ADULT SERVICES AND HEALTH SCRUTINY PANEL

Venue:	**Town Hall, Moorgate Street, Rotherham.**	**Date:**	**Thursday, 12 February 2009**
		Time:	**10.00 a.m.**

A G E N D A

1. To determine if the following matters are to be considered under the categories suggested in accordance with 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 and Communications.

4. Declarations of Interest.

5. Questions from members of the public and the press.

6. Second Health Scrutiny Review (herewith) (Pages 1 - 11)

7. Local Involvement Network (LINk) - work programme and update (copy herewith) (Pages 12 - 24)

8. NAS Forward Plan (Pages 25 - 27)

9. Burn Care Services - Proposed Changes (Delia Watts to report)

10. Minutes of a meeting of the Adult Services and Health Scrutiny Panel held on 8 January 2009 (herewith). (Pages 28 - 35)

11. Minutes of a meeting of the Cabinet Member for Adult Social Care and Health held on 12 & 26 January 2009 (herewith). (Pages 36 - 41)

Date of Next Meeting:-
Thursday, 5 March 2009

Membership:-

Chairman – Councillor Jack
Vice-Chairman – Barron
Councillors:- Blair, Clarke, Doyle, Hodgkiss, Hughes, McMahon, St. John, Turner, Wootton and F. Wright

Co-opted Members

Mrs. I. Samuels, Kingsley Jack (Speakability), Jim Richardson (Aston cum Aughton Parish Council), Russell Wells (National Autistic Society), Taiba Yasseen, (REMA), Mrs. A. Clough (ROPES), Victoria Farnsworth (Speak Up), Jonathan Evans (Speak up), Mr. G. Hewitt (Rotherham Carers' Forum), Ms. J. Mullins (Rotherham Diversity Forum), Mr. R. H. Noble (Rotherham Hard of Hearing Soc.) and Pat Wade (Aston cum Aughton Parish Council)

Agenda Item 6

ROTHERHAM BOROUGH COUNCIL – REPORT TO MEMBERS

1.	**Meeting:**	**ADULT SERVICES AND HEALTH SCRUTINY PANEL**
2.	**Date:**	**12 February 2009**
3.	**Title:**	**2nd Health Scrutiny Review**
4.	**Programme Area:**	**Chief Executive's**

5. Summary

The Adult Services and Health Scrutiny Panel is committed to undertaking two health scrutiny reviews during the 2008/09 municipal year. The second review will use a new methodology which has been developed by the Improvement and Development Agency for local government (IDeA) and Doncaster MBC. This report explains the approach.

Steve Turnbull, will give a presentation at the meeting, providing background to a number of suggested review topics, to enable the Panel to choose which one it wishes to look at.

6. Recommendations

a. That the Panel identifies which health condition it wishes to review;

b. This scrutiny review be started in March 2009;

c. That members of the Panel indicate whether they would like to be involved in the review.

7. Proposals and Details

The model for carrying out a review of health inequalities has been developed to provide a structured approach to reviewing inequalities relating to a particular medical condition. It is designed to provide members of the scrutiny panel with an opportunity to research issues within their own constituencies, require commissioners and service providers to provide information, pose questions to identify gaps and then reach conclusions about the need for change.

7.1 Basic Methodology

The model is designed around four components, detailed in the attached papers:

Paper 1: A timeframe of ten stages covering the whole review process

The stages set out in the paper are a pragmatic attempt to try and put an overall timeframe on the conduct of a review. It takes into account the range of activities that will be required during a review and provides a reasonable period of time for delivering each stage.

Paper 2: A diagram of the structure of the Panel Review Session

This puts a structure to the review session itself, dividing the topic area into six elements:

- Assessment of Need
- Prevention/Lifestyle
- Early Diagnosis
- Treatment
- Self Management
- Outcomes

And the format of the review session into four stages:

- Defining the Issue
- Actions/Interventions
- Gap Analysis
- Conclusions

7.2 Condition Review

To conduct a review, members use the two papers on basic methodology (1 and 2) and the two 'question' papers (3 and 4). The administration of the process of review will be carried out by Delia Watts, Scrutiny Adviser.

Paper 3: A set of Pre-review Questions for Panel Members
These questions allow members to use their own knowledge and that of their constituents to provide a realistic picture of direct patient and public experience that will add richness and focus to the debate.

Paper 4: A set of Generic Review Questions to be used at the Panel Review Session

These questions are used when questioning the participants/expert witnesses and will form the basis of the brief given to them for their presentations. Not all questions will be asked of all witnesses and there may be additional questions asked, depending on the review topic.

7.3 Timing

To date, the model has been developed by Doncaster Council to look at the condition of cancer. Doncaster is planning to further test the approach by using again, this time to look at diabetes, in March. It is therefore suggested that any development of the model (particularly with respect to the questions in Paper 4), be incorporated into the Panel's use of it in its own scrutiny review.

8. Finance

The costs of the scrutiny review will be met from existing budgets.

9. Risks and Uncertainties

This model requires a high degree of commitment from Elected Members that are on the review team. Although the review meeting itself takes only half a day, its success or otherwise will depend on the pre-review work undertaken by both the supporting officer and the Elected Members involved.

10. Policy and Performance Agenda Implications

Assessing health inequalities and identifying ways to tackle them is one of the priorities of the Alive theme of Rotherham's Community Strategy.

11. Background Papers and Consultation

Use of the IDeA/Doncaster Council model has been agreed with both organisations. The principle of using the model in Rotherham is supported by Cllr Hilda Jack, Chair of the Adult Services and Health Scrutiny Panel.

Contact: *Delia Watts, Scrutiny Adviser, direct line: (01709) 822778*
e-mail: delia.watts@rotherham.gov.uk

METHODOLOGY FOR REVIEWING HEALTH INEQUALITIES

The process of review is divided into a number of stages that start with preparation for the review right through to the production of a final report with conclusions and recommendations. A review could follow the whole of this process but it could also be used in a reduced way to conduct a 'min-review'. The stages and timetable are as follows:

STAGE 1 (Week 1) Initial Notification

- Decision on the subject for review
- Consideration of whether expert opinion is required
- Notification to prospective participants in the review of the need to collect evidence
- Panel members canvass opinions in their constituencies

STAGE 2 (Week 5) Evidence Collection

- Collation of evidence and development of an information pack for the review

STAGE 3 (Week 7) Final Notification

- Despatch of information to members and participants

STAGE 4 (Week 8) Review Part 1

- Presentations by participants
- Questions by members on presentations
- Contributions by members from opinions canvassed

STAGE 5 (Week 8) Review Part 2

- Discussion on evidence and identification of gaps in services, potential improvements and desired outcomes
- Determination of conclusions from the review and recommendations

STAGE 6 (Week 9) Reporting Part 1

- Preparation of draft final report

STAGE 7 (Week 10) Reporting Part 2

- Review of draft final report by panel members
- Confirmation of report, conclusions and recommendations

STAGE 8 (Week 11) Reporting Part 3

- Despatch of final report to participants, Adult Services and Health Scrutiny Panel, Performance and Scrutiny Overview Committee and Cabinet.
- Request to participants for responses to conclusions and recommendations

STAGE 9 (Week 15) Participant Responses

- Analysis of responses to recommendations from participants
- Preparation of reports for Panel Members

