ADULT SERVICES AND HEALTH SCRUTINY PANEL

Venue:	**Town Hall, Moorgate Street, Rotherham.**	**Date:**	**Thursday, 9 December 2010**
		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. Communications.

4. Declarations of Interest.

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

10.00 am

6. Charge Comparisons - Home Care and Other Non-Residential Social Services (Pages 1 - 4)

10.30 am

7. JSNA Refresh Programme Update (Pages 5 - 11)

11.00 am

8. Carers Centre - the first 6 months (Pages 12 - 21)

11.30 am

9. Diabetes Review - Presentation by Delia Watts, Scrutiny Adviser

For Information

10. Public Health White Paper - Summary (Pages 22 - 33)

11. Minutes of a meeting of the Adult Services and Health Scrutiny Panel held on 11th November, 2010 (Pages 34 - 40)

12. Minutes of a meeting of the Cabinet Member for Adult Independence Health and Wellbeing held on 25th October 2010 and 8th November 2010 (Pages 41 - 48)

Date of Next Meeting:-
Thursday, 6 January 2011

Membership:-
Chairman – Councillor Jack
Vice-Chairman – Steele
Councillors:- Barron, Blair, Burton, Goulty, Hodgkiss, Kirk, Middleton, Turner and Wootton
Co-opted Members
Jim Richardson (Aston cum Aughton Parish Council), Russell Wells (National Autistic Society), Mrs. A. Clough (ROPES), Jonathan Evans (Speak up), Victoria Farnsworth (Speak Up), Ms J Dyson, Ms J Fitzgerald and Mr P Scholey (UNISON)

Agenda Item 6

Appendix 1

ROTHERHAM BOROUGH COUNCIL – REPORT TO MEMBERS

1.	**Meeting:**	**Adult Services and Health Scrutiny Panel**
2.	**Date:**	**2nd December 2010**
3.	**Title:**	**Charge comparisons - Home Care and other non residential Social Services**
4.	**Directorate:**	**Neighbourhoods and Adult Services**

5. **Summary**

5.1 As requested by Members this report sets out the Directorate's current charges benchmarked against local neighbours and members of a Chartered Institute of Professional Financial Accountants (CIPFA) benchmarking group.

5.2 The average amount people pay each week is lower when compared to other Council's referred to in this report.

5.3 The amount people pay is the same whether the service is provided by the council or an independent sector provider.

6. **Recommendations**

6.1 That Members receive this report and note its contents

7. **Proposals and Details**

7.1 A revised charging policy was introduced from April 2003 to ensure that the Council met its statutory requirements to implement fairer charging guidance 'Fairer Charging Policies for Home care and Other Non Residential Social Services' issued in August 2002 under Section 7 of the Local Authority Social Services Act 1970. This policy was informed by a detailed consultation exercise and a series of briefing sessions with Cabinet Members and Scrutiny.

7.2 At that time Members ratified the Charging Policy objectives to underpin the Councils values and priorities to promote: Independent living, social inclusion, accessible quality services, sustainability, anti poverty and fairness and equity.

7.3 Prior to the introduction of this guidance home care charges were based on flat rates, everyone was required to pay irrespective of their ability to pay. The Financial Assessment shifts the burden of charges to people who have higher income and savings. Members wanted to minimise the impact on service users. This led to the introduction, within the financial assessment scheme, of the disposable income allowance. The disposable income allowance was also established as an income regulator, to be increased or decreased depending on budget setting targets. Originally it was set at 80% but has been reduced on a phased basis to 20%. Disposable income is the amount remaining after deducting a service user's weekly expenses/ allowances from their income. This is the amount people are assessed as being able to contribute towards the cost of their care.

7.4 The financial assessment applies to people with savings of less than £23,500. People who have more than this amount have to pay the cost of their care at £12.85 per hour upto the Council's maximum charge, currently £200 per week.

7.5 Details of charges in Rotherham compared to similar councils are set out in Appendix 1 Table 1 below.

7.6 Appendix 1 Table 2 below sets out a comparison of the amount people pay per week for their care. The table shows that a high proportion of people pay less for their care in Rotherham, for example 50% receive a free service compared to an average of 33% in similar councils.

7.7 People with savings below £23,500 pay less in Rotherham than those living in similar councils. This is because Rotherham's allowances are more generous. For example Rotherham gives a discretionary disposable income allowance of 20%, our near neighbours give no disposable income allowance and the CIPFA benchmarked average is 9%.

7.8 However people with savings greater than £23,500 will pay more in Rotherham for home care than similar councils. This is because Rotherham's charge per hour is higher than similar councils. This affects around 250 people out of the 2200 who receive a home care service.

7.9 There is no difference between domiciliary care charges for internal and externally provided services. We have to set a standard maximum charge that applies irrespective of who provides the service. The financial assessment scheme is also generic. It would be unfair to charge someone more because the only service available in a particular area is more expensive to provide. It would also be complicated to administer as some people receive a service from different providers. As contract prices vary between different providers we set a charge based on the average cost to the council.

8. Finance

8.2 Financial information is contained in the tables attached at Appendix 1 to this report.

9. Risks and Uncertainties

9.1 There are no risks or uncertainties associated with this report.

10. Policy and Performance Agenda Implications

10.1 There are no policy and performance issues associated with this report

11. Background Papers and Consultation

11.1 This report is for information only so there has been no consultation undertaken

Contact Name ; : Doug Parkes Business Finance and Commissioning Manager ext 23927 e. mail Doug.parkes@rotherham.gov.uk

Table 1	**Charge Comparison : CIPFA and Local Neighbours**					
Service	**Rotherham**		**CIPFA average**	**Sheffield**	**Barnsley**	**Doncaster**
	Unit Cost	Current Charges				
Hourly Rate for Domiciliary Care	£18.00	£12.85	£11.72	£9.29	£5.00	£10.15
Maximum Weekly Charge	N/A	£200.00	£227.03	£109.23	£60.00	£403.00
Charge for Day Care	£76.00	£4.00	£10.68	£6.01	£3.00	£8.10
Meal at Day Centre	£5.20	£4.10	£2.86	£0.00	£2.00	£2.40
Transport Day Centre (Return)	N/A	£1.00	£1.46	£0.86	£1.00	£0.00
Warden Service	£12.74	£8.61	N/A	N/A	Various	£5.00
Community Alarm (Weekly)	£3.25	£3.25	£3.30	£3.95	£3.00	£2.73
% of Disposable Income allowance	N/A	20%	9%	0%	0%	0%

Table 2	**CIPFA Benchmark Club average weekly payments**	
The table shows the percentage of people and the amount they pay each week		
Charge Band	**Rotherham %**	**CIPFA Average %**
£200 +	0	0.10
£150 – £200	1.70	0.50
£100 - £149	2.00	2.90
£50 - £99	6.90	13.10
£25 - £49	17.30	25.40
£10 - £24	14.30	16.80
< £10	7.80	7.80
Nil	50.00	33.30

Agenda Item 7

ROTHERHAM BOROUGH COUNCIL – REPORT TO MEMBERS

1.	**Meeting:-**	**Adult Services and Health Scrutiny Panel**
2.	**Date:-**	**2nd December 2010**
3.	**Title:-**	**Joint Strategic Needs Assessment**
4.	**Directorate:-**	**Commissioning & Partnerships**

5. Summary

Local Authorities and Primary Care Trusts are under a statutory duty, under the Local Government and Public Involvement in Health Act to produce a Joint Strategic Needs Assessment (JSNA) which establishes the current and future health and social care needs of the Rotherham population. It informs the strategic priorities and targets which informs commissioning priorities with a view to helping improve outcomes and reduce health inequalities.

Rotherham's Joint Strategic Needs Assessment is available and can be viewed on the Rotherham MBC and NHS Rotherham intranet. This was produced by the Joint Commissioning Team working in collaboration with various key partners in Local Authority, Health and the Voluntary and Community sector in February 2009.

The Rotherham's JSNA is currently being refreshed which is due to be completed by end of March 2011.

6. Recommendations

It is recommended that the Adult Services and Health Scrutiny Panel;

- Note the Joint Strategic Needs Assessment refresh programme

7. Proposals and Details

7.1 Why we need a JSNA

Since 1 April, 2008, Local Authorities and Primary Care Trusts are under a statutory duty under the Local Government and Public Involvement in Health Act to produce a Joint Strategic Needs Assessment (JSNA). The JSNA forms the basis of a new duty to co-operate. This partnership duty involves a range of statutory and non-statutory partners, informing commissioning and the development of appropriate, sustainable and effective services.

The coverage of the JSNA is defined by the Department of Health's JSNA Core Dataset, which was published on 1st August, 2008. Rotherham's JSNA fully complies with the DH Core Dataset. It is anticipated that a revised JSNA Core data set will be published from the DH in December 2010 which will inform the refresh programme.

7.2 The Refresh Programme

The Joint Commissioning Team is co-ordinating the refresh of the current JSNA, working in partnership with the RMBC Commissioning Team.

