13	89.13	92.16		97	Band 3 [4] of 5	Brian Doughty
17		AS LPI (PAF C73) Number of admissions of supported residents under 65 to residential and nursing care	Lower is better, 0<1.5 is best Rate calculation	2.25 4 of 5	0.19	1.09Acc' 1.49proj	1.42		1.49	Band 5 [5] of 5	Brian Doughty
18		AS LPI PAF E 82 Assessments of adults and older people leading to a provision of service	Within range 68<77 is best % Percentage	85.77% 3 of 5	84.22%	85.46%	85.23%		80.00%	Band 3 [4] of 5	Brian Doughty
Outcomes Framework 5: Freedom from Discrimination											
19		Ethnicity KT - Assessment / reviews	Lower is better, 0<10 is best % Percentage	1.04	0	0.13	0.08		<10	Not PAF / banded	Brian Doughty
20		Ethnicity KT - Services	Lower is better, 0<10 is best % Percentage	0.37	0.1	0.1	0.09		<10	Not PAF / banded	Brian Doughty
21		AS LPI PAF E 47 Ethnicity of older people receiving assessment	Within range 1<2 is best % Percentage & Rate calculation	1.78% 3 of 3	0.88%	0.97%	0.77%		1.90%	Band 2 [3] of 3	Brian Doughty
22		AS LPI PAF E 48 Ethnicity of older people receiving services following an assessment	Within range 0.9<1.1 is best % Percentage & Rate calculation	0.85% 2 of 3	1.19%	1.17%	1.02%		0.91%	Band 3 [3] of 3	Brian Doughty
Outcomes Framework 6: Economic Well-being											
Outcomes Framework 7: Maintaining Personal Dignity and Respect											
23		AS LPI (PAF D37) Availability of single rooms	Bigger is better, 95<=100 is best % Percentage	100 5 of 5	Annual Measure Proxy measure = 100 Dec 07				99	Band 5 [5] of 5	Kim Curry
Outcomes Framework 8: Leadership											
24		Ethnicity KT - Staffing	Lower is better, 0<10 is best % Percentage	<1 rounded	n/a	n/a?	3.87Est		0	Not PAF / banded	All Directors
25		AS LPI (PAF D75) Practice Learning	Bigger is better, 17+ is best Rate calculation	17.47 5 of 5	n/a	Accum' 16.3 proj'd 34	20.76		21.6	Band 5 [5] of 5	Kim Curry
Outcomes Framework 9: Commissioning and Use of Resources											
26		AS LPI (PAF B11) Intensive home care as a % of intensive home and residential care	Within range 27<45 is best % Percentage & Rate calculation	28 rounded 5 of 5	n/a	n/a	29.35 est		31.00	Band 5 [5] of 5	Brian Doughty

Red Triangle = Warns not on target and high risk – Action needs to be taken immediately to improve performance if we are to achieve target.

Green Star = Shows that performance is on course to achieve or exceed the year end target

Improvement in performance

Deterioration in performance

No change in performance against last reported position

YTD Signifies this Pi is one of the CSCI critical PI's for 2007/08

Agenda Item 10

ROTHERHAM BOROUGH COUNCIL – REPORT TO MEMBERS

1.	Meeting:	**Cabinet Member for Adult Social Care and Health**
2.	Date:	**Monday 31 March 2008**
3.	Title:	**Capital Budget Monitoring Report 2007/08** - All Wards affected
4.	Directorate:	**Neighbourhoods and Adult Services**

5. Summary

To inform members of the latest projections and commitments against the approved Adult Services capital programme for the 2007/08 financial year.

6. Recommendations

Members receive and note the latest capital expenditure monitoring report for 2007/08.