STAGE 10 (Week 17) Panel Evaluation

- Panel review of responses to recommendations by participants
- Evaluation of the impact of the review

METHODOLOGY FOR REVIEWING HEALTH INEQUALITIES
PANEL REVIEW SESSION STRUCTURE

STAGE	(A) DEFINING THE ISSUE	(B) ACTIONS/INTERVENTIONS	(C) GAP ANALYSIS	(D) CONCLUSIONS
(1) ASSESSMENT OF NEED	Info / No Info			
(2) PREVENTION/ LIFESTYLE	Info / No Info			
(3) EARLY DIAGNOSIS	Info / No Info			
(4) TREATMENT	Info / No Info			
(5) SELF MANAGEMENT	Info / No Info			
(6) OUTCOMES	Info / No Info			

Areas for pre-review questions for members based on the chosen condition

Areas for generic review questions

Areas for exploration, discussion and agreement at Scrutiny Panel

Not applicable

PAPER 3

METHODOLOGY FOR REVIEWING HEALTH INEQUALITIES

PRE-REVIEW QUESTIONS – CONDITION REVIEW

These are questions that members could ask themselves on the basis of their detailed knowledge of their constituency and constituents.

- How common do you think this condition is in your Ward?
- What do you think are the main determinants of the condition?
- In your Ward do you think people have good access to information about the condition?
- Are there any particular factors in your Ward that you feel contribute to the incidence of the condition?
- What do you think needs to change in terms of the condition?
- How do you think Rotherham compares nationally in terms of the incidence of the condition?
- What is your view on the condition and who is experiencing it?
- What issues need to change in relation to the experience of the condition?
- What role do you think Rotherham Council should play in narrowing health inequalities in relation to the condition?

PAPER 4

METHODOLOGY FOR REVIEWING HEALTH INEQUALITIES

GENERIC REVIEW QUESTIONS – CONDITION REVIEW

These are questions that are part of the basic process of the review but can also act as a prompt for those that are called to the review to enable them to gather appropriate evidence for presentation. The questions are generic but can be broadened to be more specific depending on the condition being reviewed.

1. Assessing Needs.

Focus: Ensuring that there is a realistic assessment of the size of the problem locally and its distribution geographically and demographically including people's own perceptions of need.

Question	Evidence
• What do morbidity and mortality trends show and how do they compare with national trends?	Statistical analysis
• What does an analysis of need at a neighbourhood level show and have health or access inequalities been identified?	Statistical analysis and mapping

2. Prevention/Lifestyle

Focus: Ensuring that appropriate prevention measures are in place and that people are adopting healthy lifestyles.

Question	Evidence
• Are there actions that people can take to help themselves with this condition and is there evidence that people are doing so?	Research evidence
• Are there health promotion campaigns and programmes in place in Rotherham to provide information and support to people?	Details of services and throughput
• Are prevention programmes in place in primary care and at a neighbourhood level?	Details of services, including throughput and mapping
• Are prevention programmes in place in secondary care and tertiary care?	Details of services and throughput

• Are there other evidence-based prevention programmes available in other areas/countries that have transferability	Research evidence

to this area?	
• Are there inequalities in terms of uptake of prevention programmes between different neighbourhoods/wards/ groups in Rotherham?	Comparative analysis
• How do the wider determinants of health impact on this condition and how can other partners contribute to reducing its impact?	Research evidence

3. Early Diagnosis

Focus: Ensuring and that as many people with symptoms as possible present in a timely and appropriate fashion.

Question	Evidence
• Is there a screening programme in place for this condition and, if so, how successful has it been?	Details of services and throughput
• Are there inequalities in uptake of screening programmes between different neighbourhoods/wards/groups in Rotherham?	Comparative analysis
• Are there other evidence based screening programmes available in other areas/countries?	Research evidence
• Are case-finding initiatives feasible for this condition and have they been tried?	Details of initiatives
• If there is no screening programme for this condition, what other methods are used to achieve an early diagnosis?	Details of programmes
• Are there any proposals for future screening programmes for this condition?	Details of programmes
• Is there sufficient information about the condition for people to make an informed decision on seeking early advice and diagnosis?	Details of information resources

4. Treatment

Focus: Ensuring that when patients present with problems:

- They are afforded equal access to timely beneficial interventions according to need.
- That life saving interventions for which there is strong evidence are implemented equitably.
- That staff are achieving optimal clinical outcomes through their use of interventions.
- That services are designed with the minimum barriers to access.

Question	Evidence
• What services are available for treating this condition in primary, secondary and tertiary care and what are the levels of uptake?	Details of services and throughput
• Are there inequalities in uptake of services between different neighbourhoods/wards/groups in Rotherham?	Comparative analysis
• Are there other evidence based treatment services for this condition available in other areas/countries that have transferability to this area?	Research evidence

5. Self Management

Focus: Ensuring that patients are educated and supported to make choices and manage their treatment to best effect.

Question	Evidence
• What review mechanisms are in place to support patients managing their own condition?	Management protocols
• What local education and information materials on condition management are available in primary, secondary and tertiary care?	Copies of information
• Does information cater for minority languages, poor literacy and social marketing groupings?	Copies of information
• Has the quality of the information been accredited?	Accreditation scheme
• What local support groups are there?	Details of groups

6. Outcomes

Focus: Ensuring that a detailed analysis of outcomes is available that allows comparison with other areas and acts as a driver for improvement.

Question	Evidence
• What are the potential outcomes for this condition?	Clinical/operational information
• How does Rotherham compare for all of those outcomes against similar areas elsewhere in this country?	Comparative analysis
• How do the outcomes for this condition in other countries compare with Rotherham and England?	Comparative analysis
• Are there inequalities in outcomes between different neighbourhoods/wards/groups in Rotherham?	Comparative analysis

Local Involvement Networks (LINks)

Local Involvement Networks were set up throughout England to give communities a stronger voice in how their health and social care services are delivered.
Independent networks of local people, voluntary organisations and community groups with a flexible approach to involvement

The Rotherham Local Involvement Network (LINk)
The Rotherham LINk will be owned, developed and shaped by groups, organisations and individuals at grass-roots level.
Local: based on local authority boundaries driven by the local voluntary and community sector and local people.
Involvement: ensuring all voices have equal strength to be heard
Network: opportunities to engage and share information in a flexible way that can be understood by everyone.

The Rotherham LINk will be:-

- **Creative -** building on existing networks and partnerships
- **Flexible** – enabling different methods of involvement
- **Powerful** – having legal powers to require information from commissioners and providers of services, and to receive a response to comments
-

The Rotherham Local Involvement Network will change how health and social care services are delivered, but to be successful we need a diverse and inclusive membership.

Local Authority Overview and Scrutiny Committees (OSCs) will want to assure themselves that local improvement targets in the LAA are being set in consultation and co-operation between the council executive and partners. They will be particularly interested in the opportunities given to local people and communities to influence the development of the targets. Local Involvement Networks will be a key vehicle for councils and partners to find out from local people and groups about their priorities for improvement.
OSCs will want to assure themselves that Councils and PCTs are co-operating around the assessment, the robustness of the information relied on to make the assessment and that local people and communities have opportunities to feed their views into the assessment. LINks will be a key vehicle for councils and PCTs to find out about health and social care needs of local people and groups.