Phase one of this process has focused on updating and validating the current statistical data and supporting analysis and interpretations. Sections within the document have been re-written to reflect current priorities and emerging trends observed since the last publication. The refresh programme has highlighted radical changes in the landscape such as Mental Health, therefore indicating a much more in-depth needs analysis. The time allocated for this area and its analysis has therefore been extended to continue into the phase 2 of the refresh programme.

User perspective and wider community engagement will be considered during phase 2 which will include various consultation activities to reflect user perspective within the JSNA.

There are 4 key areas which are being strengthened within the Rotherham JSNA which includes:

- Migrants (e,g asylum seekers, refugees, family joiners, international students)
- Vulnerable adults (Homelessness, Domestic Violence, Offenders, HIV and AIDS, Teenage Pregnancy)
- The third sector (Engagement and potential asset to community – RNIB, Stroke Association, Age Concern, Crossroads, Alzheimer's Society, Citizen Advice Bureau, Turning Point)
- Financial Implications

7.3 Emerging Needs

- Population trend in Rotherham indicates an expected increase by 5.5% by 2010 with a further 9.8% by 2030.
- The gap between the over 50 age group (1 in 3 people) and the under 16 (1in 5 people) is widening.
- The over 85 age group will significantly increased to 9,800, which represents a 50% increase by the Year 2028.
- The number of people with a social care need is predicted to increase by 26% in the next 10 years. The number of people with a high or very high need is also predicted to increase by 26%.
- It is estimated that in 2015 there will be 28,199 people over 65 in Rotherham with a limiting long-term condition. By 2025, it is estimated that the number will have risen to 33,831
- This has been a significant increase in unemployment (17.3%) over the last two years, as the number of people has increased to 26,170 who are claiming out-of-work benefits.
- This has led to an increased demand in rented accommodation due to increasing the number of repossessions.
- Rotherham is currently 58th most deprived Borough out of 354 English districts.

- Overcrowding within the BME household in Rotherham is significantly high as this ranges from 13.2% - 22.8%, as compared 3.6% within the white population
- Smoking prevalence is high in Rotherham (26.4%) which is above the national average (22.21%)
- A high death rate of alcohol attributable conditions are higher than the national average for both males at 51.1, compared with 36.1 and females at 19.0, compared with 15.2 prevalence.
- Obesity prevalence for adults in Rotherham is 28.3%. This is slightly above the national estimate of 24.2% and the regional estimate of 26.3%.

7.4 Summary

These are the key issues that Rotherham MBC and NHS Rotherham will have to address over the next 5 years.

- The impact of an ageing population.
- The potential impact on health, well-being and services of the economic downturn
- The most effective way to promote healthy living initatives such as increasing physical activity and exercise, nutritional diet and raising awareness of risks of smoking and alcohol consumption
- The most effective way to reduce the gap between healthy and actual life expectancy
- The most effective way of increasing the independence of people with life limiting long-term conditions
- The most effective way of increasing independence, choice and control for people suffering with dementia and the development of new service models to address this effectively in the future
- The effectiveness of using preventative strategies to save future care costs
- Service to refelcet the changes in the demographic profile of the learning disability population

7.5 Service User Engagement

The JSNA incorporates the findings of a service user and carer engagement exercise. A wider consultation exercise was undertaken at Fairs Fayre in October 2010 to update the refresh Joint Strategic Needs Assessment. The consultation element will be widened further at a later stage. Emerging feedback during the current phase one of the consultation suggests the following:

- Support for a services which promote independence and maintain people at home
- More support for carers both in the caring task and their own well-being
- Development of low-level support services
- Targeting people who are socially isolated
- Better supported housing options including Extra Care Housing
- Alleviation of the impact of the economic downturn
- Access to transport and activities, especially in the evenings

As part of the refresh programme this area will be further strengthened during phase 2.

7.6 Next Steps

The primary purpose of the JSNA refresh is to ensure that Rotherham data is kept up to date and accurate information is made accessible to support current joint commissioning, decommissioning and reconfiguration plans, but also an opportunity to evaluate our future needs for commissioning intelligence.

The next key steps to be taken are as follows:

1 More analysis at locality level, some of our current information can only be easily expressed for the whole of Rotherham and work is needed to make more data available at area assembly level.

2. Continue the process of reconfiguring services so that they address future needs.

3. Ensuring that the refreshed JSNA is accessible to health and social care professionals so that they can access up to date information. Work to develop a web-based JSNA, which is regularly updated and incorporates all the information from the DH dataset is initiated as part of the phase 2 of this work programme.

4. Bring together the JSNA and the Corporate Needs assessment so that there is clear demarcation and no duplication. Work has begun in linking with various key areas such as children and substance misuse services.

8. Finance

There are no immediate financial implications. However the JSNA is now a key tool contributing to local intelligence on basic needs assessment. It informs service plans, key strategies, commissioning as well as decommissioning and reconfiguration decisions.

9. Risks and Uncertainties

There are a number of risks associated with non-endorsement of the refresh programme of the Rotherham Joint Strategic Needs Assessment. Rotherham is well placed compared to other local authorities on the development and of the JSNA. Non-endorsement of the JSNA refresh will put Rotherham back compared to neighbouring local authorities in maintaining up to date data.

The JSNA should form the basis of all joint work between RMBC, Health and the voluntary sector. It acts as a platform for strategic development and commissioning decisions. Failure to maintain a JSNA which complies with the DH Core Dataset could set back joint working arrangements.

10. Policy and Performance Agenda Implications

The development of a Joint Strategic Needs Assessment addresses the majority of the National Indicators and Vital Signs for Local Authorities and Local Authority Partnerships for Adult Health & Well-being.

The development of a JSNA is part of the Neighbourhood and Adults Service Plan. Scheduled for completion at the end of this financial year, this document constitutes the completion of this element of the plan link to the Joint Commissioning strategy.

11. Background Papers and Consultation

- JSNA Main Report: Rotherham MBC and NHS Rotherham Intranet

Contact Name : Shiv Bhurtun; Joint Commissioning Manager

Rotherham Metropolitan Borough Council
Where Everyone Matters

THE CARERS'CORNER

THE STORY SO FAR

The vision established by carers was that the Carers' Corner would be a one stop shop for carers and this is exactly how the centre is developing.

Rotherham Metropolitan Borough Council
Where Everyone Matters

Background

- Concept of a Carers Centre developed with customers and carers
- Series of events to determine what carers required within the centre
- Carers forum left the Rain building needing a new venue
- 12th May 2010 official opening of the Carers Centre – named Carers' Corner
- A superb location right at the centre of Rotherham
- Under new management from July 2010

The objective of the Carers' Corner is to provide carers in Rotherham with a first point of contact for all enquiries relating to caring. It is accessible to all carers from all service areas and enables carers to access information, advice and guidance to support them to continue in their role as a carer.

Rotherham Metropolitan Borough Council
Where Everyone Matters

Main Achievements

- increased by 400%
- Carers Centre Manager appointed – Bev Pepperdine
- Performance monitoring system has been introduced
- Hard to reach areas / outreach
- 1000th Customer story made the local press and radio over 2000 people have now been through the doors at the centre
- Focus on personalisation and individual budgets
- Continual focus on raising the profile of carers

Rotherham Metropolitan Borough Council
Where Everyone Matters

Caring and Sharing

Carers will be supported to continue in their caring role by a range of agencies providing specialist professional advice and guidance

- Alzheimers Society
- South Yorkshire Centre for Inclusive Living
- McMillan Support
- Howells Solicitors
- Tassibee
- Parent Carers Forum
- Jobcentre Plus
- Home Improvement Agency
- Crossroads
- Shelter
- Carers Mental Health Support Tear

Getting Out There

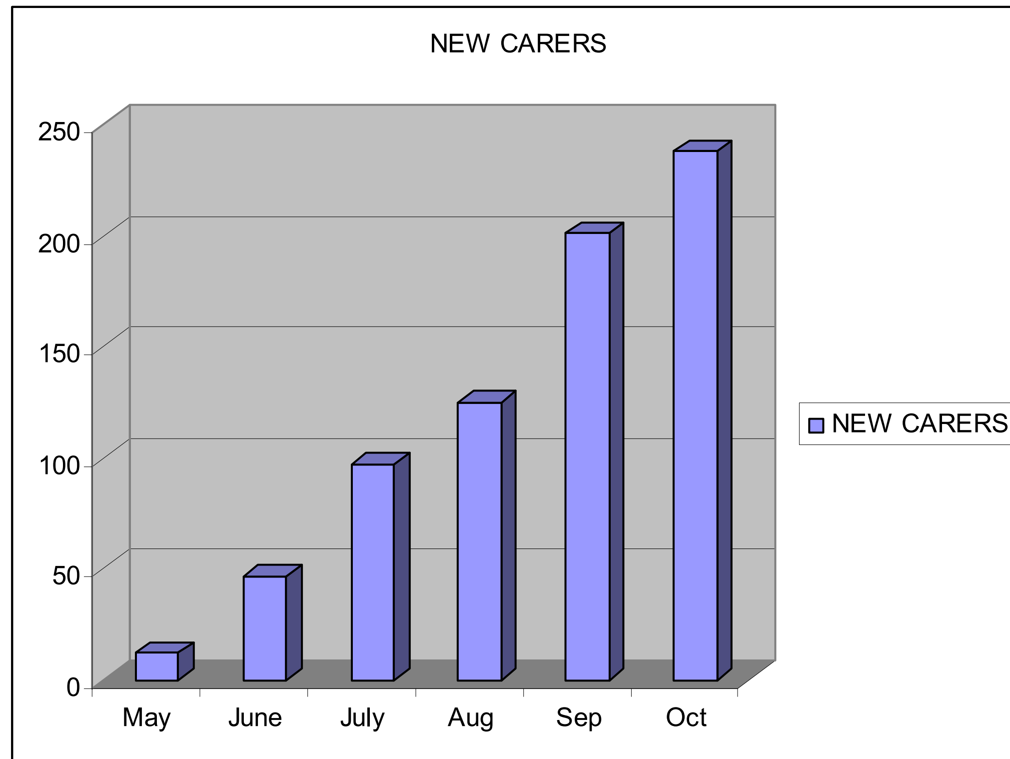
- Rotherham Show – over 300 contacts
- Fairs Fayre at Magna – built around carers and personalisation
- Women's Diversity Event
- B and Q – Rotherham (10% discount)
- Outreach – hard to reach
- Carers Rights Day
- Event calendar for the year ahead