7. Proposals and Details

This capital monitoring report provides detail of the approved capital programme for the Adult Services department of the Neighbourhoods and Adult Services Directorate, actual expenditure for the period April to the mid February 2008 and the projected expenditure for each scheme to the end of March 2008.
The approved 2007/08 capital budget for Adult Services has been revised to take account of slippage in a number of schemes reducing from £15.6m to £12.5m. The main revision being in respect of the two new residential care homes which are experiencing some delays on completion. Actual expenditure to mid-February 2008 was £6.1m. The approved schemes are funded from a variety of different funding sources including, unsupported borrowing, allocations from the capital receipts, Supported Capital Expenditure and specific capital grant funding. Appendix 1 shows actual expenditure to date against the approved budget together with projected expenditure to the end of the financial year.

8. Finance

The following information provides a brief summary of the latest position on the main projects within each client group.

<u>Older People</u>

The construction of the two new residential care homes commenced early this year with an estimated completion date of July/August 2008. EDS are project managing the scheme and have revised the estimated total expenditure for 2007/08 from £14m to £11.5m to take account of slippage on the scheme. A report was submitted to The Cabinet on 13 February 2008 requesting additional funding in respect of the settlement for the land transaction at the Dinnington site, which was approved. EDS have also indicated potential pressures on the construction project which are being reviewed with the aim to be contained within the approved budget.

The Assistive Technology Grant (which includes funding from the PCT) is being managed jointly and is being used to purchase Telehealth and Telecare equipment to enable people to live in their own homes. The spending profile has been revised with the Primary Care Trust and a balance will be carried forward into 2008/09 to meet future commitments.

A new specific grant was allocated by the Department of Health to improve the environment within residential care provision. The grant has been allocated mainly across the independent sector and in accordance with the grant conditions. Claims from the independent sector are being pursued and regularly monitored to ensure the grant is fully spent in 2007/08.

Learning Disabilities

The balance of funding available from the refurbishment of Addison Day Centre and Parkhill Lodge has been used to meet the shortfall in funding phase 1 of alterations at Oaks Day Centre. This work has now been completed.
Phase 2 developments at Oaks Day Centre have also just been completed and the refurbishment of Addison Day Centre, funded from the Council's Strategic Maintenance Investment fund, is due to commence in March 2008, the profiled budget has therefore been revised to take account of expenditure to be incurred in 2008/09.

Mental Health

The final costs for the refurbishment of Cedar House have now been charged. A large proportion of the Supported Capital Expenditure (SCE) allocation has been carried forward from previous years due to difficulties in finding suitable accommodation for the development of supported living schemes. Suitable properties have now been identified and spending plans are being developed. Also, expenditure on equipment purchased for direct payments is to be charged to the SCE budget to reduce the pressures on revenue budgets. SCE funding is not time limited and at this stage £357k has been identified to be carried forward into 2008/09 to meet future commitments. Further options are being considered to provide more intensive supported living schemes with a range of providers.

Management Information

The Specific Capital Grant of £146,000 has been earmarked to further develop Electronic Social Care Records within Health and Social Care working with the Council's strategic partner RBT and Children & Young People's Services. A recent circular from the Department of Health has advised that as this is the last year of the grant any underspend can be carried forward into 2008/09. Therefore based on current spending profiles £111,000 will be carried forward into 2008/09. A bid for £760,000 additional funding has also been secured from the Council's IT Development Budget to meet the balance of the cost of the whole project. This element of funding is accounted for as part of the Chief Executive's Capital programme.

9. Risks and Uncertainties

The main risk relates to the potential budget pressures on the two new residential care homes including delays in completion. Also projects funded through Supported Capital Expenditure or capital grants where spending must be in accordance with certain conditions. Any shortfall in capital funding will delay implementation and may result in the Directorate not meeting national agendas and targets.
Projects funded through the Council's capital programme can carry any remaining balances over into the following financial year until the project is fully completed.

10. Policy and Performance Agenda Implications

The approved capital budget for 2007/08 allows Adult Services to invest and develop it's assets to improve and maintain existing levels of service to support the most vulnerable people and continues to contribute to meeting the Council's key priorities.