Anyone can join the Rotherham LINk .Organisations or community groups who have contacts through working with local people and have an understanding of their needs. Individuals who have personal experiences and knowledge, that they can share to ensure that Rotherham communities have the best health and social care service.
Joining the LINk will ensure the People of Rotherham have a strong, united voice.

Extracts taken fro the NCI LINk Guides

Rotherham Local Involvement Network (LINk)

Draft Workplan December 08 – March 09

Workplan	Context	Time scale
Personalisation	Be actively involved in the planning, formatting and consultation process	
Rotherham NHS Mental Health Delivery Consultation	Promote the consultation	Completed with a view to monitoring the outcome of the consultation
084 Telephone numbers in the NHS	Promote the consultation	16.12.08 – 31.03.09 with a view to monitoring the outcome of the consultation
Patient Journeys	Caring out a series of Patient/ customer journeys within the Health and Social Care sector	Ongoing
Promoting the Rotherham LINk	Organising , facilitating events, workshops, awareness sessions to promote the Rotherham LINk	Ongoing

Guide No. 1

The National Centre for Involvement

Local Involvement Networks

Summary Local Government and Public Involvement in Health Act 2007

Introduction

The Act received Royal Assent on 30 October 2007. The Act provides a legislative framework for a number of proposals in the Local Government White Paper 2006; copies of the Act can be downloaded from the NHS Centre for Involvement website: www.nhscentreforinvolvement.nhs.uk/LGPIHAct/.

A number of legislative provisions made in the Act relate to health and social care:

Part 5 – Partnerships and Scrutiny

The Act introduces a duty on 'named partners' to cooperate with another in the development and agreement of Local Area Agreements (LAAs), which have been given a statutory basis. The Act also provides powers for Overview and Scrutiny Committees (OSCs) to review and scrutinise the actions of key local public service providers, as well as empowering councillors to raise issues with Overview and Scrutiny Committees through a 'councillor call for action'.

Part 14 – Patient and public involvement in health and social care

The Act abolishes Patient and Public Involvement Forums and introduces Local Involvement Networks (LINks). LINks will be networks of local people and groups that will ensure local communities can monitor service provision, influence key decisions and have a stronger voice in the process of commissioning health and social care. LINks will cover the geographical area of Local Authorities that have social services responsibilities. To enhance their independence, LINks must be hosted by a body other then a Local Authority or an NHS body. The task of finding the Host has been given to Local Authorities.

There were some late amendments to the Bill, particularly relating to transitional arrangements for Local Involvement Networks (LINks) and the role of Strategic Health Authorities in consultation.

The NHS Centre for Involvement is a consortium made up of The University of Warwick, The Centre for Public Scrutiny and LTCA and is funded by the Department of Health.

Local Area Agreements, consultation and co-operation with 'partner authorities'

Primary Care Trusts, NHS Trusts and NHS Foundation Trusts are included in a long list of 'partner authorities' that County, Unitary, Metropolitan Borough and London Borough Councils (together with the Council of the Isles of Scilly and the Corporation of the City of London) must consult with when preparing draft local area agreements (LAAs). Councils must co-operate with the listed 'partner authorities' in determining the local improvement targets to be specified in the draft agreement, having regard to their community strategy and guidance from the Secretary of State.

Comment

Local Authority Overview and Scrutiny Committees (OSCs) will want to assure themselves that local improvement targets in the LAA are being set in consultation and co-operation between the council executive and partners. They will be particularly interested in the opportunities given to local people and communities to influence the development of the targets. Local Involvement Networks will be a key vehicle for councils and partners to find out from local people and groups about their priorities for improvement.

Local Improvement Targets, co-operation of partner authorities and duty to have regard to targets

Local improvement targets are defined as 'targets for improvement in the economic, social or environmental well-being' of the authority's area that 'relates to the authority, one or more partners or one or more other persons acting or having functions exercisable' in the authority's area. 'Partner authorities' must co-operate with Councils in determining the local improvement targets to be specified in the draft LAA. Councils and 'partner authorities' must have regard to local improvement targets specified in the LAA which relate to them.

Comment

OSCs will want to be assured that partner authorities are co-operating with councils in setting improvement targets. OSCs will also want to check that councils and partners are 'having regard' to relevant targets. 'Having regard' implies that targets cannot be ignored. LINks will be able to provide valuable intelligence about how local improvement targets are impacting upon the health and social care of local people.

Scrutiny of local improvement targets

The Act provides for Joint Overview and Scrutiny Committees of County and District Councils (described as a 'group of partner authorities') to make reports and recommendations about local improvement targets. District Councils are able to make reports and recommendations to related County Councils about local improvement targets in the County Council's LAA. Under separate provisions, County Councils might have to respond to and 'have regard' to reports and recommendations from District Council OSCs.

Comment

The 'group of partner authorities' appoint the joint scrutiny committee. That group includes the County Council, so without the County Council's participation there is no 'group' and thus no prospect of forming a joint committee under these provisions. In this scenario, District Councils would need to rely on their own OSCs to make reports and recommendations to County Councils or rely on their ability to form joint OSCs under previous legislation. LINks may well form 'constituencies of interest' that focus on health and social care for particular communities, for instance within a District Council area. They will be able to inform joint OSCs about how local improvement targets are influenced by local people.

Joint Strategic Needs Assessment

An assessment of 'relevant needs' must be prepared in relation to the area of a responsible Local Authority by the responsible Local Authority and its partner Primary Care Trusts (PCTs). The authority must publish the assessment of relevant needs in relation to its area. In preparing the assessment the authority and the PCT must co-operate and County Councils must consult District Councils.

'Relevant needs' are those which appear to the responsible Local Authority and the partner PCT to be capable of being met to a significant extent by the exercise of functions by the Local Authority and could also be met or affected to a significant extent by the exercise of functions by the PCT or vice versa.

Comment

OSCs will want to assure themselves that Councils and PCTs are co-operating around the assessment, the robustness of the information relied on to make the assessment and that local people and communities have opportunities to feed their views into the assessment. LINks will be a key vehicle for councils and PCTs to find out about health and social care needs of local people and groups.

Strengthening Scrutiny

Council executives (often called 'cabinets') must respond to OSC reports and recommendations within two months by considering the report or recommendations, saying what action (if any) it proposes to take and publishing the response (if the OSC published its report or recommendations).

OSCs can make reports and recommendations to the 'partner authorities' listed as having to co-operate with councils around Local Area Agreements – NHS bodies are included in the list of partner authorities that have to co-operate around the LAA and 'have regard' to targets, but are excluded from this part of the Act because they are covered by provisions in previous legislation (health scrutiny legislation that is now consolidated into the NHS Act 2006).

Comment

There *may* be an opportunity for District Councils to engage in a form of health scrutiny as a result of regulations that might define 'associated authorities' that District Councils can require information from – for example if PCTs and NHS Trusts are defined as 'associated authorities'. However, it is possible that NHS bodies will be excluded from any list of 'associated authorities' as they are already subject to scrutiny under health scrutiny legislation.

Local Involvement Networks

Councils to make contractual arrangements for LINks

Local Authorities with social services responsibilities must make contractual arrangements for the activities specified below to be carried on in their area from 1 April 2008:

- Promoting and supporting the involvement of people in the commissioning, provision and scrutiny of local care services (health care and social care).

