ADULT SERVICES AND HEALTH SCRUTINY PANEL

Venue: **Town Hall, Moorgate Street, Rotherham. S60 2RB**

Date: **Thursday, 3rd March, 2011**

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

10.00 a.m.

6. Assistive Technology Review Update (Pages 1 - 10)

10.20 a.m.

7. Public Health White Paper Consultation (Pages 11 - 23)

10.50 a.m.

8. Winter Pressures (Pages 24 - 36)

11.20 a.m.

9. Diabetes Testing

10. Adult Services and Health Scrutiny Panel (Pages 37 - 44)
    - minutes of meeting held on 10th February, 2011

11. Adult Social Care and Health (Pages 45 - 55)
    - minutes of meetings held on 31st January and 14th February, 2011

For Information

12. KWILT Project Summary (Pages 56 - 57)

Date of Next Meeting:-
Thursday, 14th April, 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

ROTHERHAM BOROUGH COUNCIL – REPORT TO MEMBER

1	**Meeting:**	**Adult Services & Health Scrutiny Panel**
2	**Date:**	**14 February 2011**
3	**Title:**	**Assistive Technology – Update on Progress**
4	**Programme Area:**	**Neighbourhood and Adult Services**

5 Summary

The Adult Social Care and Health Scrutiny panel undertook a scrutiny review of Assistive Technology (AT) in October 2010. The scrutiny report provided the background to the development of AT within RMBC and made a number of recommendations. These recommendations have been considered and this report provides an update on progress to date and evaluates our current position.

6 Recommendations

THAT CABINET MEMBER:

- **Notes the NAS response to the scrutiny review.**
- **Notes the progress that has been made in delivering assistive technology within Rotherham.**

7 Proposals and Details

7.1 **Background** – Assistive Technology (AT) / Telecare involves the provision of equipment that can be used to enable people to live independently. The aim of the provided equipment is to monitor and assist customers in their daily living and to encourage confidence and independence. Appendix A of this report gives two case studies that illustrate the personalised outcomes that may be obtained from the provision of such technology.

7.2 A report was received in October 2010 from the Adult Services and Health Scrutiny Panel that evaluated the use of AT in Rotherham. The report contained certain findings and recommendations. This report shows how these issues have been addressed.

7.3 The recommendations that were made were as follows

- That the Council and NHS Rotherham produces a joint and overarching long term Assistive Technology strategy, with a view to developing a 'single point of entry' for service users and carers.

- A robust monitoring system for AT is put into place to record savings in terms of the prevention of avoidable admissions to hospital, the prevention / delay of admission to long-term residential care, and savings from individualised homecare packages.

- The Council continually seeks to expand and promote the Assistive Technology it has to offer.

- The Council examines ways for more cost effective approach to excessive usage or repair.

- That awareness of AT/Telecare across professionals, including domiciliary care providers, is continued and strengthened so that all view it as an option for all Service Users and Carers.

- Good quality information and signposting needs to be provided by the Council and NHS Rotherham for both Carers and Service Users to enable them to understand their AT options and so to self assess with confidence.

7.4 A number of significant changes have been made to the delivery of AT that address the issues raised within the Scrutiny report. These include

- **The appointment of a dedicated Assistive Technology Officer.** In order to ensure that the advantages of AT were realised it was agreed that an officer should be appointed on a temporary secondment basis to raise the profile of AT and to address some of the issues that had been raised by Scrutiny. This had the added

benefit of giving a focal point to the provision of equipment so that staff find it easier to provide support easily and without blockages

- **A series of visioning events at which staff were able to identify the difficulties that they associated with the provision of AT.** From these events the process for recommending AT was simplified to take the onus away from bureaucratic complexity to simple and appropriate recommendations. This has seen a significant improvement in the numbers of staff who are now considering AT as a viable alternative to reduce expensive care packages.

- **The establishment of a system to monitor and demonstrate the savings that AT can bring about.** As part of the process of allocating equipment a database has been established to show the savings that have been occasioned by such provision. When staff are requesting AT support they are also asked to detail the provision that they would have made under traditional care packages.

- **A change in emphasis during the assessment process.** The introduction of a new Independent Social Care Assessment (ISCA) brought about by changes linked to personalisation also allowed the opportunity to include a question in the assessment process that involved the provision of AT. Whereas in the past the assessment had asked staff to give reasons why they believed that AT was necessary. This has now been changed to ask the Social Worker to give reasons why they had decided **not** to recommend AT provision. This change in emphasis has highlighted the importance of AT and engaged staff in greater deliberation about the provision of support.

- **Identification of simple and direct access to equipment.** Following comments made by staff and customers that they were confused about AT a session was held with providers, staff, customers and carers to identify the main items of equipment that would benefit vulnerable people. These packages were then presented as a series of cards that were allocated to all staff. The Carer Package, Medication Management Package, Epilepsy Package, Environmental Package, Purposeful Walking Package and Falls Package are included as Appendix B to this report. This innovative way of identifying the most frequently allocated packages has been seen by one of our major providers as an excellent way of raising the profile of AT and they will be rolling out the Rotherham example across the whole country.

- **Highlighting good news stories with an emphasis on outcomes.** In order to encourage and convince staff that there are significant benefits to the provision of AT a number of case studies have been circulated to emphasise the personal dimension to successful implementation of support. Such case studies have always proved to be an effective vehicle for demonstrating the benefits to the customer that can be shown by positive processes and the provision of AT is no exception to this rule.

- **Better use of our available information.** At the time of writing we are just about to introduce a piece of work that will give us credible data to demonstrate the benefits of AT provision in one particular area. One of the major benefits of AT is to vulnerable people who may suffer from falls within the home. We have established with Rothercare the one hundred customers who have contacted their service the most over the last 12 months with alerts related to falls. These people will be allocated a falls package that will monitor their wellbeing at home. The results will be studied to better understand the savings that can be made from the allocation of such packages. Analysis of changes in outcomes for these 100 people will help to demonstrate the improvements that can be made by such provision.

- **Prevention of avoidable admissions to hospital and the prevention / delay of admission to long term residential care.** The card scheme outlined earlier in this report places emphasis on a defined package matrix that clearly identifies how assessment for AT equipment can be linked to delaying residential care, supporting the provision of domiciliary care and improving the support we give to carers. This link between the issuing of equipment and improving our customers lives is essential to the success of AT. We are developing an ethos of preventing problems before they happen and AT is vital to this ethos. These cards are also included as part of Appendix B

- **The provision of information and signposting.** A campaign to raise the profile of AT in Rotherham has been started with a dedicated AT week to take place in March. A fixed display of available equipment has been set up in Rotherham Carers' Corner and visits have been arranged to various groups in order to demonstrate the benefits of AT.

- **Direct involvement of staff in developing AT.** Aside from the work that has taken place with staff to understand the main provision of AT outlined above we have also encouraged staff to pursue more unusual solutions to problems. The appointment of an Assistive Technology Officer has meant that we now have a resource who can research and benchmark equipment rather than relying on the same handful of solutions. This has meant that we are far more flexible in our responses to individual issues as the Officer works with the member of staff to ensure that the solution is the best individually personalised outcome for the customer. Such personalised solutions are then reported back to staff on a regular basis to encourage such thought and to showcase achievements.

- **Better use of resources.** We have started to demonstrate the financial savings that can be brought about by intelligent allocation of resources and at the same time assisted in the assessment process. An example of this has been encouraging staff to use the 'Just Checking' package. This package allows the 24/7 monitoring

of a customer in order that the Assessing Officer may develop a more accurate picture of the needs of the person being assessed. This process leads to more accurate allocation of packages and a better understanding of how to support the customer. We now have seven of these packages in Rotherham and they are all being used on a regular basis.

- **Better liaison with Rothercare.** A large proportion of the AT available depends on the customer receiving a service through the lifeline monitors that are issued as part of Rothercare. There has been closer working with Rothercare staff to solve issues related to the fitting of equipment and identifying exactly how Rothercare will respond to any given alert. This improved understanding of the process has been brought about by the training of Rothercare staff that has taken place since October.