The centre should reach out into the community to involve more carers.

New Carers Every Day

Rotherham Metropolitan Borough Council
Where Everyone Matters

One of the most important aspects of the centre is to identify new carers.



"I would like to thank everyone who has helped me at the centre . Before I walked through your doors I didn't even know I was a carer"

Rotherham Metropolitan Borough Council
Where Everyone Matters

FUTURE PLANS

- Continue to ensure the positive development of the centre and attract new customers
- Increased promotion of the services offered
- Increase the outreach work offered by the centre ensuring hard to reach groups are supported
- Ensure positive outcomes for carers can be monitored.
- Improve links with children's services to promote support for young carers.
- Increase opportunity for carers to be in paid work/ voluntary work. (job club link with job centre)
- Increase Direct Payments uptake for carers.
- Increase the amount of carers' assessments
- Improve staffing arrangements via AAA (Access all Areas) to ensure opening times of centre
- Continue to engage with carers on the future of their centre

Thank you

Rotherham Metropolitan Borough Council
Where Everyone Matters

- Please drop in for a coffee (please take an invite)

Making a Difference
Quotes from carers

Rotherham Metropolitan Borough Council
Where Everyone Matters

- Carers Centre manager "Carers are the unsung heroes who support thousands of people in Rotherham and now Carers Corner is here to support them"

- Carers through Carers Corner are accessing advice, support and information to support them in their role and in some way going towards giving carers the same rights and choices that everyone has.
- Quote from Customer 1 – "You provided me with some quick information about a service I did not know how to find and this has now made a difference to my life and the life of my husband I care for, I wanted to make sure I came back into see you to say Thank You"
- Quote from Customer 2 – "You have been able to signpost me to the best possible service I could find to support my daughter, who I care for. We are now getting the support and care I expected to get from the service"
- Quote from Customer 3 – "Thank you for the information & advice you provided for me on the service available to support my Mum in Rotherham, great choice to look at, to help her stay active"

Making a difference Quotes from Carers

Rotherham Metropolitan Borough Council
Where Everyone Matters

- J Mallinder "The Carers Centre has become a place for carers to come and receive support and information to meet their specific needs. The carers often come in needing some one to talk to and always leave better than when they arrived"
- Thanks to carers corner for being there for me when I needed you most. The fact that your there means I can continue caring. Thank you
- Very pleasant service felt at ease and informed fully of schemes to join. Nice place to come and visit. Will be coming again.
- Turned up here at the end of my tether, 10 minutes later I felt so much better. I spoke to people that understood and offered support and information – fantastic Thank you
- Thank you so much for sorting my problem . I came in feeling very angry left smiling and sorted out see you again
- Thanks you for all the help and advice given. At least I know there are people available, when requested.

Summary Paper

The white paper responds to Sir Michael Marmot's *Fair Society, Healthy Lives* report and adopts its life course framework for tackling the wider determinants of health.

It sets out a new approach to public health, with proposals to develop a public health service which achieves excellent results; helping people to live longer, healthier, more fulfilling lives, and improving the health of the poorest, fastest.

1. Seizing opportunities for better health

Accompanying the white paper is the *Our Health and Wellbeing Today* report, which provides a more detailed story of the health of people living in England today, headlines include:

- Public health has made advances over the years and infectious disease now only accounts for 1 in 50 deaths. However tuberculosis and STIs are rising and pandemic flu remains a threat. More people are expected to have long-standing illness in future, particularly due to an aging population. Our causes of premature death are dominated by 'diseases of lifestyle', where smoking, unhealthy diet, excess alcohol consumption and sedentary lifestyles are contributory factors.
- Health inequalities in life-expectancy and disability-free life expectancy are large. Many factors drive inequalities, such as early years care, housing and social isolation – despite which most health efforts focus more on treatment than the causes of poor health. The government are working to re-balance this focus and prioritise public health funding.
- The Marmot Review highlights a social gradient of health – the lower a person's social position, the worse their health; life expectancy gap is on average 7 years between the richest and poorest communities, and up to 17 years in disability-free life expectancy.
- There are also huge inequalities based on race, disability, religion, gender and sexual orientation which can interact in complex ways with socioeconomic position in shaping people's health. Some vulnerable groups and communities, for example people with learning disabilities or travellers have significantly poorer health and life-expectancy than would be expected based on their socioeconomic status alone.

The opportunities and challenges set out in the report are stark, for example:

- Improving maternal health could give children a better start in life; reducing infant mortality and low birth-weight babies
- Taking better care of children's health and development could improve educational attainment and reduce mental illness, unhealthy lifestyles, road deaths and hospital admission due to tooth decay
- Being in work leads to better physical and mental health
- The majority of mortality and morbidity today is due to 'lifestyle' factors; changing adult's behaviour could reduce premature death, illness and costs to society
- Many excess winter deaths could be prevented through warmer housing and take-up of seasonal flu vaccinations

2. A radical new approach is proposed

The white paper proposes a new approach, which will:

- Protect the population from health threats, led by central government
- Empower local leadership and encourage responsibility across society
- Focus on key outcomes
- Reflect the government's core values of freedom, fairness and responsibility
- Balance the freedoms of individuals and organisations with the need to avoid harm to others; using the least intrusive approach necessary to achieve desired effect

This new approach is set out to address the root causes of poor health and wellbeing, reaching out to families and individuals who need most support, and will be:

Responsive

Local government will be freed-up to decide how best to improve the health and wellbeing of their citizens, deciding on actions locally with the NHS and other key partners, this will be done through:

- A proposed new public health outcomes framework which will sit alongside the NHS outcomes framework (set out in the NHS white paper) and be based on 5 domains of public health:
    - Health protection; protecting people from major health emergencies and serious harm
    - Tackling the wider determinants of ill-health
    - Health improvement; promoting the adoption of 'healthy' lifestyles
    - Healthy life expectancy; preventing people from dying prematurely
- A proposed 'health premium' will incentivise local government and communities to improve health and reduce inequalities
- Data will be published to make it easier for local communities to compare themselves with others across the country and incentivise improvements

Resourced

Prevention has not enjoyed parity with treatment over the years, to prioritise prevention the government proposes to:

- Ring-fence public health funds from within the overall NHS budget to ensure it is prioritised – although it will still be subject to cost reductions and efficiency gains that will be required across the system
- Allocate ring-fenced funds for public health to local authorities to enable them to secure better health and reduce inequalities

Rigorous

Public health professionals have been disempowered and their skills not sufficiently valued when compared with counterparts in the NHS acute services. To address this imbalance, government proposes to:

- Set up a new public health service within the Department of Health – called Public Health England, which will unite the family of professionals who spend time on improving people's health and tackling inequalities
- Build and apply the evidence base for 'what works' and develop a culture of using evidence to prioritise what we do
- Harness the information revolution to make best use of evidence and evaluation and support innovative approaches to behaviour change throughout society

Resilient

The current system for health protection is fragmented, although public health incidents and emergencies in recent years have been excellent, the system lacks integration and is over-reliant on goodwill to make it work. Government is therefore proposing:

- To enhance the functions of the Secretary of State for Health, making accountabilities in the system clearer
- To create a more streamlined public health service to lead health protection and public health efforts across the country

2.1 Effective intervention

The white paper proposes a new approach to intervening in people's health, based on the belief that previous arguments about when to intervene have become oversimplified; either intrusive intervention into people's lives, or complete hands-off. The proposed criteria for intervening will include:

- Firstly, the government recognises that protection and improving people's health covers a wide spectrum of issues, such as serious biological, chemical and infectious disease threats where central government must take a strong lead, to diseases such as diabetes, heart disease and depression, which are linked to people's lifestyles and situations and require more local solutions
- Second, the government will balance freedoms of individuals with the need to avoid harm to others – looking carefully at the case before deciding whether to intervene and to what extent