- Enabling people to monitor and review the commissioning and provision of local care services relating to:
  - the standard of provision;
  - whether and how local care services could be improved; and
  - whether and how local care services ought to be improved.

- Obtaining the views of people about their needs for and their experiences of local care services.

- Making such views known and making reports and recommendations about how local care services could or ought to be improved to people responsible for commissioning, providing, managing or scrutinising local care services.

The body that will carry out these activities is defined as a 'Local Involvement Network' (LINk). The contractual arrangements made by the Authority are a way of providing independence for the LINk from the council by contracting a Host to set up and support the LINk.

Comment

OSCs will want to make sure their Council Executive (or Cabinet) are taking LINks seriously by facilitating wide discussions with local people, groups and communities about the 'look and feel' of the local LINk. The outcomes of these conversations should inform the contractual and performance management arrangements with a Host so that the Host has the right skills to create and support the local vision for the LINk. The Department of Health has given social services authorities £10,000 to get the process started and OSCs will want to find out what the Executive is doing with this money. They will also want to scrutinise how councils' full allocations for LINks (a three year non-ring fenced allocation contained in the Area Based Grant) is being

spent. Details of the allocation for each Local Authority can be found at www.nhscentreforinvolvement.nhs.uk/docs/linksbulletin8.pdf.

Many councils have decided that they need to follow European Union tendering rules when seeking a Host. The timescales involved may mean that councils are unable to contract with a Host before 1 April 2008.

The Department of Health has written to councils expressing its view that the role of Hosts is materially different from Forum Support Organisations and so it does not believe that TUPE regulations will apply.

As a result of late amendments to the Bill regarding transitional arrangements and governance issues for LINks, the Secretary of State is to make regulations that will affect the specifications that councils will need for Hosts.

Exclusions from being a Host or a LINk

The contractual arrangements must be made with a person (called 'H' in the Act) commonly referred to as a 'Host'. Local Authorities, NHS Trusts, NHS Foundation Trusts, PCTs or Strategic Health Authorities cannot be Hosts (this is to create independence between councils, the NHS and LINks). The Host, Local Authorities, NHS Trusts, NHS Foundation Trusts, PCTs and SHAs cannot be Local Involvement Networks (in other words they cannot carry out LINk activities themselves – the Host must reach out to local communities to engage local people and groups in carrying out the activities of LINks).

Comment

These arrangements are designed to ensure that LINks are independent of local councils and the NHS (but see note on transitional arrangements below which might mean that some councils need to support LINk activity until they are able to appoint a Host). LINks will use the skills of the Host to help them plan and carry out their work and will need to tell councils how they think the Host is performing its role. This will help councils to judge whether Hosts are meeting their contractual requirements.

LINKs able to co-operate together

There is provision for Local Involvement Networks to co-operate with other Local Involvement Networks – what the Act calls 'other English networks'.

Comment

LINks will need to develop relationships with health and social care commissioners, providers and scrutineers that cover not only their own areas but those of neighbouring LINks. In these circumstances it makes sense for the work of LINks to be co-ordinated through co-operation with other LINks. This provision also enables the prospect of a national body for LINks.

Secretary of State to make regulations

The Secretary of State must make regulations to require arrangements made for Local Involvement Network activity to include prescribed provisions about:

- ways in which certain decisions of a LINk are taken;
- authorisation of individuals as 'authorised representatives';
- use of money by LINks resulting from arrangements made by Local Authorities; and
- consequences of contravention by a LINk of any provisions of the arrangements.

Providers of health and social care services must:

- respond to requests for information made by a LINK;
- deal with reports and recommendations made by a LINk; and
- deal with any reports or recommendations from a LINk that have been referred by another services provider.

Services providers are:

- NHS Trusts;
- NHS Foundation Trusts;
- PCTs;
- Local Authorities; and
- Persons prescribed by the Secretary of State (to be set out in regulations).

Service providers will be under a duty to allow authorised representatives of LINks to enter and view and observe the carrying on of activities on premises owned or controlled by the services provider. The Secretary of State may describe:

- the types of premises covered and excluded;
- the types of activities 'carried on' included or excluded;
- any conditions that need to be satisfied before the duty arises;
- any limit to the extent of the duty;
- conditions and restrictions on the carrying out of any viewing or observation;
- the authorisation of individuals by a LINk; and
- any limits to the number of authorised representatives and the hours during which the duty applies.

Viewing and observation must be carried out for the purposes of LINk activities.

Comment

The Bill was amended fairly late on in the Parliamentary process in order to provide some common standards relating to how LINks are governed, how people are authorised to undertake the 'entering and viewing' role and how that role should be exercised responsibly. These are aspects which councils will need to include in contracts with Hosts and so the regulations will need to be published before any contracts can be finalised.

Referrals to OSCs

LINks can refer matters relating to social care services to an OSC. The referral must be in relation to a LINk activity as defined in the Act. The committee must acknowledge receipt and keep the referrer informed of the committee's actions. The Secretary of State may specify the time by which the acknowledgement must be given.

OSCs must decide whether or not their powers are exercisable in relation to the referral and if they are, they must decide whether or not to exercise them. If it decides to exercise its powers, the OSC must have regard to information it has received from the LINk.

Comment

OSCs and LINks are encouraged to begin an early dialogue about developing a protocol for managing expectations around referrals. Previous guidance from the Centre for Public Scrutiny about how OSCs and PPIFs could work together may be helpful (www.cfps.org.uk/publications).

Annual reports

The arrangements made by Local Authorities for the carrying on of LINk activities must include provision of reports for each financial year (by the 30th of June) to be prepared by the LINk or by the Host if not done by the LINk. Copies of annual reports are to be publicly available and copies sent to:

- relevant Local Authorities;
- relevant PCTs and SHAs;
- relevant OSCs;
- the Secretary of State; and
- any others people prescribed by the Secretary of State.

The annual report must include:

- anything the Secretary of State directs;
- details of amounts spent by the Host in respect of LINk activity and what the amounts were spent on; and
- details of amounts spent on 'non-networked' activity and what the amounts were spent on.

Comment

Publishing annual reports about their activities is one of the ways LINks can be accountable to local people but should not be the only way. LINks should use the skills of the Host to keep in touch with local people, groups and communities on an ongoing basis via a number of mechanisms that meet different needs. LINks are particularly encouraged to focus on people and groups that are traditionally 'hard to reach' and this is unlikely to be achieved simply through publishing an activity report once a year.

Transitional arrangements

Councils that have the duty to make contractual arrangements with a Host to ensure that LINk activities are carried out in their areas may be subject to a temporary duty 'to ensure that until the relevant time there are means of carrying on LINk activities in the authorities area'. The temporary duty relates to councils that do not have a Host in place by 1 April 2008.

Comment

This was a late amendment to the Bill to cover situations where councils have not appointed Hosts by the time LINk activity needs to take place (1 April 2008). Examples of reasons why councils might not have contracted a Host in time are:

- few organisations with skills to turn the vision for the local LINk in to reality,
- the long lead time for procurement (in cases where EU procurement rules apply).