11. Background Papers and Consultation

Department of Health Local Authority Circular (2007)7– Mental Health Supported Capital Expenditure (revenue) 2007/08.
Department of Health Local Authority Circular (2006) 1 – Supported Capital Expenditure (Capital Grant) for Improving Management Information 2007/08.
Personal Social Services (PSS) Funding 2007-08

This report has been discussed with the Strategic Director of Neighbourhoods and Adult Services and the Strategic Director of Finance.

Contact Name : Mark Scarrott, Service Accountant (Adult Services), Extension 2007, mark.scarrott@rotherham.gov.uk

CAPITAL PROGRAMME 2005-10

Directorate **Adult Services**

Expenditure Code	Scheme description	Budget Holder Details	Scheme Total Cost Profiled					Scheme Total Cost	Scheme Total Funding Profile: Supported Capital Expenditure (SCE(R))	Specific Grant		Other Contributions		Unsupported Borrowing/Capital Receipts	Approval date /Committee/minute number
		(Initials)	2005/06	2006/07	2007/08	2008/09	2009/010								
			£	£	£	£	£	£	£	£	Detail	£	Detail	£	
	Older People														
UXB149	Adult's Older Peoples Modernisation Strategy	S Mc	52,009	729,290	11,500,000	4,816,701	0	17,098,000						17,098,000	Cabinet 7 Sept 2005
UXB150	Assistive Technology	KE			300,000	200,000		500,000				500,000	PCT Funding		
UXB151	Residential Care - Improving the Environment	S Mc			420,000			420,000		420,000	DOH Capital Grant				Local Authority Circular (2006)16
	Learning Disabilities														
UXL128	Addison Day Centre/Parkhill Lodge	AB			4,561			4,561						4,561	
UXL135	LDDF for Supported Living	AB	4,452	0	8,548			13,000				13,000	PCT Funding		
	Strategic Maintenance Investment Programme														
UXZ001	Oaks Day Centre Alterations	AB		94,514	486			95,000						95,000	
UXZ004	Addison Day Centre - Alterations	AB			50,000	200,000		250,000						250,000	
UXZ005	Oaks Day Centre Alterations - Phase 2	AB			100,000			100,000						100,000	
	REACH Day Centre	AB				250,000		250,000						250,000	
	Mental Health														
UXH098	Cedar House	JP	7,051	12,473	20,253			39,777						39,777	
UXH101	Supported Capital Expenditure	JP	32,500	21,462	75,000	357,513		486,475	189,849					296,626	Local Authority Circular DH (2007)7
	Management Information														
UXT002	Improving Information Management Grant	PM/JD	140,650	143,932	35,000	111,433		431,015		431,015	DOH Capital Grant				Local Authority Social Services Letter (2006)1
TOTALS			236,662	1,001,671	12,513,848	5,935,647	0	19,687,828	189,849	851,015		513,000	0	18,133,964	

Budget Holder Key

S Mc	Shona McFarlane
KE	Kirsty Everson
AB	Anne Baxter
JP	Janine Parkin
PM	Phil Morris/Jayne Dickson