- **Development of benchmarking opportunities.** Adrienne Lucas is the Regional Assistive Technology Manager for Yorkshire and Humber. She has provided Rotherham with excellent support for improving our processes and demonstrating outcomes based on AT provision. She recently used Rotherham at an Association of Directors of Adult Social Services (ADASS) meeting as the example of an authority that had improved provision of Telecare and suggested that she will use our card scheme across other authorities as an example of best practice. She attended the Fairs Fayre event that was held in October and paid particular attention to the promotion of AT at the event. She recently commented that, '**I was just having a look through the information for the conference in November and am struck by the pathway that Rotherham has travelled. I would like to use Rotherham as an indicator of success in a report to ADASS this week.**

7.5 This section specifically addresses the recommendations that were raised in the original Scrutiny report

- **That the Council and NHS Rotherham produces a joint and overarching long term Assistive Technology strategy, with a view to developing a 'single point of entry' for service users and carers.**

- An AT strategy has been developed within NAS with an action plan that has monitored the improvements and progress that has been outlined above. The initial targets for the AT Officer centred around the promotion of AT and the collection of data that would demonstrate the outcomes and financial savings that can be achieved. The demonstration of achievable savings will lead to the discussions that are needed to ensure that RMBC are working with colleagues in health to develop a joint strategy. There are significant savings to be made by both organisations and this has been identified as the next major area for development.

- **A robust monitoring system for AT is put into place to record savings in terms of the prevention of avoidable admissions to hospital, the prevention / delay of admission to long-term residential care, and savings from individualised homecare packages.**

- A database has been built up to demonstrate the financial savings that can be made from the provision of AT. The next stage is to start to demonstrate that the provision of AT can lead to significantly improved outcomes for our customers. Two pilots are being set up in February based around provision to customers who are susceptible to falls and customers who have Alzheimers. A comparison between pre and post AT provision will start to give the kind of detail that is required to address this recommendation. The packages that have been established and the card scheme that supports their allocation focuses entirely on these areas. Copies of the cards will be made available at the meeting to demonstrate this.

- **The Council continually seeks to expand and promote the Assistive Technology it has to offer.**

- There has been a concerted campaign to raise the profile of AT among customers, carers, staff and Members. Case studies have been promoted to demonstrate the outcomes that are possible with AT and there are regular updates to staff and Members to demonstrate how AT can improve lives. Regular meetings are held with the major providers that we are always aware of the latest technology that is available. Staff have been encouraged to outline details of cases to the AT Officer who has been instrumental in suggesting solutions that would not have been considered before.

- **The Council examines ways for more cost effective approach to excessive usage or repair.**

- Previously a significant proportion of the AT grant had been used to replace lifeline units that were no longer appropriate. Discussions have started with the major supplier to bring about a change in such provision. New lifeline units are now put in when the customer has extra equipment added rather than as part of a rolling programme. This means that the units are fit for purpose. It is our intention to encourage the provider to provide these units at nil cost to RMBC based on the increased amount of business that is being generated through the strategy outlined in this report.

- **That awareness of AT / Telecare across professionals, including domiciliary care providers, is continued and strengthened so that all view it as an option for all Service Users and Carers.**

- The allocation of AT is now the default option in every social care assessment that takes place in Rotherham. Social Workers now

have to explain why they have **not** considered allocating AT and they have to show the savings that they have made by allocating the equipment. Training has taken place with all Social Workers in order to identify less bureaucratic and simplified processes. Training is about to take place with care enablers in order that they are fully aware of the benefits of AT. There has not been specific training yet with external domiciliary care providers but this is included in the next phase of the action plan.

- **Good quality information and signposting needs to be provided by the Council and NHS Rotherham for both Carers and Service Users to enable them to understand their AT options and so to self assess with confidence.**

- An awareness raising campaign will focus around an AT week in March modelled around the success of previous weeks that have focused on safeguarding adults and personalisation. One of the major AT providers is setting up a fixed display in the Carers' Centre in order that carers are made aware of the benefits of AT. The aim is that aspects of AT can be self assessed and available direct from the Carers' Centre. Work has begun on developing information for customers and this will be part of the campaign of raising awareness.

8 Finance

8.1 RMBC continues to hold £232,351 on behalf of NHSR, in the form of the Strategic Capital Grant (SCG). An unspent total of £90,000 was carried forward to 2010/11 and this will be spent as part of the continuing development of AT outlined in this report.

8.2 RMBC increased it's spend on AT by £ 225,000. More staff have started to allocate AT solutions and the simpler pathways and removal of blockages has led to an understanding of the funding that is available and the outcomes that can be realised. Expenditure to date has centred predominantly around the packages identified in appendix B of this report. A significant indicator of staff being more aware of how to allocate AT may be illustrated by the fact that prior to October 2 members of staff has issued AT and since October 54 staff have allocated packages.

8.3 An example of the kinds of benefits that may be brought about by the allocation of AT can be seen by considering the allocation of an epilepsy package. The hardware available is fitted to the client's bed at the cost of around £ 280. It generates an alert whenever a seizure is detected and immediately lets the carer know that there is a problem. The package removes the need for waking night care. The care that is saved could cost the Council around £ 15,000 per annum.

9. Risks and Uncertainties

9.1 The increased staff awareness of AT is already leading to greater demand for equipment. The budget of £ 225,000 may be exceeded by demand. One area that may be considered is top-slicing the Adult Social Care budgets to provide AT. The case for achievable savings must be made in order to assure that this process would lead to savings.

9.2 The Assistive Technology Officer allocated to raise the profile of solutions and improve ease of access returns to her substantive post at the end of March. The secondment has been very successful and good practice in other authorities certainly suggests that a dedicated officer is needed in order to maintain profile, performance and outcomes.

9.3 Any increase in telecare provision within Rotherham needs to be tempered with the fact that Supporting People will fund the £3.00 per week cost of Rothercare for customers who qualify for support. The maximum Supporting People capacity has never been achieved by Rothercare however any increase in service could mean the requirement for Rothercare waiting list. This will be particularly important next year when the number of people qualifying for such support will, almost certainly. outweigh the funding available. Currently Supporting People fund the weekly charge for customers who need financial support but they only have the capacity to fund a further 200 customers.

10. Policy and Performance Agenda Implications

10.1 Performance Indicator NI136, relating to supporting people to live independently will only be measured for any new customers who are provided with telecare following assessment through the FACs criteria.

10.2 Currently the only statutory returns relate to the Self Assessment Survey (SAS).

10.3 Inclusion of telecare on the Adult Integrated System and the ISCA will allow performance monitoring of the effectiveness of telecare to be effectively monitored.

10.4 Yearly surveys to all Rothercare users will be interrogated to ensure that Rothercare continues to deliver a platinum service.

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Appendix A

Two case studies outlining the benefits of Assistive Technology

THIS MAKES ME A BETTER CARER

‘This is a great idea – it answers the question who cares for the carers’ – Mr Albert Corker

Mr Albert Corker’s life changed a year ago when his wife was diagnosed with Alzheimer’s / Dementia.

‘My main worry was that during the night she would get out of bed and I was so nervous that she would fall down the stairs which are so very steep in our home. It got to the stage where I could not look after her properly during the day because I was not sleeping at night. Even when she did not get up I would never get a deep sleep as I was worried.”

“Unless people have been through this experience they do not know what we have gone through. We had fantastic support from Social Services right from the start but night time was becoming a real problem – leading to me being worried about how I could cope in the day. We were on the verge of getting support at night but another solution was offered us.”