- Thirdly, the government will consider different approaches for different groups, taking into account the significant barriers some people face – capable, responsible adults will be treated as adults, children will be treated differently as they rely more on adults to help make decisions and some individuals require different approaches due to particular barriers

A 'ladder 'of interventions will be used:
- Public expect government to prepare and tackle serious threats and emergencies, these will demand direct intervention from central government
- Some activities require intervention once centrally, then many times locally; including air, food and water standards, buying vaccines and legislation to ban some types of drugs
- Banning everything and lecturing does not work, few people choose 'good' or 'bad' health and everyone makes personal choices about how they live – capable adults are responsible for these choices. However, not everyone has total control over their lives and circumstances and a range of factors constrain and influence what they do, therefore strengthening self-esteem and confidence, positively promoting 'healthier' behaviours and adapting the environment to make healthier choices easier will be key

3. Key proposals and Responsibilities

3.1 A new public health system

- *Public Health England* will be established within the DoH to protect and improve the public's health, accountable to the Secretary of State for Health.
- It will include the current functions of the health protection agency (HPA) and national treatment agency (NTA), bringing together a fragmented system with a new protected public health budget, supporting local action through funding and the provision of evidence, data and professional leadership
- It will also include elements of public health activity currently held within the DoH and strategic health authorities (SHAs), along with functions of the Public Health Observatories and cancer registries, it will also work with local government, the NHS and other government agencies and partners as necessary.
- Public Health England will have a local presence in the form of Health Protection Units (HPUs), working with NHS and local government for emergency preparedness.

Public Health England's role will include:
- Providing public health advice, evidence and expertise to the Secretary of State for Health and the wider system
- Delivering effective health protection service
- Commissioning or providing national-level health improvement services
- Jointly appointing DPH and supporting them through professional accountability arrangements
- Allocating ring-fenced budgets to local government and rewarding them for progress made against the public health outcomes framework
- Commissioning some public health services from the NHS
- Contributing internationally-leading science to the UK and globally

This new service and the strengthening of public health within local authorities will not lead to the NHS stepping back from its crucial role on public health. The NHS has a critical role to play in emergency preparedness and response and in promoting health and preventing avoidable illness. There will need to be close partnership working between Public Health England and the NHS at a national level and between local government, DPH and GP consortia at a local level.

3.2 A new role and freedoms for local government

- Local government already plays a significant role on protecting and improving public health, through environmental health, air quality, planning, transport and housing. Local councils will continue to carry out their statutory duties under the Public Health Act 1984.
- New ring-fenced budgets, enhanced freedoms and responsibilities for local government will help areas to improve the health and wellbeing of their populations and reduce inequalities.

- Embedding public health within local government will make it easier to create tailored solutions in order to meet varying local needs – enabling joint approaches to be taken with other areas of local government's work; such as environment, transport, planning, children's services, social care as well as with key partners such as NHS, police, business, early years, schools and the voluntary sector.
- The DPH will be employed by the council to lead local public health efforts, a role that can be shared with other local council's if agreed locally. How local government decides to fulfil their role in public health will be left up to them locally, with constraints being minimal.
- Payment will be made for progress made against the public health outcomes framework

3.3 Directors of Public health

- The DPH will be employed by local government and jointly appointed by the relevant local authority and Public Health England.
- The DPH will be a public health professional, with the skills to be the strategic leader for public health locally.

Their critical tasks will include:
- Promoting health and wellbeing within local government
- Providing and using evidence relating to health and wellbeing
- Advising and supporting GP consortia on the population aspects of NHS services
- Developing an approach to improving health and wellbeing loally, including promoting equality and tackling health inequalities
- Working closely with Public Health England health and protection units to provide health protection as directed by the Secretary of State for Health
- Collaborating with local partners on improving health and wellbeing, including GP consortia, other local DPH, local businesses and others

3.4 Health and Wellbeing Boards

- Following consultation on the NHS white paper, detailed proposals will be published for the establishment of local health and wellbeing boards. There will be a proposed minimum membership of elected representatives, GP consortia, DPH, Directors of Adult Social Services, Directors of Children's Services, local HealthWatch and where appropriate, the participation of the NHSCB. These members will be subject to legislation and local areas will be able to expand membership to include local voluntary groups, clinicians and providers where appropriate.
- GP consortia and the DPH will have equal and explicit obligation to prepare the JSNA and do so through the arrangements made by the Health and Wellbeing Board.
- It is proposed that health and wellbeing boards develop joint health and wellbeing strategies, based on their JSNA. This strategy will provide the overarching framework within which more detailed and specific commissioning plans for the NHS, public health, social care and other services that the health and wellbeing board agrees to consider, are developed. The joint strategy will also have to include consideration relating to pooled budgets joined-up commissioning.

4. Funding and commissioning for public health

4.1 National public health budget

- The national public health budget will be ring-fenced within the overall NHS budget
- Early estimates suggest that current spend on areas that are likely to be the responsibility of public Health England could be over £4 billion.

4.2 Local public health budget

- Public Health England will allocate ring-fenced budgets, weighted for inequalities for improving the health and wellbeing of local populations
- The ring-fenced budgets will fund both improving population health and wellbeing, and some non-discretionary services such as open access sexual health services, and certain immunisations.

- There will be scope to pool budgets in order to support public health work
- The public health budget will be a ring-fenced grant, which will carry some conditions for how the budget should be used; however, there will be some flexibility for local areas to determine how best they can use this funding.
- 'Shadow' allocations will be made to local authorities for the 2012/13 budget, providing an opportunity for planning before allocations are introduced 2013/14.

4.3 Health Premiums

- A new health premium will be introduced to incentivise action to reduce inequalities, which will apply to the part of the public health budget which is for health improvement. Local authorities will receive an incentive payment, or premium, for services that depends on progress made in improving health of the local population, based on a baseline allocation that is weighted towards areas with the worst health outcomes and most need.
- Disadvantaged areas will see a greater premium if they make progress, recognising that they face the greatest challenges.

4.4 ***Commissioning of public health services***

- Public Health England will fund those services that contribute to health and wellbeing primarily by prevention rather than aimed at treatment, provision will include services such as; health protection, emergency preparedness, recovery from drug dependency, sexual health, immunisation programmes, alcohol prevention, obesity, smoking cessation, nutrition, health checks, screening, child promotion including those led by health visiting and school nursing, elements of the GP contract such as immunisation, contraception and dental public health.
- A forthcoming consultation document will set out proposals in more detail.

Public Health England will have 3 principal routes for funding services:
- Granting the public health ring-fenced budget to local government
- Asking the NHS Commissioning Board (NHSCB) to commission services, such as screening and relevant elements of the GP contract
- Commissioning or providing services directly, e.g. national purchasing of vaccines, national communication campaigns, health protection functions currently conducted by the Health protection Agency (HPA)
- There may also be the option for GP consortia to commission on behalf of Public Health England

Because of the crucial role of early years development, the Public Health England budget will fund health visiting, school nursing and the child health promotion services they lead, in particular the Healthy Child Programme. The DoH then the NHSCB will lead the commissioning of health visiting services in the first instance on behalf of Public Health England, to ensure the workforce growth needed to meet the coalition commitment (4,200 health visitors). The NHSCB will then work with PCTs, GP consortia and local partners so that in the longer term health visiting services can be commissioned locally.

4.5 Local Commissioning

- Local authorities will be encouraged to contract for services with a range of providers across the public, private and voluntary sectors and to incentivise and reward those organisations to deliver the best outcomes for their population – the forthcoming consultation on funding and commissioning in public health will explore how this will best be achieved.
- The DoH expects that the majority of services will be commissioned, given the opportunities this would bring to engage local communities in the provision of public health, and such efforts will be supported by the proposed new right for communities to bid to take over local state-run services, and a new Big Society Bank, which will lever in new social investment for charities and social enterprises.

5. National-level partnership with the NHS

- The NHS still has a crucial role to play in public health; ensuring health services meet the needs of the whole population.
- Public Health England will benefit the NHS by reducing pressures from avoidable illnesses, such as obesity and smoking related illness, and allowing the NHS to focus its efforts elsewhere.
- Public Health England will work closely with the NHS at national level and provide advice and support to the wider DoH and NHS; ensuring services meet the needs of the whole population.
- The DoH will strengthen the role and incentives for GPs and practices on prevention services – both as primary care professionals and commissioners.
- GP consortia will have responsibility for the whole population in their area, which should encourage them to work closely with their local authority, nurses, midwives, health visitors, pharmacists and dentists.

The DoH will strengthen the public health role of GPs by:

- Public Health England and the NHSCB will encourage GP consortia to maximise their impact on improving population health and inequalities; looking specifically at equitable access to services
- Information on achievement by practices will be available publicly, supporting people to chose their GP practice based on performance
- Incentives and drivers for GP-led activity will be designed with public health in mind
- Public Health England will strengthen the focus of public health in the education and training of GPs as part of the DoH workforce strategy

Consultation question

a. Are there additional ways in which we can ensure that GPs and GP practices will continue to play a key role in areas for which Public Health England will take responsibility?