Total profiled funding details

CAPITAL EXPENDITURE MONITORING 2007-8

Directorate Adult Services

Monitoring Period : 1 April to 15 February 2008

Expenditure Code	Scheme description	**Approved** Capital PROGRAMME 2007/08	Actual Expenditure 01/04/07 - 15/02/08	Projected Expenditure to 31/03/2008	Scheme 2007/08 Funding Profile: **Supported Capital Expenditure (SCE))**	**Specific Grant**		**Other Contributions**		**Unsupported Borrowing/Capital Receipts**	RAG Status	Comment Note number
		£	**£**	**£**	**£**	**£**	**Detail**	**£**	**Detail**	**£**		
	Older People											
UXB149	Adult's Older Peoples Modernisation Strategy	11,500,000	5,517,827	11,500,000						11,500,000	A	1
UXB150	Assistive Technology	300,000	235,510	300,000				300,000	PCT		A	2
UXB151	Residential Care - Improving the Environment	420,000	244,261	420,000		420,000	DoH Grant				G	3
	Learning Disabilities											
UXL128	Addison Day Centre/Parkhill Lodge	4,561	0	0						4,561	G	4
UXL135	LDDF for Supported Living	8,548	0	8,548				8,548	PCT		A	5
	Strategic Maintenance Investment Programme											
UXZ001	Oaks Day Centre Alterations	486	3,152	5,047						486	G	6
UXZ004	Addison Day Centre - Alterations	50,000	0	50,000						50,000	G	7
UXZ005	Oaks Day Centre Alterations - Phase 2	100,000	90,576	100,000						100,000	G	8
	Mental Health											
UXH098	Cedar House	20,253	7,825	10,000						20,253	A	9
UXH101	Supported Capital Expenditure	75,000	7,279	75,000	60,887					14,113	G	10
	Management Information											
UXT002	Improving Information Management Grant	35,000	500	35,000		35,000	DoH Grant				G	11
TOTALS		12,513,848	6,106,930	12,503,595	60,887	455,000		308,548	0	11,689,413		

Comments

1 Awaiting revised spending profile from external consultants who project managing the scheme currently estimated £11.5m spend in 2007/08
2 Review of spending profile in respect of Telehealth and Telcare equipment confirm balance to be carried forward into 2008/09.
3 Department of Health Capital Grant will be fully allocated within 2007/08
4 Funding from PCT will be vired to fund the budget deficit on UXZ001 - Oaks Day centre
5 Funding is earmarked for equipment within supported living schemes
6 Final costs on scheme - see note 4 above.
7 New approved scheme to commence in March 2008.
8 New approved scheme now completed.
9 Committed expenditure on providing support for early interventions and crisis move on.
10 Committed funding on developing new supported living schemes plus Individual Budgets and direct payments
11 Department of Health Capital Grant - final year of grant. LAASL (2008)1 Feb 2008 allows carry forward of any balance into 2008/09

Agenda Item 11

ROTHERHAM BOROUGH COUNCIL – REPORT TO MEMBERS

1	**Meeting:**	**Cabinet Member for Adult Social Care and Health**
2	**Date:**	**Monday 31 March 2008**
3	**Title:**	**Adult Services Revenue Budget Monitoring Report 2007/08.**
4	**Directorate :**	**Neighbourhoods and Adult 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 2008 based on actual income and expenditure to the end of February 2008.

During the year there have been a number of budget pressures within the service, mainly in respect of the non-achievement of a number of savings proposals, built into the 2007/08 budget, for reducing service level agreements with voluntary and community sector providers in addition to demand pressures on domiciliary and residential care budgets. These have been reported throughout the year in previous budget monitoring reports. A number of management actions to reduce these pressures were also identified however subsequent to implementing these actions, a significant pressure remained. As part of the Revised Estimates process the Cabinet approved an additional one-off budget allocation of £974k to reduce the projected overspend in 2007/08. The forecast position for the year assuming the remaining management actions are fully implemented is now a balanced budget.

6 Recommendations

Members are asked to note:

The latest balanced financial projection against budget for the year based on actual income and expenditure to the end of February 2008 for Adult Social Services.

7 Proposals and Details

7.1 The Current Position

7.1.1 The approved revenue budget for Adult Services for 2007/08 is £60.55m. Additional funding was approved for 2007/08 as part of the MTFS to fund a number of demographic and existing budget pressures, however, a number of underlying pressures remained. A range of management actions have been determined through budget performance clinics together with the additional one off budget allocation for 2007/08 of £974k agreed by Cabinet on 12 December 2007 to offset these budget pressures.

7.1.2 The latest budget monitoring report for Adult Services shows a projected balanced budget by the end of the financial year. All management actions have now been incorporated into the financial projections.

7.1.3 There still remains underlying budget pressures within Domiciliary Care services, including a shortfall in income from charges against the approved budget plus pressures within Physical and Sensory Disabilities mainly within residential care due to increased demand and an increase in the average cost of care packages.