It is expected that the temporary duty will last until 30 September 2008 or the point at which a Host is appointed and brings people together to carry out LINk activity (whichever is earlier). The Department of Health is encouraging councils that think they might not be able to find a Host by 1 April 2008 to begin to think about the alternative arrangements they might make for ensuring LINk activity can take place. For example, this might be through the council bringing together people involved in community/user groups and PPI activities to undertake LINk work, supported by the council as 'transitional Host' until an arms length Host is in place and people have been brought together to carry out LINk activity.

Consultation about health services

Duty on NHS bodies to involve

The new 2007 Act has amended Section 242 of the NHS Act 2006 (previously Section 11 of the Health and Social Care Act 2001) which related to the duty on NHS bodies to involve and consult service users.

Under the new Act Strategic Health Authorities, Primary Care Trusts, NHS Trusts and NHS Foundation Trusts must make arrangements for people who receive or may receive services to be involved in:

- planning of the provision of those services;
- developing and considering proposals for changes in the way those services are provided; and
- decisions to be made affecting the operation of those services.

The Act says that people can be 'involved' either by being consulted or provided with information or in other ways. The Act also says that 'involvement' can be either direct or through representatives.

The NHS needs to involve people in the development and consideration of proposals for changes in the way services are provided and decisions about the operation of services only if implementation of the proposal or decision would have (at the point when those services are received by users) an impact on:

- the manner in which the services are delivered; or
- the range of health services available to those users.

The Secretary of State is going to issue guidance about the discharge of the duty to involve that will include when, or how often, involvement is to be carried out and the form to be taken by such involvement.

Comment

The requirement to involve where there is an 'impact' at the point of delivery clarifies that people do not need to be consulted about changes in service provider where the manner of service delivery and range of services available remain the same. This appears to be a response to the High Court judgment involving a change of service provider of GP services in North East Derbyshire. Provisions in the original Bill that sought to clarify the nature of 'significant' changes are missing from the Act. This means that NHS bodies are still required to consult relevant OSCs about proposals for 'substantial' changes to services. There is useful guidance already available from the Centre for Public Scrutiny about how OSCs should tackle consultations about 'substantial' service changes (www.cfps.org.uk/publications).

Additional Duties on Strategic Health Authorities to involve

The Secretary of State will make regulations requiring each Strategic Health Authority to make arrangements which secure that health service users are, directly or through representatives, involved (whether by being consulted or provided with information, or in other ways) in prescribed matters. Guidance will be issued about this duty that SHAs must have regard to.

The Secretary of State may make regulations enabling SHAs to direct a PCT that people who would otherwise be involved in a particular matter by the PCT are not to be involved in that matter by the PCT. The circumstances when this might happen are where the people concerned are to be involved (whether by the SHA or by the SHA and PCT acting jointly, or otherwise) under arrangements made or to be made by the SHA.

Reports on consultation

Strategic Health Authorities and Primary Care Trusts must prepare reports about consultations they have carried out, or propose to carry out, before making commissioning decisions, and on the influence that the results of consultation have on commissioning decisions.

'Commissioning decisions' in relation to a Strategic Health Authority means decisions as to the carrying-out of functions exercisable by it for the purpose of securing, by arrangement with any person or body, the provision of services as part of the health service.

'Commissioning decisions' in relation to Primary Care Trusts, means decisions as to the carrying out of its functions under Parts 4 to 7.

The Secretary of State may give directions as to:

a) the periods to be covered by reports;
b) the matters to be dealt with by reports;
c) the form and content of reports;
d) the publication of reports; and
e) decisions that are to be treated as being, or that are to be treated as not being, commissioning decisions.

Comment

OSCs have always been keen to ensure that 'involvement' has given local people opportunities to 'influence' change. These provisions mean that the NHS will need to report directly to communities about the difference that involvement has made to decisions about health care.

Appendix

Acronyms

- National Centre for Involvement – NCI;
- Patient and Public Involvement – PPI;
- Department of Health – DH (not DoH);
- Local Involvement Networks – LINks;
- Early Adopter Programme sites – EAPs or EAP sites;
- Overview and Scrutiny Committee – OSC;
- Local Authority – LA;
- Local Area Agreements – LAAs;
- Strategic Health Authority – SHA; and
- Primary Care Trust – PCT.

Glossary

- **Commissioning –** The process of identifying a community's social and/or health care needs and finding services to meet them

- **Local Area Agreements –** Three-year funding arrangement between central Government and a local area.

- **Overview and Scrutiny Committees –** Overview and Scrutiny Committees of all local authorities with social services responsibilities have the power to examine health services. This contributes to local authorities' wider role in health improvement and reducing health inequalities for their area and their populations.

- **Community strategy –** Document setting out a vision for the future of a local area, aiming to benefit everyone living and working in the area. Strategies describe the long term vision and include a number of shorter-term actions.

- **Non-ring fenced grant –** Funding from central Government to a Local Authority relating to an initiative or service where there are no restrictions or conditions on how the Local Authority should spend that funding.

- **Area Based Grant –** Funding from central Government to Local Authorities to provide local services. Authorities are free to decide the money will be used, and to negotiate with partner organisations about how priorities set out in Local Area Agreement are to be funded.

- **TUPE regulations –** Regulations designed to protect the rights of employees in a transfer situation enabling them to enjoy the same terms and conditions, with continuity of employment, as before.

KEY DECISIONS TO BE MADE BY THE CABINET MEMBER, STRATEGIC DIRECTOR AND DIRECTORS FOR NEIGHBOURHOODS AND ADULT SERVICES

Strategic Director: Tom Cray
Representations to: The Strategic Director for Neighbourhoods, Rotherham Borough Council, Neighbourhood Services, Norfolk House, Walker Place, Rotherham S65 1HX.

KEY DECISIONS BETWEEN 1 February 2009 to 31st May 2009					
Matter subject of key decision	**Proposed date of key decision**	**Proposed consultees**	**Method of consultation**	**Steps for making and date by which representations must be received**	**Documents to be considered by decision-maker and date expected to be available***
February 2009					
Assistive Technology Update	23rd February	Cabinet Member for Adult Social Care	Report	13th February	Report
March 2009					
Home from Home	23rd March 2nd April	Cabinet Member for Adult Social Care Adult Services and Health Scrutiny Panel	Report / Presentation	12th March	Report
Reviews of Day Care services	9th March	DMT and Cabinet member as required by DMT	Report and or presentation	27th February	Report
Voluntary and Community Sector Reviews	9th March	DMT and Cabinet member as required by DMT	Report and or presentation	27th February	Reports to be available by February 09, but some priority

KEY DECISIONS BETWEEN 1 February 2009 to 31st May 2009					
Matter subject of key decision	**Proposed date of key decision**	**Proposed consultees**	**Method of consultation**	**Steps for making and date by which representations must be received**	**Documents to be considered by decision-maker and date expected to be available***
					reports will be available prior to this date as they are completed
Review of Charges for Non Residential Services 2009/10 – Effective April 09	23rd March	Cabinet Member For Adult Social Care Strategic Director of Finance	Consideration of Report	13th March	Report 22nd January
Independent Living Centres	23rd March	Cabinet Member of Adult Social Care	Report	13th March	Report
April 2009					
Supporting People Strategy 2008-13	6th April 4th June	Cabinet Member for Adult Social Care Adult Services and Health Scrutiny Panel	Report / Strategy	26th March	Report and Strategy
Reviews of Day Care services	6th April	DMT and Cabinet member as required by DMT	Report and or presentation	26th March	Report
Voluntary and Community Sector Reviews	6th April	DMT and Cabinet member as required by DMT	Report and or presentation	26th March	Report