- Community pharmacies have potential to help improve health and wellbeing; Public Health England will influence the development of community pharmacies through the NHSCB. Alongside the JSNA, local authorities, through the proposed Health and Wellbeing Boards, will have responsibility for producing pharmaceutical needs assessments, which will inform commissioning in this area.
- The dental public health workforce will increase its focus on effective health promotion and prevention of oral disease.

5.1 National leadership and responsibilities

The DoH will be freed from the operational management of the NHS, refocusing efforts on protecting and improving health. This includes new powers for the Secretary of State for Health:

- Accounting to Parliament and the public for the government's public health activities and spending
- Ensuring the health and care system works to deliver better health and wellbeing
- Setting ring-fenced budget for public health from within the overall NHS budget
- Setting direction for Public Health England and the context for local public health efforts
- Leading public health across central government, through the Cabinet sub-committee on public health
- Leading public health work across civil society
- Participating in public health work across the UK with Devolved Administrations and at European and international levels
- Proposing legislation
- Commissioning research for public health

6. Enhanced protection for health

- The government will devolve public health leadership wherever possible, but will keep powers and strengthen them where there is a strong case for central government leadership.

- Public Health England will build on current arrangements for emergency preparedness and response. Together with the NHS, Public Health England needs to be able to respond to major disruptive challenges, such as infectious disease outbreaks, terrorism and impacts of climate change.
- Public Health England will bring together the health protection and emergency planning and response functions from the DoH, HPA and SHAs.
- In the response phase, there will be national leadership, with most incidents managed locally by teh Public Health England HPUs and the DPH working together.

6.1 Health protection services

A range of health protection functions will be done at national levels, Public Health England will:
- Provide a coherent framework for rapid responses to threats
- Act in co-ordination across government and with national partners in response to threats
- Provide evidence-gathering functions
- Provide information and independent advice on hazards to health to professionals and public
- Provide specialist microbiology function
- Set standards for the national immunisation programme
- Commission communication campaigns
- Respond to legislative requirements

7. Evidence for public health

Public Health England will promote information-led, knowledge driven public health interventions.

Public Health England will draw together the existing complex information, intelligence and surveillance functions performed by multiple organisations into a coherent form to make evidence more easily accessible to those who will use it.
Their approach will be based on 3 principles:
- Quality – evidence will be timely, reliable, relevant to the audience and scientifically robust
- Transparency – evidence will be as accessible and user-friendly as possible
- Efficiency – information will be collected once but used many times with new knowledge applied rapidly as it becomes available

7.1 Research

The National Institute for Health Research (NIHR) will continue to take responsibility for the commissioning of public health research on behalf of the DoH. Public Health England will work with the NIHR to identify public health research priorities.

7.2 Information and intelligence

Public Health England will:
- Strengthen public health surveillance by ensuring fit-for purpose data collection and analysis
- Work with and measure the impact of different communication channels, including NHS Choices
- Ensure the National Institute for Health and Clinical Excellence (NICE) adds value to the evidence of effectiveness and cost effectiveness of public health interventions
- Develop intelligence about the relative cost effectiveness of different interventions to support DPH in commissioning local services

Consultation with those interested in public health practice – comments requested on:
- Publishing an annual review of the latest evidence on what works best in achieving better public health outcomes
- Developing a single, accessible and authoritative web-based evidence system for professionals, particularly DPH, to make evidence easily available to all and to encourage the use of the best evidence in practice
- Encouraging recognition and peer-sharing of successful innovative evidence-based approaches

Consultation questions

b. What are the best opportunities to develop and enhance the availability, accessibility and utility of public health information and intelligence?
c. How can Public Health England address current gaps such as using the insights of behavioural science, tackling wider determinants of health, achieving cost effectiveness and tackling inequalities?
d. What can wider partners nationally and locally contribute to improving the use of evidence in public health?

8. Workforce for public health

- The government wants to maintain a well-trained, highly motivated public health workforce.
- A range of public health staff will work within Public Health England, employed by the DoH.
- There will also be many other critical roles in public health not employed by Public Health England, such as clinicians and professionals from GPs to dentists, pharmacists, nurses and environmental health officers.
- The DoH is encouraging PCTs and local authorities to discuss the future shape of public health locally.
- A more detailed workforce strategy will be developed by autumn 2011.
- The DoH is publishing a review by Dr Gabriel Scally on the regulation of public health professionals, as government believe statutory regulation should be a last resort. The preferred approach is to ensure effective and independently-assured voluntary regulation for any unregulated public health specialists.

Question

e. We would welcome views on Dr Gabriel Scally's report. If we were to pursue voluntary registration, which organisation would be best suited to provide a system of voluntary regulation for public health specialists?

9. Making it happen

By early 2011
More detail on the proposed shape and structure of the new Public Health and care system and proposals for managing the transition in a series of publications, including:

- Detailed roadmap for the system; the NHS, Public Health England and the DoH – setting out transition milestones
- Further detail on the public health system, based on responses to the consultation on this white paper and forthcoming consultation documents, including
    - funding and commissioning for public health
    - Public health outcomes framework
- HR frameworks setting out the principles for managing people moving between organisations
- The Health and Social Bill, introduce to Parliament following the NHS white paper consultation
- The NHS operating framework and the announcement of PCT allocations for 2011/12, published in December 2010

The first step in determining budgets for public health will be to establish the baseline health spend for those services for which Public Health England will take responsibility for. Local PCT spending on such services during 209/10 will be used as the baseline to reflect recent historic spending, rather than spending during a transition year.

9.1 Proposed timeline

Dec 2010 – March 2011

- Consultation on this white paper and forthcoming documents

During 2011

- Set up shadow-form Public Health England within the DoH
- Start to set up working arrangements with local authorities, including the matching of PCT Directors of Public Health to local authority areas

Autumn 2011

- Public Health England will take on full responsibilities, including functions of the HPA and NTA
- Publish shadow public health ring-fenced allocations to local authorities

April 2013

- Grant ring-fenced allocations to local authorities

The DoH will publish a range of key documents that link to this white paper, including:

Winter 2010/11

- Health visitors
- Mental health
- Tobacco control

Spring 2011

- Public Health Responsibility Deal
- Obesity
- Physical Activity
- Social Marketing
- Sexual health and teenage pregnancy
- Pandemic flu

Autumn 2011

- Health protection, emergency preparedness and response

Health and wellbeing throughout life – Summary of Actions

The Marmot Review adopts an approach which addresses the wider factors that affect people at different stages and key transition points in their lives. In response to this the government wants all parts of society taking responsibility for health and wellbeing, where most action happens locally, tailoring support to the needs of individuals and families at different stages in their lives:

Starting well

Early intervention and prevention is a key priority for government, developing universal public health and early education with an increased focus on disadvantaged families:

- The Department of Health (DoH) will work with the NHS to strengthen the prevention aspects of maternity services
- The Department for Education (DfE) will continue to offer all families 15 hours a week of free nursery care for pre-school children
- The healthy Child Programme will continue to be delivered by increased numbers of health visitors and their teams providing support to families
- In local government there will be new opportunities to develop integrated local strategies between health services, children's services and the NHS.
- The family partnership programme (FNP) will be doubled in capacity, to support families in need of more intensive support. The first phase of Community Budgets for families with complex needs will enable focus on prevention through locally co-ordinated support
- Children's centres will focus particularly on engaging with families where children are at riosk of poor outcomes – they will act as hubs for family support and as a base for voluntary and community groups
- Central government will continue to tackle child poverty, aiming to eradicate it by 2020 and will publish a strategy during spring 2011
- The Department of health will work in partnership with employers to encourage breastfeeding-friendly employment policies

Developing well

The shift in power from central government to schools and local communities will provide opportunities and incentives to forge partnerships to deliver better health outcomes for children and young people:

- Directors of Public Health (DPH) will be able to work with their local authority children's services colleagues, schools and other partners to determine local strategies for improving child health
- Healthy Schools, healthy Further Education and healthy Universities programmes will continue to be developed where appropriate
- Schools will continue to provide age-appropriate teaching on relationships and sexual health, substance misuse, diet, physical activity and some mental health issues through the current non-statutory PSHE framework.
- The DfE will conduct an internal review to determine how schools can be supported to improve the quality of PSHE teaching
- Young people will be helped to reduce their susceptibility to harmful influences, such as sexual health, drugs and alcohol through easy access to young-people friendly services such as 'You're Welcome'. Public health funding, alongside the new early intervention grant will allow areas to develop tailored approaches for young people
- Improving self-esteem and developing positive social norms throughout school years will be the focus of local strategies
- The DoH will broaden the Change4Life programme to take a more holistic approach to childhood issues, e.g. covering mental wellbeing and strategies to help parents talk to their children about other health behaviours
- The DfE will ensure the requirement to provide PE in all maintained schools is retained and will provide support to encourage take-up of competitive sports
- The Healthy Child Programme for school-age children will continue to be commissioned to provide a clinical evidence based framework
- The national child measurement programme will continue to run to provide information about levels of overweight and obesity in children