7.1.4 These pressures are being reduced by:-

- projected underspends in independent residential care and extra care housing within Older Peoples services,
- slippage in developing supported living schemes within Learning Disability services and further additional income from continuing health care funding and
- management actions identified from budget performance clinics

7.2 Current Action

To mitigate the financial pressures within the service recruitment to all vacancies continues to require the approval from each Director. Financial performance clinics continue to operate to review areas where financial performance is projected to exceed the approved budget.
All care packages continue to be reviewed against the eligibility criteria and funding pursued with the Primary Care Trust in respect of continuing health care. Further reviews are also currently taking place on the provision of meals on wheels and transport to ascertain whether any savings may be achieved in these services in future years.

8. Finance

Finance details are included in section 7 above and the attached appendix shows a summary of the overall financial projection for each main client group.

9. Risks and Uncertainties

The demand for services over the winter months may impact on the revenue budget and therefore is being closely monitored and managed through the weekly placement panel. Non delivery of the proposed management actions will also impact on the ability to achieve a balanced budget. Budget performance clinics have again been scheduled for March to monitor progress. 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.

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 28 February 2007 –Proposed Revenue Budget and Council Tax for 2007/08.
- The Council's Medium Term Financial Strategy (MTFS) 2007-2010.
- Revised Estimates Report to Cabinet – 12 December 2007.

This report has been discussed with the Strategic Director of Neighbourhoods and Adult Services and the Strategic Director of Finance.

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ADULT SOCIAL SERVICES

REVENUE BUDGET MONITORING SUMMARY

		EXPENDITURE/INCOME TO DATE (As at 29 February 2008)									PROJECTED OUT-TURN							
		Expenditure			Income			Net			Net							
Last Net Projected Variance	Directorate/Service Area	Profiled Budget	Actual Spend to date	Variance (Over (+) / Under (-) Spend)	Profiled Budget	Actual Income to date	Variance (Over (+) / Under (-) Recovered)	Profiled Budget	Actual Net Expenditure to date	Variance (Over (+) / Under (-) Spend)	Annual Budget	Proj'd out turn	Variance (Over (+) / Under (-) Spend)	Current Financial RAG Status	Financial Impact of Management Action	Revised Projected Year end Variance Over(+)/Under(-) spend	Revised Financial RAG Status	* Note
£		£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000		£000	£000		
	Adult Services																	
335	Older People's Services	51,072	51,343	271	(13,848)	(14,040)	-192	37,224	37,303	79	35,142	35,497	355	Red	0	355	Red	1
(530)	Learning Disabilities	18,908	18,488	-420	(6,568)	(6,532)	36	12,340	11,956	-384	12,352	11,822	(530)	Green	0	(530)	Green	2
155	Physical & Sensory Disabilities	5,009	5,449	440	(377)	(635)	-258	4,632	4,814	182	5,138	5,237	99	Red	0	99	Red	3
100	Mental Health	4,473	5,056	583	(256)	(639)	-383	4,217	4,417	200	3,415	3,566	151	Red	0	151	Red	4
19	Head of Services & Policy & Development	361	376	15	(56)	(65)	-9	305	311	6	278	297	19	Red	0	19	Red	5
0	Supporting People	6,916	6,916	0	(7,536)	(7,536)	0	-620	-620	0	94	94	0	Green	0	0	Green	
	Commissioning, Quality & Performance																	
20	Adult Services Business Unit	1,783	1,776	-7	(29)	(26)	3	1,754	1,750	-4	2,881	2,883	2	Red	0	2	Red	6
(63)	CQP Management	173	176	3	(24)	0	24	149	176	27	262	199	(63)	Green	0	(63)	Green	
(36)	Planning Workforce & Compliance	1,002	985	-17	(585)	(677)	-92	417	308	-109	961	928	(33)	Green	0	(33)	Green	
0	Performance Information & Quality	469	469	0	(8)	(4)	4	461	465	4	608	608	0	Green	0	0	Green	
0	**Total Adult Social Services**	90,166	91,034	868	(29,287)	(30,154)	-867	60,879	60,880	1	61,131	61,131	0		0	0		