‘Before Christmas we had a Telecare system fitted. Now as soon as she gets out of bed a vibrator under my pillow wakes me up. If I am in another room I have a portable monitor that rings and vibrates. It even occurred to me that if the carer was deaf the system would still be brilliant as the vibration is enough to wake the carer. Now I get a good nights sleep and I feel more secure about my own health. We have also had a Rothercare box fitted as I have a heart condition and I can summon support at the press of a button. I would recommend Telecare support to anybody – it has literally given me back my sleep and I am much more alert during the day – I can care for my wife and have the security of knowing that I can care for myself. It probably saves money as well for the Council as we need less support and respite because I feel better in myself.

It’s a 24/7 job being a carer but at least you know that there is support and help available that can provide a simple solution to what could be a massive problem Well done to everyone in Rotherham Council for this support”

SAFETY FIRST

‘It’s not just a benefit to my Mum – I feel more confident that she is safe and sound when I can’t be there’ – Paul Hart

Mr Paul Hart lives in Sheffield but his Mum; Mrs Hart is Rotherham born and bred and lives in Rawmarsh.

They are both benefiting from innovative use of technology in the form of a special assistive home package that has been fitted into Mrs Hart's Rawmarsh home.

Mrs Hart already benefited from the peace of mind that being part of the Rothercare scheme gave her but both she and her son now feel even more secure due to an additional 'falls package' that has been added to her Rotehrcare unit.

Paul explained, "I used to worry about my Mum falling during the day. She lives alone and sometimes forgets to wear her Rothercare alert pendant. With this new technology if she falls over and can not reach the phone an alert goes directly through to Rotehrcare and help is on hand. It has made her more confident around the house and she is much happier now. They even fitted a sensor to her bed – if she gets up at night and does not come back in a set time then the alert is sounded. It's a fantastic and reassuring package – I think that everybody who wants to remain safe and confident in their own homes should have one. I think this is a great example of a Council offering first class support to help people help themselves "

Mrs Hart added, "It took them about 20 minutes to fit the system and straight away I felt better. I love living at home and this has made me more confident about getting about.. You don't have to worry about batteries or anything as all that is taken care of. I think this has changed my life and I know my son feels that I am much safer than I was."

The difference that a simple telecare package can make to a person's life is immeasurable. They feel more confident and independent and in many cases there are significant financial savings as the person requires less expensive support. The falls package is just one of the innovative ways that allows customers, family and carers more independence and peace of mind.

APPENDIX B

The AT packages identified in the report that have been developed with staff, customers and carers are included here as attachments.

ROTHERHAM BOROUGH COUNCIL - REPORT TO MEMBERS

1.	**Meeting:**	**Adult Services and Health Scrutiny Panel**
2.	**Date:**	**3 March 2011**
3.	**Title:**	**Healthy Lives, Healthy People: Public Health White Paper Consultation**
4.	**Directorate:**	**Chief Executive's**

5. Summary

Following the presentation to ASH Panel on 10 February 2011 on the Public Health White Paper consultation documents, this report is to update panel on the draft response to date and to allow for further input now panel members have had the opportunity to look through the questions.

Consultation has taken place with Directorates and with other Elected Members via PSOC. The deadline for responses to the consultation is 31 March 2011 and is due to be signed off by Cabinet on 9 March 2011.

6. Recommendations

That the Adult Services and Health Scrutiny Panel:

- **Note and discuss the proposals set out in the white paper and consultation documents**
- **Discuss and consider the draft response to date**

7. Proposals and details

The Government is consulting on the proposals within the main White Paper and two supporting documents in relation to the commissioning and funding of public health services and the new outcomes framework. The deadline for responding to the consultation is 31 March 2011. ASH panel members are being asked to consider the questions and draft response to date, to contribute towards the final RMBC response.

The two supporting document questions and draft responses are attached as appendix A and B.

7.1 Main White Paper Consultation Questions

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?

Notes to consider:
The Department of Health (DH) will work to strengthen the public health role of GPs in the following ways:

- Public health England and the NHS Commissioning Board will work together to support and encourage GP consortia to maximise their impact on improving population health and reducing health inequalities
- Information on achievement by practices will be available publicly, supporting people to choose PG practices based on performance
- Incentives and drivers for GP-led activity will be designed with public health concerns in mind
- Public Health England will strengthen the focus on public health issues in the education and training of GPs as part of the DHs workforce strategy

Question b: What are the best opportunities to develop and enhance the availability, accessibility and utility of public health information and intelligence?

Question 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?

Question d: What can wider partners nationally and locally contribute to improving the use of evidence in public health?

Note to consider:

- Public Health England (PHE) will promote information-led, knowledge-driven public health interventions.
- The DH will develop an evidence-based approach to public health alongside and evidence-based approach to healthcare
- PHE offers a potential opportunity to draw together the existing complex information, intelligence and surveillance functions performed by multiple organisations into a more coherent form and to make evidence more easily accessible

- The national Institute of health Research (NIHR) will continue to take responsibility for the commissioning of public health research on behalf of the DH
- The DH will establish an NIHR School for Public Health Research to conduct high-quality research to increase the evidence base for public health practice
- The DH will draw together existing public health intelligence and information functions; Public Health Observatories, cancer registries and parts of the HPA, working to eliminate gaps and overlaps

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?

Note to consider:

- There will be a wide range of public health staff working with Public Health England, who will be employed by the Department of Health (DH), along with the range of public health staff following the transition to local authorities. The Government intends to publish a detailed workforce strategy by autumn 2011 which will provide further details of these staff members.
- The DH is also publishing a review by Dr Gabriel Scally of the regulation of public health professionals. The government believes that 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. There will however be a range of professionals such as the Director of Public Health and other clinical professionals who will continue to be regulated.

Concerns were raised at the previous Panel around the potential self-regulation of alternative therapists, such as homoeopathists and reflexologists which will be included in the final consultation response.

8. Finance

There are no direct financial implications to this report.

9. Risks and Uncertainties

Further clarity on the proposals will be provided following the consultation process, which ends 31 March 2011.

10 Policy and Performance Agenda Implications

Public health will transfer to local authority responsibility as of 2013, when the Director of Public Health will be employed by the council.

RMBC will need to consider the future shape of the public health workforce following this transition period.

11 Background Papers and Consultation

Healthy Lives, Healthy People: strategy for public health in England (2010)

Healthy Lives, Healthy People: Transparency in outcomes consultation document

Healthy Lives, Healthy People: consultation on the funding and commissioning roites for public health

12 Contact

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Table A Funding and Commissioning

Question	(Draft) Response
1. Is the health and wellbeing board the right place to bring together ring-fenced public health and other budgets?	To an extent. The difficulty with ring fenced budgets (e.g. community care) is that they are targeted and this can limit the flexibility with which spending can be allocated. The Health and Wellbeing Board will give an opportunity to look at ring fenced budgets in the context of the wider community strategy which will enable a more strategic approach to developing preventative measures which will in turn mean that we can focus on maximising budgets
2. What mechanisms would best enable local authorities to utilise voluntary and independent sector capacity to support health improvement plans? What can be done to ensure the widest possible range of providers are supported to play a full part in providing health and wellbeing services and minimise barriers to such involvement?	• Publish a clear plan (Health and Wellbeing Strategy) that indicates the direction of travel (based on need identified in JSNA , other health inequalities and the vision for Rotherham) • Evaluate current procurement / contracting procedures to ensure that they do not disadvantage small providers, voluntary sector etc through being too bureaucratic or procedure driven so that we develop a wider range of providers • Effective communication between Assessment staff and commissioners, to support the micro-commissioning or person centred commissioning of services is also vital • Grant fund on an outcomes basis to promote prevention Best practice example - A multi disciplinary approach to road safety exists in South Yorkshire (The South Yorkshire Safer Roads Partnership) to direct and co-ordinate the activities of a range of providers, including those from the voluntary and independent sector. In view of its success it is proposed to continue with this approach.
3. How can we best ensure that NHS commissioning is underpinned by the necessary public health advice?	A robust and regularly updated JSNA Expectation on the Director of Public Health to deliver information and advice that can be acted on in relation to commissioning of services In terms of road safety and sustainable / healthy travel this can be achieved by running adequately funded and resourced education,