- The school nursing programme will work with other professionals to support schools in developing health reviews at school entry and key transitions
- For children and adolescents with mental health problems, central government will support interventions that promote mental health resilience and effective early treatment. The DoH will set out its approach in a mental health strategy to be published shortly
- Government will address point of sale tobacco advertising, through plain packaging and protect children through tobacco control legislation and enforcement
- Legislation to stop tobacco sales from vending machines will come into force on 1 October 2011
- The forthcoming Special Educational Needs and Disability Green Paper will set out in detail the government's plans to improve outcomes for children and young people
- The government pledges to create 75,000 additional apprenticeship places by 2014/15 to support the transition from school to work

Living well

The government is proposing to turn to local communities to devise local solutions which work for them:

- The Public Health Responsibility Deal will be launched early 2011, which includes collaboration with the business and voluntary sector to announce agreements on reformation of food to reduce salt, better information for consumers about food and promotion of socially responsible retailing and consumption of alcohol
- During January 2011, the Change4Life 'Great Swapathon' will see partners giving vouchers to make healthy lifestyle choices easier
- Defra have recommended that food containing fruit and vegetables with other types of food should be added to the 5 A Day licensing scheme
- The DoH will support local areas by proving good evidence on how to make regular physical activity and healthy food choices easier for their populations
- The Department for Transport's £560 million Local Sustainable Transport Fund will promote sustainable and active travel
- The Department for Culture Media and Sport (DCMS) has announced a £100 million Mass Participation and Community Sport Legacy Programme, which will improve community sport facilities, improve and protect playing fields, provide opportunities for sports volunteers and leaders and deliver an open programme of personal challenge
- The Walking for Health programme of volunteer-led health walks and Let's Get Moving will also provide important opportunities for people to be active
- The Department for Communities and Local Government (DCLG) will support local areas with streamlined planning policy that aligns social, economic, environmental and health priorities into one place
- DCLG is working with Defra to create a new designation to protect green areas of particular importance to local communities and provide practical guidance to support community groups in the ownership of public spaces
- Defra will also lead a campaign to increase tree-planting throughout England, particularly in areas where increased tree-cover would help improve residents' quality of life The Home Office will seek to overhaul the Licensing Act to give local authorities and police stronger powers to remove licenses from, or refuse licenses to, any clubs, bars and pubs that are causing problems, close any shop or bar found to be persistently selling to children and charge more for late-night licenses
- Reducing smoking will continue to be a focus for public health; the DoH will publish the Tobacco Control Plan shortly
- NHS health Checks will continue to be offered to men and women aged 40-74
- The DoH will align funding streams on drug and alcohol treatment services across the community and in criminal justice settings
- Details of how public health professionals will work locally to prevent people from taking harmful drugs, reduce drug use of existing users and to help people to be rug free, will be published in the forthcoming cross-government drugs strategy
- Government propose to work towards an integrated model of service delivery to allow easy access to confidential, non-judgmental sexual health services. The DoH is piloting interventions on alcohol misuse linked to sexual health risks in order to manage broader risk-taking behaviour

- Public health services will have a role in tackling violence and abuse – the DoH have produced *Improving services for women and child victims of violence* which sets out how the health response to violence will be improved

Working well

Local government, central government and businesses will work to create new jobs and opportunities:

- Central government will support the creation of apprenticeships, internships, work pairing and college and workplace training places, as well as promoting the expansion of volunteering and opportunities for an effective route to gaining skills and employment
- Central government will make it pay to work; a reformed Welfare to Work programme is being developed, replacing existing means-tested working-age benefits with a single Universal Credit.
- Central government will also help people stay in work through the innovative Fit for Work Service; pilot projects are currently being delivered which support workers who are off sick back to work faster and to keep them in work
- The Fit Note was introduced April 2010, allowing GPs and individuals to focus on how to get people on sick leave back into work
- New provisions in the Equality Act 2010 prohibits employers from asking health or health-related questions before offering employment, except where it is intrinsic to the job
- Central government, in conjunction with the Faculty of Occupational Medicine, is developing an accreditation process for the new occupational health service standards.
- The DoH will work in partnership with employers, through the Public Health Responsibility Deal to improve health at work
- Central government will provide evidence and data to raise awareness among employers of the clear case for investing in the health of their employees – including further development of the Change4Life employee wellness programme
- NHS will lead by example in looking after the health and wellbeing of its staff; all NHS organisations will produce local health and wellbeing strategies for staff during 2011

Ageing well

All western countries are experiencing ageing populations, which is a major challenge for health and care systems typically geared towards treating short-term sickness, rather than preventing and managing long-term mental and physical conditions in later life:

- Public health will be better integrated with areas such as social care, transport, leisure, planning and housing
- Strong partnerships between communities, business and the voluntary sector will help address a range of health challenges such as depression and winter deaths e.g. the Department for Energy and Climate Change will develop a Green Deal to improve energy efficiency and warmth of homes from 2012
- Local government provides a range of services to promote active ageing and help people live independently in their homes, a commitment is being made to keep people on their homes longer through funding for adaptations and programmes such as Supporting People, the Disabled facilities Grant and Decent Homes
- The DoH carers' strategy sets out how government will support carers to recognise the value of their contribution, involve them in care delivery and support their mental and physical health
- The government's vision for adult social care sets out the ambition to increase prevention action, keeping people active and independent in the community
- DPH and Directors of Adult Social Services will be able to work together to commission specific services for older people and those who care for them
- Social norms and attitudes will also need to be changed, the Equality Act 2010 prohibits age discrimination against people over 18 when providing a service or exercising a public function
- Local and central government will work in partnership with businesses, voluntary groups and older people to create opportunities to become active and reduce social isolation
- The Department for Work and Pensions will provide Active@60 grants to voluntary and community groups to establish Community Agents in their area
- The default retirement age will be phased out, enabling people who wish to, work for longer to maintain their health and wellbeing
- The DoH will continue to promote the implementation of the End of Life Care Strategy

ADULT SERVICES AND HEALTH SCRUTINY PANEL
Thursday, 11th November, 2010

Present:- Councillor Jack (in the Chair); Councillors Barron, Blair, Burton, Hodgkiss, Kirk, Middleton and Steele.

Councillor Doyle was in attendance at the invitation of the Chair.

Also in attendance were Russell Wells (National Autistic Society), Mrs. A. Clough (ROPES), Victoria Farnsworth (Speak Up) and Mr P Scholey.

Apologies for absence were received from Councillors Goulty and Wootton; Ms J Dyson, J Evans and J Richardson

43. DECLARATIONS OF INTEREST.

No declarations of interest were made at the meeting.

44. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS.

There were no members of the public and press present.

45. STROKE SERVICES IN ROTHERHAM

Dominic Blaydon, NHS Rotherham gave a powerpoint presentation in respect of the CQC Stroke Review.

The presentation drew specific attention to:-

- The Review Summary
- Areas of Good Performance
- Areas needing further work
- The National Stroke Strategy
- Stroke Strategy Impact Assessment
- Current Service Model
- Stroke Action Plan
- Accelerated Stroke Indicators

A question and answer session ensued and the following issues were discussed:-

- Reference was made to the TIA scans which were undertaken within 24 hours of a patient presenting themselves to their GP. A query was raised as to who was responsible for reading the results, and also how the patient was kept informed and what the timescales were. It was confirmed that if the scan was undertaken within normal hours then the consultant would

be responsible for reading the results and should inform the patient of the outcome as soon as practicable. However if the scan was done out of normal hours then this would become more complicated.

- A query was raised about the number of staff involved in the running of the Stroke Unit in order to establish how large it was.
- Reference was made to the calculation for the estimated savings for social care and health as a result of the impact of the stroke unit and a query was raised as to how the figures had been arrived at.
- An explanation was sought into what was involved in the "early supported discharge" Confirmation was given that following the initial medical intervention which was generally only for a short time, the next stage would be intensive therapy ie Speech, Physiotherapy and Occupational Therapy. Most of these sessions would be done away from the stroke unit but would still require a vast amount of support.
- A query was raised about the incidence of strokes in Rotherham and whether there had been any change in the last 20 to 30 years. It was confirmed that there would be an increase in the incidence as a result of old people living longer and also with the increase in obesity and poor diet.
- Reference was made to the action plan and what the estimated costs were in relation to it. In addition it was queried whether there were adequate facilities for acute care.
- Reference was made to the care of patients once they had finished therapy sessions. It was noted that responsibility for their care was then transferred to district nurses and support workers, and a query was raised about the level of training available to them.
- It was noted that there had been a Stroke Strategy Group in Rotherham in the past which had ceased to exist and it was queried whether this would be resurrected. It was confirmed that the Stroke Pathway Group now filled this gap and this currently only involved officers. However it was felt that representation on this Group should be revisited.
- Reference was made to carotid artery scanning, at which Rotherham performs well.

Members thanked Dominic for his informative presentation.

46. ANNUAL REPORT OF THE JOINT LEARNING DISABILITY SERVICE

Shona McFarlane, Director of Health and Wellbeing presented the submitted report in respect of the Annual Report of the Joint Learning Disability Service (JLDS).