Reason for Variance(s), Actions Proposed and Intended Impact on Performance

Reasons for Variance(s) and Proposed Actions

Indicate reasons for variance (e.g. increased costs or client numbers or under performance against income targets) and actions proposed to address the

NOTES

Main Reasons for Variance

1 **Older People**

Continued increase in demand for Domiciliary Care services over and above budget due to demographic pressures including a shortfall against budget in income from Charges (£749k). Pressure on in-house residential care due to increase in cost of cover plus pressures on in-house day care (£517k). Pressures are being reduced by the current underspend on independent residential care including income from property charges (-£698k) and underspend on intermediate care beds (-£62k).
Slippage in the start up of Extra Care Housing at Potteries Court (-£178k).

2 **Learning Disabilities**

Recurrent overspend on day care transport (£114k) offset by slippage on the start up of new Supported Living Schemes (-£324k) and further underspend on residential care placements (-£277k) due to additional income from Continuing Health Care.

3 **Physical and Sensory Disabilities**

Increases in admissions to residential care over and above budget - net 5 additional placements this year plus cost of full year effect of an additional 4 placements made in March 2007 (£100k), being reduced by additional income from Independent Living Fund (£-80k).
Increase in cost of care packages for clients receiving Home Care (£26k) plus overspend on Direct Payments (£79k).

4 **Mental Health**

Overspend on residential care due to additional placements (£145k)

5 **Head of Services & Policy & Development**

Cost of Absence Officer post unbudgeted (£26k), savings from reduced sickness absence across all client groups.

6 **Commissioning, Quality and Performance**

Non achievement of Business Unit vacancy factor (£14k), increased costs of recruitment (£38k) offset by underspend on vacant posts (-£145k).

Proposed Actions to Address Variance

1 **Older People**

Review of provision of high cost Direct Payments and continuation of the review of placements at Senior Managers Panel.
Reviews on a number of services including Meals on Wheels and Transport to all client groups in order to identify potential savings.

3 **Physical and Sensory Disabilities**

Review of the cost of care packages for Residential care and Home Care plus Direct payments.

4 **Mental Health**

Efficiency savings being agreed with providers, examination of other funding streams including the use of capital resources.

6 **Commissioning, Quality and Performance**

All vacancies continue to be vetted and approved by each Service Director.
Monitor and challenge all corporate charges.

Management actions continue to be developed to ensure expenditure is contained within the approved cash limited budget, including the operation of regular finance performance clinics and the continuation of the Senior Officer Panel to review all care packages.

Performance

(List key targets and RAG status- highlight impact of actions intended to address budget

Residential/Nursing Care

Performance indicator C72 - national target to reduce admissions (Target 95) - currently predicted off target (113.22).

Home care

Any reduction in the numbers of intensive home care packages (i.e. more than 10 hours and 5 visits of care per week) would have a negative impact on performance indicator C28, which is currently off target (Target 16, performance 13.94).

Direct Payments

The increasing numbers is improving performance on key performance indicator C51.
Reducing expenditure in line with budget would have an adverse effect on performance and may impact on Star ratings.
Target 150 - current score 155)

ROTHERHAM BOROUGH COUNCIL – REPORT TO MEMBERS

1. Meeting:	Cabinet Member for Adult Social Care and Health
2. Date:	31st March 2008
3. Title:	Charging for Transport – Consultation Report
4. Directorate:	Neighbourhoods and Adult Services

5. Summary

Further to a report received by Cabinet Member on 25th February 2008 in respect of a proposal to introduce charges for transport to day care , it was agreed that a consultation exercise should take place.

Customers were consulted, using a questionnaire, and through meetings held in day centres. This report outlines the results of that consultation exercise and provides a recommendation for decision.