	training and publicity campaigns. Such campaigns should be multi agency funded.
4. Is there a case for Public Health England to have greater flexibility in future on commissioning services currently provided through the GP contract, and if so how might this be achieved?	While identification and commissioning of specific treatments can be done by GP's as can preventative interventions such as screening and vaccination programmes, many public health problems have social routes. Area Assemblies along with strategic developments across housing, education and economic development will have just as important an impact as direct provision from the NHS. Local Strategic Partnership and Adult Boards would be best placed to take this overview of strategic commissioning and Market Management.
5. Are there any additional positive or negative impacts of our proposals that are not described in the equality impact assessment and that we should take account of when developing the policy?	The economic outlook and particularly employment situation has become less secure since the document was originally written. An increase in long term unemployment and a slow recovery in employment rates will have major implications for long term health and financial dependency levels for many years to come.
6. Do you agree that the public health budget should be responsible for funding the remaining functions and services in the areas listed in the second column of Table A (pg 16)?	Yes Reductions in capital (Local Transport Plan) and revenue funding have reduced the amount and scope of road safety initiatives that can be carried out. If additional funding via the public health budget can be secured for road safety related work it will enable the good progress in reducing the number of people killed and seriously injured in road accidents over the last 10 years to be maintained. Similarly, funding for sustainable and healthy transport has been reduced however, bids to the Local Sustainable Transport Fund may recoup some of the loss. To compile a successful bid, some evidence of match funding is required and a proportion of the public health budget ought to be earmarked for that purpose.

7. Do you consider the proposed primary routes for commissioning of public health funded activity (the third column) to be the best way to: a) ensure the best possible outcomes for the population as a whole, including the most vulnerable; and b) reduce avoidable inequalities in health between population groups and communities? If not, what would work better?	It is unclear why the Children's health (0-5) has a different commissioning route to the Children's health (5-18)
8. Which services should be mandatory for local authorities to provide or commission?	Health Protection and Resilience. Tackling the wider determinants of health: In particular encouraging neighbourhood renewal and economic wellbeing are important functions for local authorities. The single conversation has gone a long way towards encouraging local authorities to take a holistic view of how the local infrastructure works to contribute to wellbeing. Tackling poverty and worklessness must be at the heart of addressing health inequality and this needs a strategic approach which local authorities are well placed to take. Road safety – under the 1988 Road Traffic Act there is a requirement for local authorities to prepare and promote a programme of measures to promote road safety. The Education and Inspections Act places a duty of local authorities to promote sustainable school travel (cycling and walking). Much of what the public health initiative wants to achieve will probably only be realised by educating children from an early age.
9. Which essential conditions should be placed on the grant to ensure the successful transition of responsibility for public health to local authorities?	Comprehensive, agreed, inter-agency plans for a proportionate response to public health incidents are in place and assured to an agreed standard. These are audited and assured and are tested regularly to ensure effectiveness. Systems failures identified through testing or through response to real incidents are identified and improvements implemented. Systems in place to ensure effective and adequate surveillance of health protection risks and hazards

10. Which approaches to developing an allocation formula should we ask ACRA to consider?	
11. Which approach should we take to pace-of-change?	
12. Who should be represented in the group developing the formula?	
13. Which factors do we need to consider when considering how to apply premium?	The extent to which we have achieved the targets set out in action plans
14. How should we design the health premium to ensure that it incentivises reductions in inequalities?	Sustaining long term employment, prevention, screening, vaccination and addressing child poverty will provide the best foundation for reducing inequalities in the long term. It is also relatively easy to identify performance indicators that can monitor progress on these areas. In terms of KSIs it is suggested that the rate of reduction in disadvantaged areas compared to the borough as a whole should be used. Alternatively, or in addition, the rate of reduction in the different categories of vulnerable road user groups could be compared to the overall rate of reduction.
15. Would linking access to growth in health improvement budgets to progress on elements of the Public Health Outcomes Framework provide an effective incentive mechanism?	Yes, this would encourage better performance however, it might worsen progress on key outcomes that prove more difficult to achieve.
16. What are the key issues the group developing the formula will need to consider?	Should look at local demographic profiles (super output areas) to identify how far behind an area is against the benchmark and the issues that are a priority for remedial action. A funding formula could then be built around this

Table B Outcomes Framework

Question	(Draft) Response
1. How can we ensure that the Outcomes Framework enables local partnerships to work together on health and wellbeing priorities, and does not act as a barrier?	• Consistent approach taken across all three Outcome Frameworks • Flexibility in how outcomes can be achieved • Reduction in bureaucracy • Staff engagement and Partnership Working. • Need clear agreements with partners in health.
2. Do you feel these are the right criteria to use in determining indicators for public health? • Are there evidence-based interventions to support this indicator? • Does this indicator reflect a major cause of premature mortality or avoidable death? • By improving on this indicator, can you help reduce inequalities in health? • Will this indicator be meaningful to the broader public health workforce and wider public? • Is this indicator likely to have a negative/adverse impact on defined groups? • Is it possible to set measures, SMART objectives against the indicator to monitor progress in both the short and medium term? • Are there existing systems to collect the data required to monitor this indicator?	Generally yes however some of the indicators are more objective and easy to measure than others. Information regarding the incidence of premature death can be based on defined criteria and can be easily measured and compared to other areas. The main causes of premature death have also been identified. Helping people recover from episodes of ill health can also be measured and judged on the extent to which and the time taken for them to regain independence. Again inequalities in these areas are easily identified and thus it should in theory be possible to identify remedial action. The other three domains are more subjective and harder to measure. Measuring people's satisfaction can be time consuming and may not always pick everything up. Quality of life indicators are also hard to define. At worst the indicator would have no effect on health inequalities and for the area of premature death and recovery, it has the potential to be a positive influence Comments in relation to road safety: • A programme of road safety and transport interventions is already in place with well established evidence bases to support the effectiveness of a range of initiatives. • Yes, road accidents are a major cause of death, especially among the 17 -24 year old age group who are over

	represented in road collision statistics. Lack of physical activity is identified in the white paper as a key reason for premature mortality. • By reducing the number of people killed and seriously injured (KSI) in road accidents, particularly in disadvantaged areas and among vulnerable road user groups, health inequalities can be reduced. An increase in the number of people walking or cycling will reduce mortality rates associated with obesity, stroke and heart disease. Fewer car trips generally will have a positive impact on road safety, health and wellbeing and air quality. • This indicator is easy to understand and meaningful as road safety issues affect most people to a greater or lesser degree. • Reducing the number of people killed and seriously injured should not have a negative/adverse impact on defined groups. • Well established monitoring arrangements are already in place to monitor progress with reducing KSIs (NI47) • Road accident data is supplied by South Yorkshire Police and kept by the council on a software package called 'Accsmap'. Regular counts and other face to face surveys adequately monitor sustainable travel modal split.
3. How can we ensure that the Outcomes Framework and the health premium are designed to ensure they contribute fully to health inequality reduction and advancing equality?	The outcome framework focuses on NHS provided services while recognising areas of overlap (particularly with Adult Social Care). However much health inequality is due to social deprivation and unhealthy lifestyles in early life. It is therefore important to ensure locally all strategic aims are aligned to ensure the most potential health gain will be wherever possible from those who experience the most inequality. In terms of road safety, the health premium should be linked to the rate of KSI reduction in disadvantaged areas (there is strong evidence that members of poorer communities are more likely to become road accident casualties than their better-off peers) compared with the borough as a whole. For sustainable and healthy travel the premium should be linked to the numbers of children and adults adopting better travel habits.