KEY DECISIONS BETWEEN 1 February 2009 to 31st May 2009					
Matter subject of key decision	**Proposed date of key decision**	**Proposed consultees**	**Method of consultation**	**Steps for making and date by which representations must be received**	**Documents to be considered by decision-maker and date expected to be available***
Review of Physical Disability Service	6th April TBC	Cabinet Member for Adult Social Care Adult Services and Health Scrutiny Panel	Report	26th March	Report
BME Hospital Action Plan	27th April 4th June	Cabinet Member for Adult Social Care Adult Services and Health Scrutiny Panel	Report / Action Plan	26th March	Report and Action Plan
Personalisation Strategy	6th April	Cabinet Member for Adult Social Care Adult Services and Health Scrutiny Panel	Strategy	26th March	Report and Strategy
May 2009					

ADULT SERVICES AND HEALTH SCRUTINY PANEL
Thursday, 8th January, 2009

Present:- Councillor Jack (in the Chair); Councillors Blair, Clarke, Doyle, Hodgkiss, Hughes, McMahon, St. John, Turner and Wootton.

Also in attendance were Mrs. I. Samuels, Kingsley Jack (Speakability), Jim Richardson (Aston cum Aughton Parish Council), Russell Wells (National Autistic Society), Taiba Yasseen, (REMA), Mrs. A. Clough (ROPES), Jonathan Evans (Speak up), Mr. G. Hewitt (Rotherham Carers' Forum), Ms. J. Mullins (Rotherham Diversity Forum) and Mr. R. H. Noble (Rotherham Hard of Hearing Soc.).

Apologies for absence were received from Councillors Barron and F. Wright.

213. COMMUNICATIONS

The following issues were reported:-

(1) Consultation on Care Quality Commission (CQC)

The Scrutiny Adviser reported that this was a new organisation which would bring together the work of the Commission of Social Care Inspection, the Healthcare Commission, and the Mental Health Act Commission. Places were available for members to attend an event in Leeds on Monday, 16th January, 2009, to give their view on consulting on how the CQC intended to use its enforcement powers, which would include the Care Standards Act (CSA) 2000 powers and three new powers under the Health and Social Care Act 2008.

Attendance allowances and expenses would be paid by the Commission.

Registration was on-line (the Scrutiny Adviser would send the link to those interested)

(2) Personalisation – training

The Scrutiny Adviser reported that a dedicated session explaining the personalisation agenda within Adult Services and the Council's approach was being provided for the Panel by Tom Sweetman in Adult Services. This session had been arranged to take place at Talbot Lane Church on Thursday, 19th February, 2009 from 2 p.m. to 4 p.m, with refreshments provided. Members of the Panel were requested to submit any questions regarding the personalisation of services to the Scrutiny Adviser before hand so that these could be covered in the presentation.

214. DECLARATIONS OF INTEREST

No declarations of interest were made at the meeting.

215. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

There were no members of the public, or the press, present.

216. CSCI ANNUAL PERFORMANCE ASSESSMENT REPORT 2008

Tom Cray, Strategic Director for Neighbourhoods and Adult Services, presented the submitted report which summarised the results and findings of the 2008 social care Annual Performance Assessment (APA) process for Rotherham conducted by CSCI (Commission for Social Care Inspectorate) which was published on 27 November 2008.

The performance judgement for Rotherham was as follows:

- Delivering outcomes: Good
- Capacity for improvement: Promising
- Rotherham Adult Social Care services performance rating was 2 Stars

The result recognised that the Council had improved the quality of outcomes in six areas, achieving an excellent standard in four overall. The performance rating received in 2006 and 2007 had been maintained. The Panel was informed that a full copy of the assessment report, in various formats, could be provided on request.

Dave Roddis, Service Quality Manager, provided details of the delivery of outcomes and capacity for improvements, together with the progress which had been made in relation to each of them. These were:

Judgement Areas	**2007 Rating**	**2008 Rating**
Delivering Outcomes	**Good**	**Good**
1. Improved health and well-being	Good	Excellent
2. Quality of Life	Adequate	Good
3. Making a positive contribution	Excellent	Excellent
4. Increased choice and control	Adequate	Good
5. Freedom from discrimination and harassment	Good	Excellent
6. Economic well-being	Good	Good
7. Maintaining personal dignity and respect	Adequate	Good
Capacity to Improve (Combined judgment)	**Promising**	**Promising**

8. Leadership	Promising	Excellent
9. Commissioning and use of resources	Promising	Promising
Performance Rating	**2 Stars**	**2 Stars**

Members of the Panel congratulated the staff of the Directorate in achieving this excellent standard given the challenging circumstances during 2007-2008.

Members of the Panel raised the following issues, and responses were given by the Strategic Director and the Director of Commissioning and Partnerships:-

- Demographics
- budget pressures
- economic downturn
- delivery of promised expectations
- resourcing of the direct payments system
- Rotherham's national profile re: direct payments
- Information sharing with other local authorities
- The personalisation agenda
- Lack of progress with the electronic single assessment process
- Finance for the new safeguarding team
- Impact of efficiency savings on the maintenance of a two star rating
- Ensuring that service users have increased choice now that many services would be provided by the private sector
- Areas where the Directorate was under performing in terms of safeguarding people against abuse
- Development of commissioning
- Clarification of outcomes in terms of commissioning
- Aims of the new senior citizens' network
- The 2009-2010 budget pressures and anticipated revenue allocation
- The Older People's Network and sources of information available from Age Concern

Resolved:- (1) That the outcome of the assessment be noted.

(2) That the 'Excellence Plan' put in place to improve the areas of weakness identified in the report be noted.

(3) That it be noted that the Cabinet Member for Adult Social Care and Health approved the investment to develop a safeguarding adults team which consists of 10 social workers, a manager and administration support to manage the increase in referral rates.

217. BME HEALTH NEEDS

Steve Turnbull, Head of Public Health, presented the submitted report, together with a PowerPoint presentation, which outlined the progress made to date and informed the Panel of the interim findings in relation to BME Health Needs.

It was explained that research was conducted on all BME communities to gather a comprehensive picture of health needs. This research was backed up by in-depth community consultations with five specific communities which were chosen for a variety of reasons to give a broad picture of needs in different communities. The initial focus had been on the more established communities and new economic migrants were not included in the detailed consultation. The five communities were:

- Pakistani/Kashmiri
- Chinese
- Yemeni
- Black African, and
- Irish

The community consultation exercises involved in-depth family interview conducted in homes, gender specific focus by ethnic minority and a general event open to all communities.

Further sources of data were also explained, together with the demography, population number predictions to 2030 and age profile.

The findings were focussed around four themes:

- Demography/changes and nature of population
- Health conditions and access to services
- Lifestyles and behaviours
- Wider determinants of health

Specific slides within the presentation detailed:-

- Practice based (2 GP practices based in areas with a high proportion of BME patients) Qualitative Health Needs Assessment 2008 – Selected measures by z scores; with particular reference to increased prevalence of coronary heart disease and diabetes in BME communities

- CHD in South Asians Equity Audit – Deaths from All Causes - % by Age Group: South Asian residents compared to Rotherham Residents

- Infant Mortality by Ethnicity and Low Birth weight by ethnicity

- Practices % ethnics v Mental Health admissions

- Smoking and Cancers
- Accidents
- Broader issues
- Ethnicity monitoring: the cycle of invisibility

Taiba Yasseen, REMA, provide further explanation about the assessment process and range of events and tools used to gather this information.