The Annual Report of the JLDS outlined the continued strong performance of the service which linked its services and priorities to those identified within the Neighbourhoods and Adults Service's Plan. The strong performance had been reflected in its contribution towards:

- Care Quality Commission (CQC) annual performance rating of Rotherham Adult Social Care performing "excellently" since 2009
- LDS Partnership Board Self Assessment which was submitted in March 2010 and achieved over 30 mentions in the Regional Good Practice and Innovations Guide
- Annual Health Self Assessment further improved, achieving 3 greens and an amber on the 4 health targets, resulting in Rotherham achieving the second highest performance across the Yorkshire and Humber region.

A range of satisfaction surveys and customer feedback experiences had been conducted in the year and actions had been identified to evaluate performance and deliver increased customer satisfaction.

LDS performance had been reported by the Customer Service Excellence performance framework as being top rated at platinum 2009/10. This had continued in the latest reporting period (July-September 2010) with satisfaction results across the board in Learning Disability achieving 100%.

Despite the overall strong performance by the JLDS in 2009-10, targets had been set which were challenging for 2010-11 aimed at achieving either benchmarked step change improvements in relation to our comparator group of local authorities or continuous improvement as a minimum, which ever was the greater.

It was noted that the annual report would be publicised via the Rotherham MBC website and formally reported through to both the Partnership Board and NHS Rotherham Board.

A question and answer session ensued and the following issues were discussed:-

- Reference was made to the "Move on" employment which was currently running 3 days per week and a suggestion was made to look at the possibilities of this being increased to 5 days.
- It was noted that the Comprehensive Spending Review had indicated that there was a need to make 30% reduction in council budgets and a query was raised as to whether this

would have an impact on the future provision. It was confirmed that, despite these reductions, priority would be given to keeping the level of customer service high.

- Reference was made to commissioning work being undertaken in respect of learning disabilities and improving the services available. It was noted that although there was no written document in respect of this yet there was an implementation plan in place.
- Clarification was sought about why the service was not achieving its target for 'People supported to live independently" NI 136. It was confirmed that Rotherham were high performers in respect of helping people to live at home, but that NI 136 was more involved and difficult to achieve. However assurances were given that every effort was being made in order to improve the performance in relation to this.

Resolved:- That the content of the Joint Learning Disability Service Annual Report and the service objectives for 2010/11 be noted.

47. HOSPITAL DISCHARGE PROCESS - IMPROVING THE CUSTOMER'S EXPERIENCE

Mark Joynes, Service Manager Access presented the submitted report which outlined the progress and developments which had been made to improve discharge for patients following the review of hospital discharge arrangements.

It was noted that the continued increase in the population of older people in Rotherham had contributed to an increase in hospital admissions. This was expected to continue with the potential for increases in hospital admissions and discharges, and subsequent pressure on finite resources to deliver quality health and social care support services to customers within specific time frames.

There were ongoing initiatives in place to avoid inappropriate admissions into acute care and developments to provide alternative levels of care pathways and support services. Different groups had been established and re-established to plan and deliver improved services.

Adult Services continued to be an active member of the Emergency Care Network Group, a multi agency membership whose purpose was to develop integrated and effective Urgent and Emergency Care Services and pathways across the Health and Social Care Community. Safe and timely discharge of patients was an element of this work.

The Discharge Monitoring Group had been re-established and now had two groups, a strategic and an operational group. The purpose of the strategic group was to bring about a substantial improvement in the discharge process, involving all stakeholder partners, in accordance with government guidance and legislation and was accountable to the Emergency Network Group. One purpose of the operational group was to review process and protocols pertaining to discharge in response to operational practice, learning and also in response to both customer comments and complaints.

The Adult Services Customer Quality Team produces quarterly Excellence Performance reports which are obtained and produced by a variety of methods including customers' involvement. The report evidenced a high level of customer satisfaction with an improvement of service delivery of social care ranging in the lower 90% satisfaction from the previous quarter to higher 90% range of satisfaction for the first quarter of 2010.

There was partnership working between Health and Social Care complaints departments both regionally and locally operating through their comments and complaints procedures, pertaining to hospital discharge.

Other developments had been the permanent appointment of a part time Health and Social Care Co-ordinator for BME patients, who would provide information and advice on their admission into hospital.

There was a proactive focus by Adult Services through their Health and Social Care Information Facilitators, to provide information to carers or family members who were likely to require community care services on discharge from hospital, and advice in respect of available health and social care services prior to the allocation of a social worker.

The continued successful recruitment to vacant posts had increased the number of new social workers and enabled some increased degree of flexibility to patients and carers in respect of appointments.

There were two part time stroke co-ordinators employed by Adult Services who operated on the stroke ward and provided additional advice and support to patients who declined or were not eligible for social worker involvement, in preparation for their discharge from hospital.

A relatively new development was the creation of a dedicated team

from Adult Services and Rotherham Foundation Trust. This team would provide consistency in the application of NHS Continuing Health Care Framework whilst also enhancing the patient's opportunity to be successfully assessed against the eligibility criteria.

A question and answer session ensued and the following issues were discussed:-

- Reference was made to the waiting times being experienced by patients for prescriptions before being discharged and a query was raised as to what action was being taken to alleviate this problem.
- A query was raised about what measures were in place to deal with the increased number of old people during the winter months.
- Reference was made to the Council's "Grow your Own" scheme which provided social care officers with training to become social workers.

Resolved:- That the contents of the report be noted.

48. CARERS' CORNER REPORT

This item was deferred to a future meeting.

49. FALLS COLLABORATIVE - EVALUATION

This item was deferred to a future meeting.

50. FORWARD PLAN

Consideration was given to the Forward Plan of Key Decisions for 1st November 2010 to 31st January 2011.

Resolved:- That the Forward Plan of Key Decisions for 1st November 2010 to 31st January 2011 be noted and received.

51. HOSPITAL AFTERCARE SERVICE

Consideration was given to the Age Concern Rotherham, Hospital Aftercare Service Evaluation 2010.

Resolved:- That the Age Concern Rotherham, Hospital Aftercare Service Evaluation 2010 be noted.

52. YORKSHIRE AMBULANCE SERVICE UPDATE

Consideration was given to the Yorkshire Ambulance Service Monthly Update for October 2010.

Resolved:- That the Yorkshire Ambulance Service Monthly Update for October 2010 be noted.

53. MINUTES OF A MEETING OF THE ADULT SERVICES AND HEALTH SCRUTINY PANEL HELD ON 7TH OCTOBER 2010

Consideration was given to the minutes of the meeting of the Panel held on 7th October 2010.

It was noted that Councillor Middleton had been in attendance at the meeting but that his attendance had not been recorded.

Resolved:- That subject to the amendment referred to above, the minutes of the meeting of the Panel held on 7th October, 2010 be approved as a correct record for signature by the Chair.

54. MINUTES OF A MEETING OF THE CABINET MEMBER FOR ADULT INDEPENDENCE HEALTH AND WELLBEING HELD ON 27TH SEPTEMBER 2010 AND 11TH OCTOBER 2010

Resolved:- That the minutes of the meetings of the Cabinet Member for Adult Independence Health and Wellbeing held on 27th September, 2010 and 11th October, 2010 be noted and received.

CABINET MEMBER FOR ADULT INDEPENDENCE HEALTH AND WELLBEING
25th October, 2010

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

Apologies for absence were received from Councillors Steele.

H30. MINUTES OF THE PREVIOUS MEETING HELD ON 27TH SEPTEMBER, 2010

Consideration was given to the minutes of the meeting held on 27th September, 2010.

Resolved:- That the minutes of the meeting held on 27th September, 2010 be approved as a correct record.

H31. MARMOT REVIEW - PRESENTATION BY JOHN RADFORD, DIRECTOR OF PUBLIC HEALTH

John Radford, Director of Public Health gave a presentation in respect of the Marmot Review.

The presentation drew specific attention to:-

- History
- Life expectancy at birth
- The Millennium Preston Curve
- Income inequality within a country correlated with outcomes in health and crime
- How we stack up in the world
- Average age of death in South Yorkshire
- Effect of politics/Microeconomics
- Summary from history
- Marmot Review- 4 tasks
- 6 Policy Objectives Identified
    - Give every child the best start in life
    - Enable all children, young people and adults to maximise their capabilities and have control over their lives
    - Create fair employment and good work for all
    - Ensure healthy standard of living for all
    - Create and develop healthy and sustainable places and communities
    - Strengthen the role and impact of ill health prevention
- Quote from Review Overview
- Summary – Key Points/Themes

Members present commented on the following:-

- the increased number of younger people dying prematurely
- how successful Sure Start had been

Resolved:- That the content of the review be noted and John Radford be thanked for his informative presentation.

H32. INFECTION CONTROL ANNUAL REPORT

Kathy Wakefield, Strategic Lead for Infection Prevention and Control presented the submitted report in respect of the Infection Prevention and Control Annual Report for 2009/10.