4. Is this the right approach to alignment across the NHS, Adult Social Care and Public Health frameworks? • Diagram on pg 14 showing how 3 frameworks sit together	A good quality JSNA is at the centre of the alignment and this is the right approach. The main weakness with the approach is it does not explicitly link in with wider areas of public policy. To promote prevention and early engagement resources not ring fenced to Social Care or health will need to be released. This is crucial to the prevention and early engagement agendas.
5. Do you agree with the overall framework and domains? • *Health protection and resilience* • *Tackling the wider determinants of health* • *Health improvement* • *Prevention of ill health* • *Healthy life expectancy and preventable mortality*	Agree in principle with these 5 domains. **Domain 2** in particular Addressing issues such as Child poverty fits in with comments earlier regarding fitting in with wider community plans **Domains 3, 4 and 5** Have specific and measurable objectives.
6. Have we missed out any indicators that you think we should include?	None that seem obvious
7. We have stated in this document that we need to arrive at a smaller set of indicators than we have had previously. Which would you rank as the most important?	• D 2.1 Children in Poverty • D 1.4 Population Vaccination • D 1. 6 Public sector organisations with board approved sustainable development management plan. • D 2.9 People in long term unemployment • D2.8 Proportion of people with mental illness *and or disability* in employment • D2.10 Employment of people with long-term conditions • D 2.3 Housing overcrowding rates. • D2.13 Fuel Poverty • D 2.17 Older Peoples perception of community safety • D 2.16 Environmental noise • D 3.8 Under 18 conception rate • D 3.6 and 4.1 Injuries to people aged 5 to 18 and 1 -5 • D 3.3 Smoking Prevalence • D 4.3 and 4.4 Prevalence of Breast feeding and low birth weight

	• D 4.7 Screening uptake • D 4.8 Chlamydia diagnosis rates per 100,000 young adults aged 15-24 • D 4.9 Proportion of persons presenting with HIV at a late stage of • Infection • D 4.11 Maternal smoking prevalence • D 4.13 Emergency readmission rate to hospital • D 4.15 Acute admission due to falls • D 5.1 Infant mortality • D 5.4 Mortality From cardiovascular diseases of people under the age of 75 • D 5.5 Mortality From cancer of people under the age of 75 • D5.9 Excess seasonal mortality
8. Are there indicators here that you think we should not include?	Some for example deaths from communicable diseases and deaths from respiratory diseases could be absorbed into excess seasonal deaths. **Suggested indicators to be taken out:** • D4.14 Health related quality of life for older people (placeholder) could be taken out as it rather subjective • D 4.6 Work sickness absence rate is a wide ranging issue and possibly too big for this agenda • D 4.5 Prevalence of recorded diabetes. Not clear why we need to know this • D 310 Self reported wellbeing is too subjective and gain from info gained probably doesn't justify the effort to obtain the information
9. How can we improve indicators we have proposed here?	Set benchmarks on which success will be judged In terms of the road safety KSI indicator this could be broken down into indicators for the number of people killed and the number seriously injured so that it is in line with indicators likely to be used in the government's new road strategy.

10. Which indicators do you think we should incentivise? (consultation on this will be through the accompanying consultation on public health finance and systems)	**D2.13** Fuel Poverty (To address this investment is needed in short term. However long term benefits in terms of health and economic wellbeing over a 5 to 10 year period will be significant) **D 2.9** People in long term unemployment (The negative effects of this are immense. It has a negative effect on health, economic regeneration and contributions to savings and pensions. This means higher dependency on means tested services in later life. Investment to encourage employers to create and sustain employment opportunities to see out the current difficult environment will have huge benefits over a 15 to 20 year period. **D 2.3** Housing overcrowding rates. While families are living in overcrowded housing due to affordability issues, many older people are living in larger houses. Incentives to build more suitable accommodation for older people with incentives to move could go a long way to addressing the acute shortage of suitable accommodation for families.
11. What do you think of the proposal to share a specific domain on preventable mortality between the NHS and Public Health Outcomes Frameworks?	This seems a sensible proposition. Preventable mortality requires interventions before health problems escalate as well as good quality acute care when crisis point is reached.
12. How well do the indicators promote a life-course approach to public health?	The inclusion of a large number of indicators covering outcomes for children suggests that a whole life approach is being taken

Winter Planning

Analysis of Winter Pressures 2010/11

(Including WIC performance)

February 2011

1. Introduction

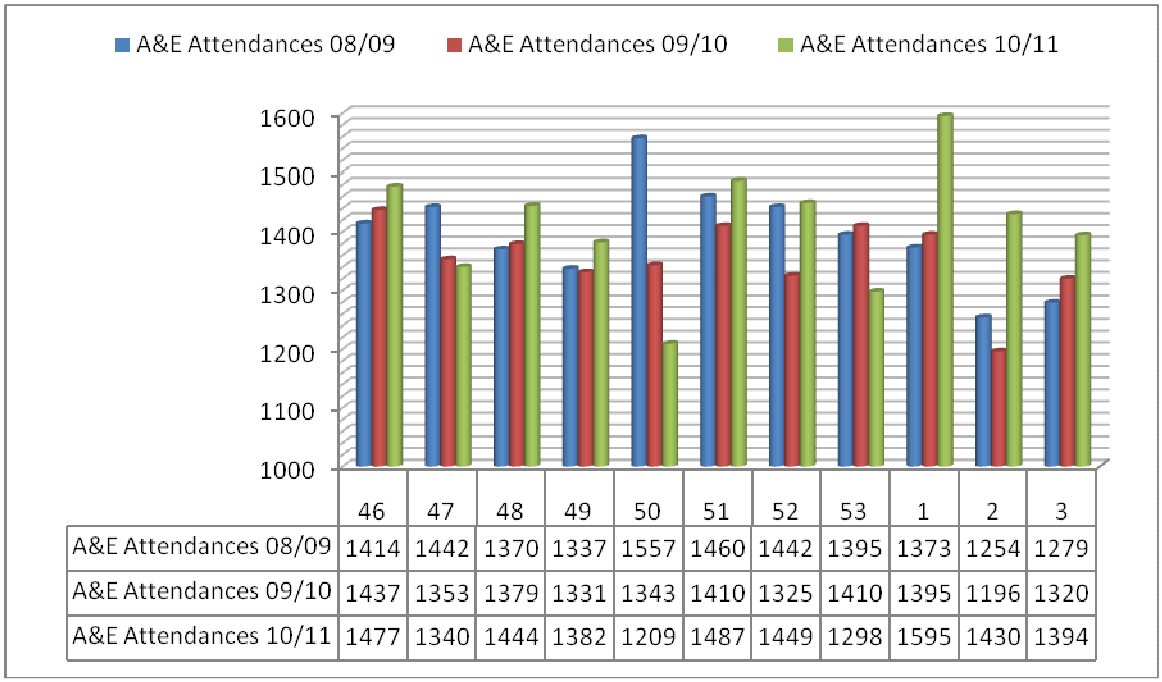
This report provides an analysis of winter pressures for 2010-11. It analyses demand for local health services between the period 5th December 2010 and 16th January 2011. The report focuses on activity at Accident & Emergency, Acute Care, GP admissions and the GP Out of Hours service. It also provides a summary of mitigation activity that took place during periods of peak demand. Finally the report sets out recommendations for future work which will assist in preparing for incidents of surge or severe weather.

This winter has presented the local health community with specific challenges. There was a severe weather event at the beginning of December when heavy snow affected the borough. This was followed by a busy bank holiday period, a significant outbreak of the swine flu virus and a follow-on outbreak of the norovirus at the hospital. Despite these pressures there was limited disruption of services. GP Practices in particular provided significant support during the periods of high demand and disruption. All service providers went to great lengths to remain open through the snow and ice and then maintained services during a busy holiday period.

2. Rotherham FT: Accident & Emergency

Figure 1 shows the A&E activity for the period 5.12.10 to 16.1.11 during the last 3 years. The activity data shows higher levels of demand for 8 weeks out of 11. There was a significant spike in activity throughout tye first half of January. This coincides with the period during which the surge plan was at active stage.