6. Recommendations

- **Agree to implement a £1 per day transport charge for people using day services, one month's notice to be given from effect from 7th April 2008**

7. Proposals and Details

Background

Cabinet Member received a report on 22nd February 2008 outlining the reasons for a proposed charge for transport to social care services. Cabinet Member requested that all affected service users should be consulted on this plan. This report outlines the results of this consultation exercise.

What were people asked?

This was a simple consultation process, with a brief range of questions asked:-

- Do you agree with a charge for transport
- What charge do you think is right – £1, £2, £3, £4
- If there is a small charge will you continue to use transport.

The consultation exercise sought to explore people's views about charging for transport. We were aware that the Learning from Customers Forum had been broadly in favour of charging and wanted to know if this was reflected across the service. Part of the consultation process also asked people what they felt was a reasonable charge. The Learning from Customers Forum had suggested a range of between £1 - £4 per day as a reasonable charge. We also wanted to understand the potential impact on service provision, so we asked people if they would continue to use the service should a charge be levied.

What did people tell us?

Broadly:-

50% of people were in favour of a charge for transport

39% of people were against a charge for transport

10% of people had no view either way

People felt the following charge was reasonable:-

£1	49 people in favour
£2	38 people in favour
£3	16 people in favour
£4	7 people in favour

In response to the question, would people continue to use transport if there was a small charge 21 people informed us that they would seek to use alternatives.

In addition, the following is a summary of the key points people raised on their questionnaires and at the meetings:-

- While I think it's not totally unreasonable to make a small charge for transport, but coming in the same week that we have had notice that dinners at the centre are going up by 60p a day total £20 for the week. It's rather a shock to say the least.
- I believe disabled people should get free transport. If they can't provide the transport then they should give petrol money to parents.
- Charge should be each journey, not return, as not all need return daily.
- Most people unable to use public transport and take advantage of bus pass.
- If there is a charge – flat rate but in zones, ie 50p within 2 miles, etc.
- Don't want to pay it.
- Expensive transport costs for short distances, maybe fair for longer distances.
- May walk, we could do with the exercise.
- Don't mind paying something. Perhaps it could be worked out on distances, like the handy bus.
- I think it all should be free.
- If people have benefits to pay for transport they should make a payment.
- I think people should make a small payment.
- It is hard for people to pay.
- No – it should be free, same as bus pass.
- Fear of ongoing increases in charges.
- If we are paying, can transport be guaranteed (as it is now if a bus breaks down there is no replacement)?
- It is not fair.
- I would like to take this opportunity to state I am delighted with the service provided by the drivers / escorts. I would rather pay for this service than see a reduction in these high standards. Messages given to the garage are always passed on to the drivers.

Conclusion

It is understood that people do not like to be charged for services which they have received free previously. The service will endeavour to ensure that everyone who should receive transport related benefits (Disability Living Allowance – Mobility Component) and free bus passes, are able to make a claim. Transport is seen as a daily living charge, in the same way as meals, for which people should be expected to pay.

On balance, a significant number of people are in favour of such a charge. The Council has discharged its statutory duty to consult with service users.

8. Finance

Estimated £70,000 income from charges in 2007/08 budget.

9. Risks and Uncertainties

- Increased costs of collection – charges will be collected in day centres along with meals charges, there should not be a significant increase in costs of collection as money is already collected in day centres.
- Unfair application of policy - service users will only be charged for actual use of transport. Systems will be set up to ensure that service users are only charged for journeys that they make.

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.

10.2 In addition the recommendations will enable funding to continue to be invested in providing users with the choice of a range of quality accessible services. The level of increases together with the aggregated impact on some users may result in a small reduction in take up of services. This in turn may have an impact on a range of key performance indicators e.g. older people helped to live at home, the number of intensive packages of care and the number of people in receipt of Direct Payments.

11. Background Papers and Consultation

11.1 The proposals set out in this report have been discussed and agreed with the Executive Director of Finance.

11.2 The outline principles have also been subject to consultation with the Learning from Customers Liaison Forum.

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