This was the first Annual Report and covered the period from November 2009 to March 2010 and gave an update in respect of the following areas:-

- Infection Prevention and Control Arrangements
- Director of Infection Prevention and Control (DIPC) reports to the Trust Board
- Healthcare Associated Infections
- Swine Flu
- Communicable Diseases
    - Blood Borne Viruses
    - TB Services
    - Chlamydia
- Vaccination and Immunisation
- Infection Prevention and Control in Care Homes
- Incidents
- Audit

A question and answer session ensued and the following issues were discussed:-

- Reference was made to representation by the Yorkshire Ambulance Service on the Strategic Infection Prevention and Control Committee and a query was raised as to why there had not been a nomination made. It was noted that the Yorkshire Ambulance Service were monitored through Bradford PCT.
- Why Community Nurses had not been involved
- How MRSA was monitored in Care Homes
- What training was available for staff in respect of barrier protection

Resolved:- That the content of the report be noted.

H33. ANNUAL REPORT OF THE JOINT LEARNING DISABILITY SERVICE

Shona McFarlane, Director of Health and Wellbeing presented the submitted report in respect of the Annual Report of the Joint Learning Disability Service.

The Annual Report outlined the continued strong performance of the Joint Learning Disability Service.

Performance against Local Authority Performance Indicators had improved with the service achieving the third highest performance in the country against D40 when measured against the other Learning Disability Services.

The Partnership Board Self Assessment was submitted in March and had achieved over 30 mentions in the Regional Good Practice and Innovations Guide.

The performance on the Annual Health Assessment had further improved achieving 3 greens and an amber on the 4 health targets resulting in Rotherham achieving the second highest performance across the Yorkshire and Humber region.

It was noted that the Learning Disability Service linked its services and priorities to those identified within the Neighbourhoods and Adults Services Plan based on Strategic Objectives and the Outcome Framework.

Resolved:- That the content of the Annual Report and the Service Objectives for 2010/11 be noted.

H34. EXCLUSION OF THE PRESS AND PUBLIC.

Resolved:- That, under Section 100A(4) of the Local Government Act 1972 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 (business/financial affairs).

H35. FIRST STEPS TO THE PERSONALISATION OF DAY CARE AND RESIDENTIAL SERVICES

Shona McFarlane, Director of Health and Wellbeing presented the submitted report in respect of the first steps to the personalisation

of day care services and residential services.

It was noted that people who lived in residential care had attended day centres. The personalisation of both residential and day services would provide the opportunity to develop and offer proper personalised 24 hour residential services and residential providers would be supported to develop person centred plans and approaches to deliver personalisation to its customers.

The Learning Disability Service had scrutinised its use of existing resources in relation to 24 hour residential care continuing to day services and proposed that residents would no longer traditionally attend the day care element of day services provision. The proposals outlined in the report would increase the flexibility of residential services, enabling them to provide a more personalised service. By developing personalised services for customers in residential care, there would be a reduction in the need for the day care element of day services. These services would provide opportunities to develop community presence and social networks, enabling customers to maintain friendships and provide opportunities to develop new relationships in a more inclusive environment and at the same time ensure that the resources were available to support young people in transition who live at home with their families.

Resolved:- That the proposals to improve the ability of the day services to accommodate the young people coming through transition service be accepted.

CABINET MEMBER FOR ADULT INDEPENDENCE HEALTH AND WELLBEING
8th November, 2010

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

Apologies for absence were received from Councillors P. A. Russell and Walker.

H36. MINUTES OF THE PREVIOUS MEETING HELD ON 11TH OCTOBER 2010

Consideration was given to the minutes of the previous meeting held on 11th October, 2010.

Resolved:- That the minutes of the previous meeting held on 11th October, 2010 be approved as a correct record.

H37. PDSI COMMISSIONING STRATEGY

Chrissy Wright, Director of Commissioning and Partnerships presented the submitted report in respect of the PDSI Commissioning Strategy.

She reported that the strategy provides a framework for the strategic commissioning for people with physical and/or sensory disabilities in Rotherham for the next 3 years from 2010-2013.

The overall strategic direction was to move towards self directed support and helping people to help themselves. This approach would achieve efficiencies through decommissioning and recommissioning services including shifting from traditional service provision.

The strategy provides a framework for the actions needed to achieve change and the action plan outlines the 3 year strategic commissioning intentions. There would be an annual implementation plan with detailed costings to support decision making on the decommissioning and recommissioning of services.

The report set out the details of the strategic intentions for the PDSI service and included comments made by people with physical and/or sensory disabilities about what they wanted and how their needs and aspirations could be met.

Formal consultation had taken place with customers and their carers utilising the nationally recognised CSED 'Anticipating Future Needs Toolkit and included face to face interviews. A process analysis followed this process and provided valuable insight into the lives,

aspirations and expectations of individuals.

Building on this approach the Service Quality team have utilised the customer experiences of mystery shopping, reality checking and auditing access to services/information to learn from customer experiences and improve services and outcomes.

The work of customer inspectors was ongoing and the outcomes of their audits were critical and central to the development of services and improvement of existing service provision. Learning from complaints, surveys and the Fairs Fayre events had also been incorporated into the strategy.

The strategy had been widely shared within NAS, and all comments and amendments had been included and the strategic approach had the support of senior officers.

It was noted that, an action plan had been produced in order to achieve the change required, and this was attached to the strategy as Appendix 1.

Reference was made to strategic intentions for the PDSI service based on what people had told us they wanted. It was felt that more emphasis should be placed on what a person needed rather than what they wanted. It was confirmed that, this would be established as part of the assessment of need, and at that point it would be agreed what method could be used to best achieve it.

The Cabinet Member questioned how work with the BME community would integrate into the strategy. It was confirmed that work was ongoing with the BME community through the Joint Improvement Partnership and that this would feed into the strategy. The strategy was a living document which would continually change and reshape services provided.

Reference was made to the provision of day care and concerns were raised at the reduction in the number of people attending day care centres. The Director of Health and Wellbeing commented that more people were opting for being supported to undertake activities on their own rather than attending day care centres.

Resolved:- That the Cabinet Member for Adult Independence Health and Wellbeing approve the draft strategy and agree that performance against the action plan be reported by exception via the

DLT performance reporting framework.

H38. SHARED LIVES ADULT PLACEMENT SCHEME

Chrissy Wright, Director of Commissioning and Partnerships presented the submitted report in respect of the Adult Placement Shared Lives Scheme.

It was proposed that the current Adult Placement Shared Lives Scheme be extended to all eligible adults. The extension of the existing scheme would support vulnerable adults to develop or maintain their independence in a stable environment, support those leaving residential care and full time education, prevent inappropriate admissions to long term care and provide preparation for independent living.

Adult Placement Schemes offer customers choice and control and personalised support and are regulated by the Care Quality Commission. They are required to have a registered manager and an Approval Panel for prospective carers which consists of approximately 5 people appointed by the scheme but operating independently.

The current Shared Lives scheme in Rotherham operates from the learning disabilities services and offers a variety of flexible and personalised services for individuals. It currently supports approximately 25 people with a learning disability on a long term, respite/short stay and day care basis.

The National Association of Adult Placement Schemes (NAAPS) was commissioned to provide a report on the quality, outcomes and cost effectiveness of Shared Lives Schemes and identified the following improved positive outcomes:

- Living the life the person wants
- Developing the person's confidence/skills/independence
- Ongoing relationship between person and carer
- Having choices and being in control
- Having different experiences
- Wider social networks
- Increase in self esteem
- Being part of the carer's family and networks
- Integration in the community
- Physical and emotional wellbeing

The report also highlighted the 'cost effectiveness being greater in larger schemes'. This evidence supports the extension of the local

scheme to achieve better outcomes for local people and to achieve cost efficiencies.

The current levels of payment for services provided are structured and these were outlined in the report.

Contributions from service users were subject to a financial assessment with a maximum charge of £200 per week being levied.

There is currently a named registered manager and a full time co-ordinator managing the LD Scheme and supporting the Approval Panel within the learning disabilities service. In order to develop the scheme an additional full time worker would be required, and it was proposed that a level 3 social worker be recruited as Shared Lives Officer. This would ensure the current high level of knowledge and skills required to recruit and retain carers, and continue to deal with safeguarding issues effectively. The current membership of the Approval Panel would also need to be reviewed in order to reflect the extension of the scheme to all eligible adults.

The average cost of a residential placement for people with a physical and/or sensory disability is £546.96 per week which compares to an average cost of £300 per week for the shared lives scheme. This equates to an annual saving of approximately £13,000 per year for each residential placement. In addition there would also be cost savings compared to current costs of respite care which average at £546.96 per week. The average cost of day care was £80 per day including transport compared to a cost of £27.85 per day for 5 hours of day care/sitting/befriending service provided by the shared lives scheme.

The funding for the pump priming of this initiative would be provided by the Supporting People Grant for 2010/11 and a review would take place at the end of six months to identify the learning and cost benefit analysis, with a view to establishing the viability of the continuance of this initiative.

Resolved:- (1) That the Cabinet Member for Adult Independence Health and Wellbeing approve the extension of the scheme to enable the provision of placements to all eligible adults.

(2) That a further report be presented in 9 months time updating the Cabinet Member on progress made.