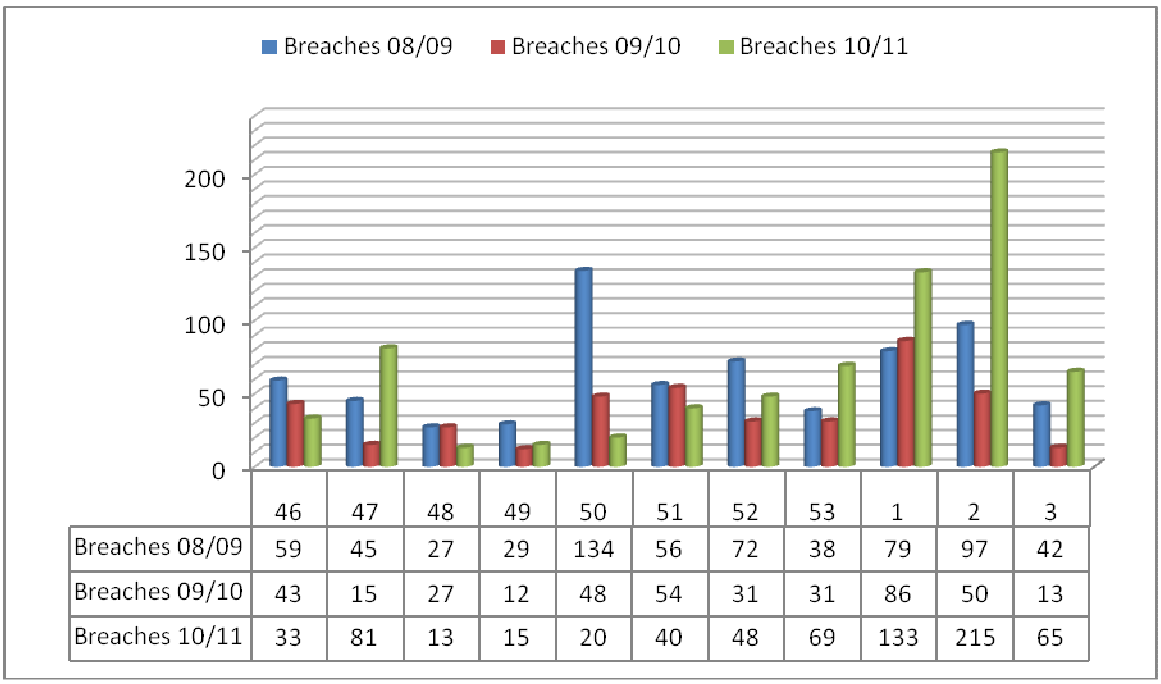
Figure 1: A&E activity



	46	47	48	49	50	51	52	53	1	2	3
A&E Attendances 08/09	1414	1442	1370	1337	1557	1460	1442	1395	1373	1254	1279
A&E Attendances 09/10	1437	1353	1379	1331	1343	1410	1325	1410	1395	1196	1320
A&E Attendances 10/11	1477	1340	1444	1382	1209	1487	1449	1298	1595	1430	1394

Figure 2 shows how performance was affected during periods of peak activity. There has been a significant increase in waiting time breaches compared to previous years. There was an increase in breaches in 5 of the 11 weeks activity covered. Again the first half of January showed a significant increase. Over a 40 day period from 1st December 67% breached the 98% contractual target. There was a 42% breach of the 95% national target.

Figure 2: A&E performance from 5.12.10 to 16.1.11



	46	47	48	49	50	51	52	53	1	2	3
Breaches 08/09	59	45	27	29	134	56	72	38	79	97	42
Breaches 09/10	43	15	27	12	48	54	31	31	86	50	13
Breaches 10/11	33	81	13	15	20	40	48	69	133	215	65

Table 1 and 2 show the total number of attendances at A&E for Quarter 3 split by referral source and disposal.

Table 1: A&E attendances split by referral source

	Self Referral	Emergency Service	GP	Other	Total
Number	2775	1035	92	442	4344
Percentage	64%	24%	2%	10%	

Table 2: A&E attendances split by disposal

	No follow up	GP follow up	Admitted	Fracture clinic	Other	Total
Number	1477	1009	833	315	710	4344
Percentage	34%	23%	19%	7%	17%	

Table 1 shows that a large proportion of attendances were self referrals. There has been concern that the OOH GP service might be diverting people to A&E inappropriately but there is no evidence from this table.

From Table 2 it can be seen that 57% of A&E attendances either received no follow up or were referred to their GP. This is the cohort that could have been diverted to the Walk In Centre. Over the whole quarter admission rates from A&E were at normal levels. However this data does not include January activity. Admission rates significantly increased during the first half of this month.

Tables 3 and 4 show the outlying practices for A&E attendances during Q3 ranked by total attendances and attendances per 1000 patients.

Table 3: Outlying GP Practices – Q3 Total Attendances

GP Practice	Total attendances	Wieghted population	Attendance/1000
St. Anns	394	17385	22.7
Clifton	269	13082	20.6
Woodstock Bower	259	11572	22.4
Broom Lane	246	12555	19.6
Morthern Road	218	11103	19.6
Swallownest	205	15974	12.8
Stag	199	11294	17.6

Table 4: Outlying GP Practices – Q3 Attendance/1000 population

GP Practice	Total attendances	Weighted population	Attendance/1000
Chantry Bridge	19	471	40.3
Canklow Road RCHS	47	1660	28.3
Surgery of Light	38	1475	25.8
Badsley Moor Lane	61	2478	24.6
The Gate RCHS	36	1503	24.0
Dalton	48	2051	23.4

GP Practices with the largest volume of A&E attendances tended tobe the largest Practices.

3. Rotherham FT: GP Admission Data

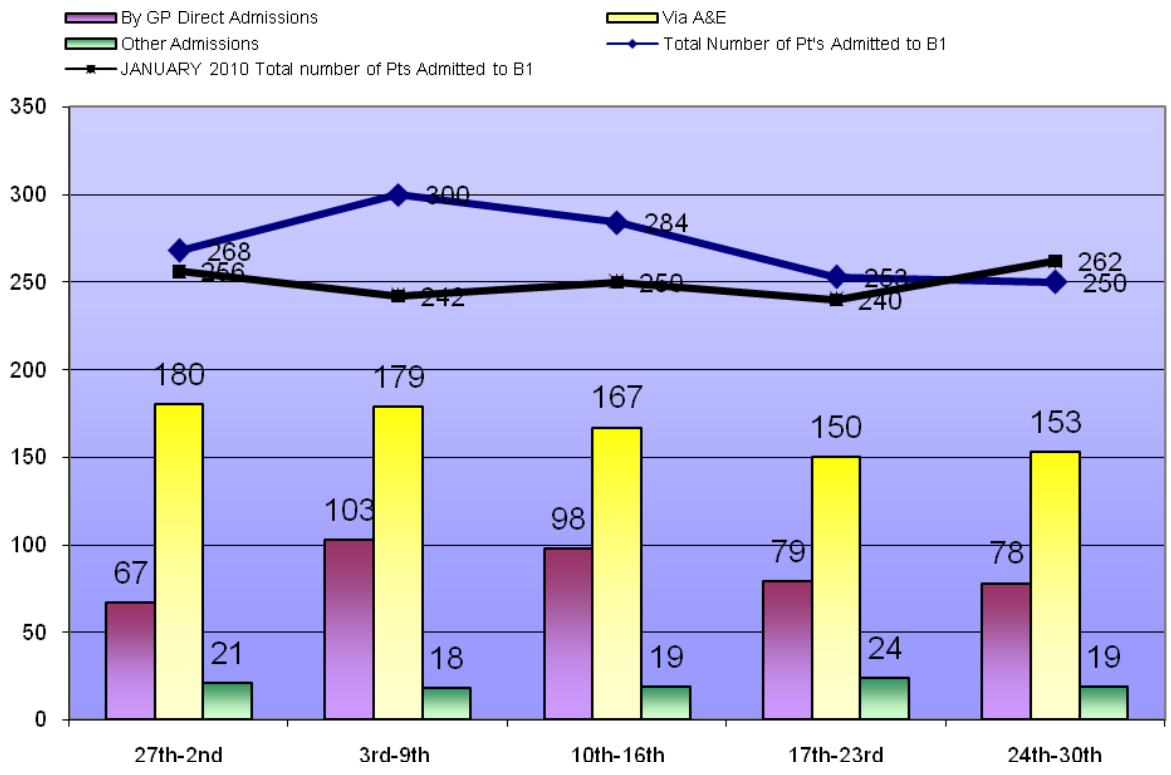
GP services were subject to unprecedented pressure as a result of severe weather in December. GP practices went to great lengths to remain open through the snow and ice. They were able to have maintained services during a busy holiday period and continued to deliver services in a hostile environment.