A question and answer session ensured covering the follow:-

- The need to add an additional category for Eastern Europeans
- Further work to increase knowledge and raise awareness about access to a wider range of services
- The widening gap between the more affluent and the deprived population groups
- Access to leisure services, particular for women, with reference to the Women's Strategy
- Accuracy and validity of the data, together with the difficulties in collecting data
- Human rights issues and methods used to obtain information
- Genetic issues:- diabetes and obesity
- Accidents in the home
- Increased incidences of tuberculosis
- BME representation on the Scrutiny Panel
- Were there any plans to include the new economic migrant communities in future health needs assessments?
- How many individuals/families were interviewed and how confident was the service that they represent their communities in terms of their health needs?
- What was meant by 'South Asian'? Did this mean both the Yemeni and Pakistani/Kashmiri communities?
- How would the next stage of assessing health priorities for action be carried out?
- Would additional resources be provided for the action that would arise following the assessment?

The Chairman thanked Steve for his informative report and presentation.

Resolved:- That the interim findings, and progress made in assessing the health needs of BME communities in Rotherham, be noted.

218. ANNUAL HEALTH CHECK WORKING GROUP

The Scrutiny Adviser reported that the Annual Health Check measured health trusts' performance using a framework of national standards and targets set by Government.

In April 2009 each health trust needed to provide a declaration of its compliance (or otherwise) against the Department of Health's 24 core standards.

Overview and Scrutiny Panels, along with patient and public involvement forums/LINks and SHA's, were invited to make evidence based comments on the performance of their local health trusts, which would be submitted unedited with the trusts' declarations.

The Care Quality Commission (which replaces the Healthcare Commission on 1st April, 2009) would take these comments into account when assessing the trusts and awarding them an overall rating for 'quality of services' and 'use of resources'.

The approach was to set up an Annual Health Check Working Group and 3 members for this Scrutiny Panel, together with 3 members from the Children and Young People's Scrutiny Panel, were invited to take part. The Working Group would hear presentations by local health trusts (a maximum of 3 meetings) and would produce draft comments for consideration by the Scrutiny Panels for eventual submission to the Care Quality Commission.

Resolved:- That the following members be appointed to the Annual Health Check Working Group

- Councillor Jack, Chair, Adult Services and Health Scrutiny Panel
- Councillor McMahon
- George Hewitt, Co-optee

219. MINUTES OF A MEETING OF THE ADULT SERVICES AND HEALTH SCRUTINY PANEL HELD ON 4 DECEMBER 2008

Consideration was given to the minutes of the meeting of the of the Adult Services and Health Scrutiny Panel held on 4th December, 2008.

Ann Clough, Co-optee, declared a retrospective personal interest in Minute No. 205 – Carers Strategy.

Resolved:- That the above declaration be noted and the minutes of the meeting of the Panel held on 4 December 2008 be approved as a correct record for signature by the Chair.

220. MINUTES OF A MEETING OF THE CABINET MEMBER FOR ADULT SOCIAL CARE AND HEALTH HELD ON 1 & 15 DECEMBER 2008

Consideration was given to the minutes of meetings of the Cabinet Member for Adult Social Care and Health held on 1st and 15th December 2008.

Reference was made to Minute No. 73 Carers Forum – Verbal Update

and it was reported that the name of the Assistant Manager from RAIN was Linda Haynes (not Hayne).

Resolved:- That the minutes of the meetings of the Cabinet Member for Adult Social Care and Health held on 1st and 15th December 2008, with the above clerical correction, be received and noted.

221. EXCLUSION OF THE PUBLIC AND PRESS

Resolved:- That, under Section 100A(4) of the Local Government Act 1972, the press and public be excluded from the meeting for the following item of business on the grounds that it involves the likely disclosure of exempt information as defined in Paragraph 3 of Part 1 of Schedule 12A to the Local Government Act 1972, as amended.

222. ADULT SERVICES BUDGET 2009/2010 - PRESENTATION

Tom Cray, Strategic Director, gave a PowerPoint presentation, explaining the corporate overview of the 2008/2009 budget, together with the current position of Directorate. Details of the aims of the 2009/2010 budget setting process, and the Directorate's approach, were also explained.

The budget pressures being experienced in the current financial year were detailed along with measures taken, and being taken, by the Directorate to manage individual service budgets. The reasons for the variances in budget heads and the current overspend were fully explained.

An indication of the target budget for 2009/2010 was given as well as the savings target with had been set both corporately and for the Directorate.

Shona Mcfarlane, Director of Health and Wellbeing, presented the Directorate's Savings Proposals, and Kim Curry, Director of Commissioning and Partnerships presented the Directorate's Investment Proposals.

A question and answer session ensued in which the following issues were highlighted:-

- Impact on service users
- Staff affected
- Risks
- Demographic pressures
- Increasing complexity of physical disabilities
- Rotherham as the pioneer of the Personalisation agenda
- Impact on CSCI Assessment 2009/2010
- Maintaining quality provision of services
- The current economic downturn and impact on service providers
- Additional pressures over and above the medium term financial

strategy
- Continued management initiatives, and possible supplementary budget estimate for 2008/2009
- Explanation of “Preserved Rights”
- Where the extra savings were to come from, as a budget gap was evident

Resolved:- That the officers be thanked for their presentations and the contents of the presentation be noted.

ADULT, SOCIAL CARE AND HEALTH
12th January, 2009

Present:- Councillor Kirk (in the Chair).

Apologies for absence were received from Councillors Gosling, P. A. Russell and Jack.

85. MINUTES OF THE PREVIOUS MEETING HELD ON 15TH DECEMBER, 2008

Resolved:- That the minutes of the meeting held on 15th December, 2008, be approved as a correct record.

86. ADULT SERVICES REVENUE BUDGET MONITORING REPORT

Mark Scarrott, Finance Manager presented the submitted report which provided a financial forecast for the Adult Services Department to the end of March, 2009, based on actual income and expenditure to the end of November, 2008.

The approved net revenue budget for Adult Services for 2008/09 was £68.5m. This included the approved budget funding for demographic and existing budget pressures together with a number of efficiency savings identified through the 2008/09 budget setting process.

The report showed that there were budget pressures, with a projected net overspend of £997,000 (1.45%) to the year end.

The latest year end projections showed there were the following main budget pressures:-

- Delays in shifting the balance of home care until January, 2009, due to the decision taken by the Council to undertake a further round of consultation with the Trade Unions and employees. This was expected to result in a forecast overspend of £1M by the end of the financial year. The latest forecast assumes the target of a 35/65 split would be achieved by the end of March, 2009. Any further delays would impact on these financial projections and would continue to be closely monitored.
- Direct payments (£194k forecast overspend), within Physical and Sensory Disabilities and Mental Health Services, which should be seen in a positive manner as it represented a substantial increase in support service users. This was part of the Local Area Agreement action plan to increase the numbers of people accessing direct payment, and in return for this excellent level of performance, the Council was on track to exceed the target which will lever £360k in Performance Reward Grant funding by March, 2009.

- Additional unforeseen placements into residential care for clients with Physical and Sensory Disabilities (£140k : a net increase of 7 placements).
- Overspends within employees budgets (£127k) within domiciliary care management and administration teams were over and above budget.

- Pressures had also been identified in respect of increased energy costs (£215k) within residential and day centres. This increase, together with energy costs across all directorates, was being monitored.

The above pressures were being partially offset by additional income from continuing health placements (£-546k) and slippage in the implementation of supported living schemes (-£154k).

The overall forecast outturn included the impact of the delays in finalising the construction on the two new residential care homes, and the decommissioning of the five residential care homes which was now scheduled to take place in the second week of January. Any further delays would impact on the current financial projections and further impact on budget, which would be reported as soon as it was identified.

Budget clinics with Service Directors and managers would continue to take place on a monthly basis to monitor performance against approved budget and to further consider options for managing expenditure within the budget.

Resolved:- That the latest financial projection against budget for the year based on actual income and expenditure to the end of November, 2008, for Adult Services.

87. ADULT SERVICES CAPITAL BUDGET MONITORING REPORT 2008/09

Mark Scarrott, Finance Manager (Adult Services) presented the submitted report which informed members of the anticipated outturn against the approved Adult Services Capital Programme for the 2008/09 financial year.

Actual expenditure to mid-December, 2008, was £7.5M against an approved annual programme of £9.8M. The approved schemes were funded from a variety of different funding sources including, unsupported borrowing, allocations from the capital receipts, Supported Capital Expenditure and specific capital grant funding.

The report provided 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 homes was now complete but the timetable for full decommissioning of existing homes into the two new homes had been delayed and would now commence from 19th January, 2009.

The Assistive Technology Grant (which included funding from NHS Rotherham) was being managed jointly and was being used to purchase Telehealth and Telecare equipment to enable people to live in their own homes. The procurement of equipment had now commenced which included lifeline connect alarms, low temperature sensors and fall detectors within people's homes.

A small element of the Department of Health specific grant (£20k) issued in 2007/08 to improve the environment within residential care provision was carried forward into 2008/09. The balance of grant was being allocated across the independent residential care sector in accordance with the grant conditions and would be fully spent in 2008/09.

Learning Disabilities

The small balances of funding carried forward from 2007/08 were to be used for the equipment for Parkhill Lodge and within supported living schemes.

The refurbishment at Addison Day Centre, funded from the Council's Strategic Maintenance Investment Fund, was now complete. There had been delays in the start of the refurbishment of the REACH Day centre due to insufficient funding, and the scheme was now due to commence in January, 2009.

Mental Health

A small balance remained on the Cedar House capital budget and would be used for the purchase of additional equipment. A large proportion of the Supported Capital Expenditure (SCE) allocation had been carried forward from previous years due to difficulties in finding suitable accommodation for the development of supported living schemes. Suitable properties were being identified and spending plans were being developed. The possibility of funding equipment purchased for direct payments was also being considered to reduce the current pressures on the revenue budgets. Further options were also being considered to provide more intensive supported living schemes with a range of providers and to fund a range of new assistive technologies for this client group, which would allow them to live in the community with access to 24 hour support.

Management Information

Part of the capital grant for Improving Management Information was carried forward into 2008/09. The funding had been earmarked to further develop Electronic Social Care Records within Health and Social Care working with the Council's strategic partner RBT and Children and Young People's Services. At the end of August the Department of Health announced a new capital grant for Adult Social Care IT infrastructure over the next three years (£276k). Spending plans were still being developed with RBT to integrate social care information across both health and social care.

Resolved:- That the Adult Services' forecast Capital outturn for 2008/09 be noted.

88. DATE AND TIME OF NEXT MEETING:- 26 JANUARY 2009

Resolved:- That the next meeting be held on Monday, 26th January, 2009 commencing at 10.00 am.

CABINET MEMBER FOR ADULT, SOCIAL CARE AND HEALTH
Monday, 26th January, 2009

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

89. MINUTES OF THE PREVIOUS MEETING HELD ON 12TH JANUARY, 2009

Resolved:- That the minutes of the meeting held on 12th January, 2009, be approved as a correct record.

90. CONFERENCE

Consideration was given to attendance at the "Asperger Syndrome in Adults – Beyond Diagnosis" conference which was to be held on Thursday 26th March, 2009.

Resolved:- That approval be given for Councillor Hilda Jack to attend the conference.

(THE CHAIRMAN AUTHORISED CONSIDERATION OF THE FOLLOWING ITEM TO KEEP MEMBERS FULLY INFORMED)

91. ADULT SERVICES REVENUE BUDGET MONITORING REPORT 2008/09

Mark Scarrott, Finance Manager (Adult Services) presented the submitted report which provided a financial forecast for the Adult Services Department within Neighbourhoods and Adult Services Directorate to the end of March 2009 based on actual income and expenditure to the end of December 2008 and forecast costs and income to 31 March 2009.

The approved net budget was £68.5m which included the funding for demographic and existing budget pressures together with a number of efficiency savings identified through the 2008/09 budget setting process.

During the year there had been a number of budget pressures, mainly in respect of the delays in implementing shifting the balance of home care from in-house to the independent sector. This had been as a result of the Council taking the decision to undertake a further round of consultation with Trade Unions and employees. Cabinet approved a revised estimate for the service of £1m on 21 January 2009 and the latest report now showed a projected balanced budget by the end of the financial year, assuming the completion of shifting the balance to 65/35 was achieved.

There still remained underlying budget pressures within residential care within physical and sensory disabilities due to an increase in demand and the average cost of care packages, increased demand and cost of direct

payments and increased energy costs.

These pressures were being offset by additional income from continuing health and care funding, slippage on developing supported living schemes within learning and disabilities and management actions identified from budget performance clinics.

The overall forecast outturn also included the impact of the delays in finalising the construction on the two new residential care homes. The decommissioning of the five residential care home was now scheduled to commence at the end of January. Any delays beyond that would impact on current financial projections and would be reported as soon as they were identified.

Budget clinics continued to take place with Service Directors and managers on a monthly basis to monitor financial performance against approved budget and to consider further options for managing expenditure within budget.

Resolved:- That the forecast balanced outturn against the revised budget for 2008/09 be noted.

92. EXCLUSION OF THE PRESS AND PUBLIC

Resolved:- That, under Section 100A(4) of the Local Government Act 1972, the press and public be excluded from the meeting for the following item of business on the grounds that it involves the likely disclosure of exempt information as defined in Paragraph 3 of Part 1 of Schedule 12A to the Local Government Act 1972, as amended.

93. FEE SETTING – INDEPENDENT SECTOR RESIDENTIAL AND NURSING CARE 2009/20010

Kim Curry, Director of Commissioning and Partnerships presented the submitted report which sought the agreement of Elected Members to the increase in fees to Independent Sector Residential and Nursing Care Providers for 2009/2010 in accordance with the established inflation formula.

Resolved:- That the report be received and the fee increases for residential and nursing care homes, as set out in paragraph 7 of the report be agreed and become effective from the 5th April, 2009.

94. DATE AND TIME OF NEXT MEETING - 9 FEBRUARY 2009

Resolved:- That the next meeting be held on Monday 9 February 2009 commencing at 10.00 am.