There is evidence that GP initiated hospital admissions increased during the surge period. NHS Rotherham issued the following advice to GP Practices at the time.

Figure 3 shows the referral rates for B1 during early January. GP referrals to B1 increased by 54% during the week that the Surge Plan was initiated. It remained at this level for the rest of the surge period. The impact of communications to GPs during this time appears to have been limited. GP referrals increased dramatically despite advice from NHS Rotherham to take the following measures;

- Where possible patients should be managed at home
- Do not to refer to A&E or the Emergency Admissions Unit unless a face to face clinical assessment is carried out first
- Where possible seek advice from A&E or the appropriate medical/surgical specialist before referring a patient to hospital

Figure 3: B1 Admission Data



4. Rotherham FT: Acute Care

The bed status at Rotherham FT during the Christmas period was good. There was bed availability throughout the Bank Holiday weekend and A&E activity was lower than previous years. However there were significant bed pressures after the New Year.

Throughout the surge period the hospital was operating 50 extra beds above its baseline.The hospital is also managing an outbreak of D&V and a high incidence of swine flu cases, with areas being cordoned off to contain infection. There were approximately 13 confirmed cases swine flu, several of which remain hospital and there are a number of patients who have suspected norovirus

Rotherham FT was running with 50 extra beds throughout the first half of January. Electives were cancelled for at least 3 days. Most of the extra demand for beds was coming through A&E. There was a significant increase in attendances and a greater proportion of these patients were being admitted. Admissions were running at 22% to 26% during the first two weeks of January. This compares to 19% overall for Q3. There was substantial pressure on critical care beds with bed availability down to zero during peak demand periods. The main reasons for the pressure on beds were

- Increased levels of swine flu which were feeding through to the hospital
- Increased levels of Norovirus which had an impact on some wards

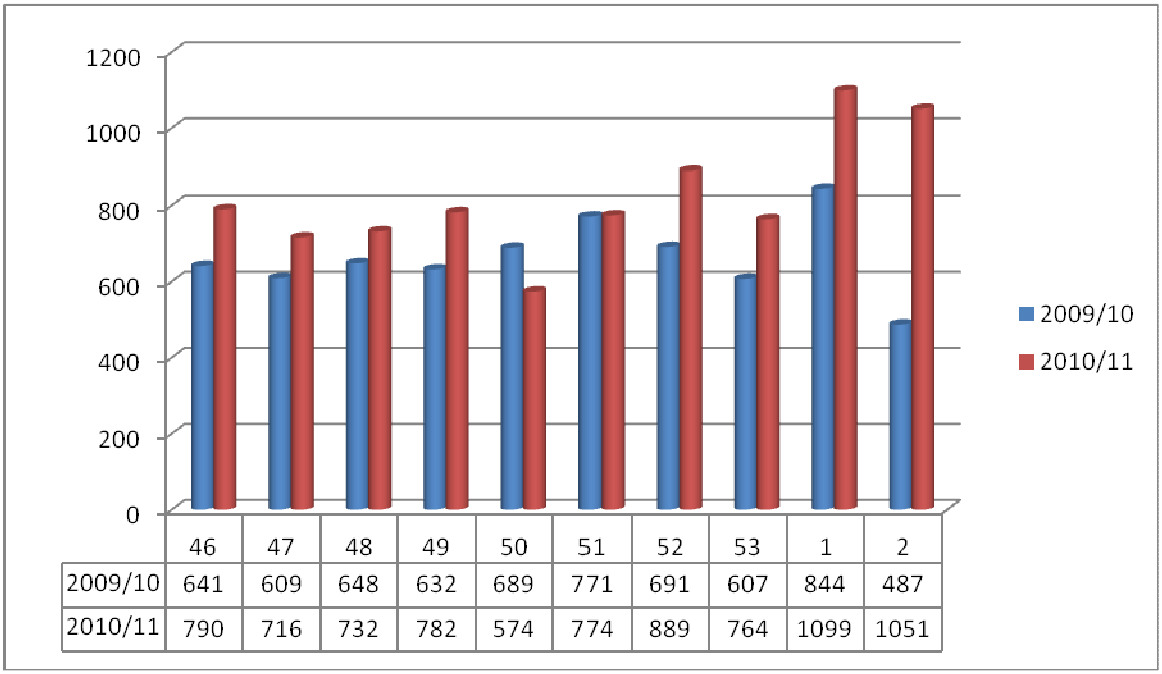
Despite being under extreme pressure at times Rotherham FT only diverted patients on 2 occasions.

5. Walk in Centre

There were significant issues with the Walk in Centre during the Christmas and New Year period. The Centre had to close on 7 occasions during the Christmas and New Year period because of spikes in demand. Figure 3 shows the levels of activity compared to 2009/10.

The activity levels for the Walk in Centre reflect those for A&E. There was a 23% increase in activity over the whole period. From Week 52 to week 2 there was a 45% increase in demand compared to the previous year. The spike in demand during early January reflects the situation at A&E. It is unclear why there was such an increase in demand during the Christmas period.

Figure 3: WIC Activity 2009/10, 2010/11



	46	47	48	49	50	51	52	53	1	2
2009/10	641	609	648	632	689	771	691	607	844	487
2010/11	790	716	732	782	574	774	889	764	1099	1051

Details of closures at the WIC are set out below (closed indicates the service was close to new registrations).

Week 51: 18 Dec – closed 6:40pm(171 pts seen) last pt registered 8.50pm
Week 52: 20 Dec – closed 7:45pm to 8:50pm (150 pts seen)
Week 53: 27 Dec – closed 12:15pm to 1:25pm (241 pts seen) 28 Dec – closed 2:35pm to 4.00pm (194 pts seen) 30 Dec – closed 5:55pm to 6:35pm (148 pts seen)
Week 1 6 Jan – last person registered 8:00pm (147 pts seen) 8 Jan – last person registered 6:40pm (145 pts seen)

Reasons for closure were:

- Volume of patients in the waiting room.
- Volume of patients registering within close timescales.
- Backlog of patients.
- Health and Safety issue around amount of people in the building and the space of waiting room.

NHS Rotherham worked with Care UK to reduce the incidence of closure. Care UK revised the advice /options given to patients when they arrived at the Centre. Patients were where appropriate advised to ring their own GP visit their GP the following day. Patients were also given a leaflet regarding minor ailments that could be dealt with at a pharmacy.

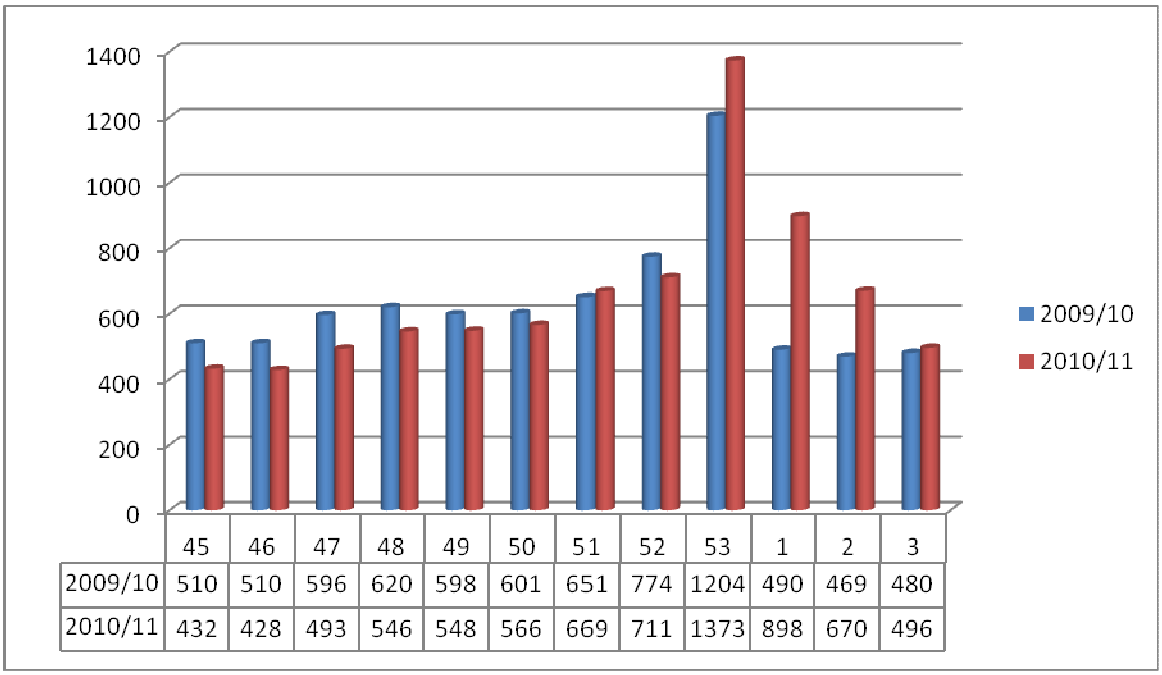
All patients that were not registered to be seen were spoken to by a nurse to assess their medical need as it appeared at the time. Most attendances were with cold and flu symptoms. Care UK also staffed the WIC until 10.00pm so that it could clear backlogs after 9.00pm. Additional doctors were drafted in to provide extra capacity, although this was restricted by the number of consultation rooms available.

Concerns highlighted by Care UK were a high number of patients being diverted to the service by NHS Direct and issues with patient attending the WIC without apparently contacting their own GP first.

6. Out of hours GP Service

There is a similar demand pattern for the GP Out of hours Service, with significant increases occurring in early January. Figure 4 shows the level of activity compared to 2009/10. Over the Christmas period there was a reduction in OOH activity compared to last year. There was a 43% increase in OOH activity from week 53 to 3. This is consistent with the demand profile for A&E.

Figure 4: OOH Activity - 2009/10 2010/11



	45	46	47	48	49	50	51	52	53	1	2	3
2009/10	510	510	596	620	598	601	651	774	1204	490	469	480
2010/11	432	428	493	546	548	566	669	711	1373	898	670	496

7. Mitigation Activity

The period of heaviest demand for the Rotherham health community was during the first two weeks of January. There was unprecedented pressure on A&E, the Walk in Centre and GP Out of Hours Service. The main cause of this pressure appears to be a surge in swine flu cases during a bank holiday period.

NHS Rotherham worked closely with all stakeholders during this period to mitigate the impact of increased demand. The following activities assisted in ensuring that the local health community worked effectively together.

Initiation of Surge Plan

The Director of Public Health initiated the NHS Rotherham Surge Plan on 5th January. The plan supports health care organisations to manage significant increase in demand in the event of a surge. The plan is invoked when:

- A service is so severely affected that it is unable to maintain its key functions without support from other service areas.
- The business interruption has affected more than one service and has potential to severely affect the overall key functions of the local health and social care community.

Initiation of The Surge Plan enabled the following actions to be taken;

- It immediately reduced the threshold for admission to intermediate care, facilitating the discharge of patients who are medically fit but unsafe to return home
- It triggered interventions by RCHS to support to the hospital on expediting discharge
- It placed the Continuing Care Team on standby to carry out fast track social care assessments for patients waiting discharge
- It triggered the delivery of extra support from Rotherham MBC to fast track social care assessments, place patients in respite and initiate home care packages

Initiating The Surge Plan did assist Rotherham FT on hospital discharges. Rotherham MBC did raise concern that the Surge Plan had not gone through proper approvals in the Council. Despite there was full co-operation from all of the local authorities support services.

Emergency Bed Management Meetings

Throughout the first two weeks of January Rotherham FT co-ordinated multi-agency bed management meetings. These provided an update of the current bed status, specifically relating to critical care, paediatrics and A&E. The main aims of the meeting were to;

- Ensure there was significant capacity in intermediate care and Breathing Space
- Enlist the support of community health services on supporting secondary care
- Anticipate future pressures on the system such as staff sickness and hospital infections

- Identify patients who were fit for discharge and reasons for delays

These meetings provided a useful interface between service providers. There was good sharing of information and a breaking down of organisational boundaries. This multi-agency team was effective at ensuring that the hospital remained operational.

Daily teleconferences

NHS Rotherham co-ordinated daily teleconferences which brought together key stakeholders in the local health community. The main aims of the teleconferences were to;

- Inform stakeholders where there were pressures in the system
- Enlist community services support on maintaining secondary care services
- Ensure that community services focused on preventing hospital admissions

These conferences had a wider representation than the Emergency Bed Management meetings. They provided a useful source of information and helped commissioners to identify where support was required.

Local Sitrep Reports

As well as the regional Sitrep reports MHS Rotherham produced local daily reports for the Rotherham Health Community. This included information on;

- Bed availability for RFT, Breathing Space and Intermediate Care
- Any staffing issues within service
- Daily activity figures for A&E, YAS, WIC and OOH

8. Future Work

The LMC Liaison Group has suggested that commissioners consider three scenarios which will help address some of the lessons from the recent snow and Christmas surge pressures. For each of these scenarios we have considered what NHS Rotherham will do and how it will be communicated.

Scenario 1: Situation where there is disruption to primary care delivery eg snow

NHS Rotherham will ensure that GP Practices have in place Business Continuity Plans which are responsive to severe weather disruption. We will, through Clinical Governance visits and the Annual Contract review process check whether plans are in place. Where Practices are concerned that their Business Continuity Plans are not robust NHS Rotherham can offer individual advice and guidance.

NHS Rotherham will develop a “Situation Report” template for GPs. It is proposed that , rather than phone round GPs during periods when primary care delivery is disrupted, NHS Rotherham will

request Situation Reports from each Practice by email. These reports will be collated at a dedicated post box with a named officer identified to pick up and analyse data.

NHS Rotherham will continue to issue communications during periods of disruption. We will issue local daily Sitrep reports and early notification of potential weather events.

NHS Rotherham will also carry out the following activities during the next few months in preparation for future severe weather events;

- Ensure that all managers have a complete list of staff details including phone numbers
- Develop an internet page which staff can access during severe weather
- Establish a list of organisations who can provide 4x4 vehicles
- Establish a list of sites that need roads outside their premises clearing and gritting by RMBC
- Ensure additional key holders are identified for Oak house
- Develop a clear procedure for access to controlled drugs

Scenario 2: Surge affecting the system eg flu where primary care capacity may not be affected

During periods of surge NHS Rotherham is able to initiate the Emergency Plan and/or The Surge Plan.

The Emergency Plan is triggered when any occurrence that presents serious threat to the health of the community, disruption to the service or causes (or is likely to cause) such numbers or types of casualties as to require special arrangements to be implemented by hospitals, ambulance trusts or primary care organisations. The Emergency Plan sets out command and control arrangements. It identifies the lines of accountability, responsibilities of partner organisations and potential actions.

The Surge Plan is intended to support Health Care Organisations to manage significant increase in demand in the event of a surge. Each Health and Social Care Organisation should already have well developed business continuity plans which deal with surge. The NHS Rotherham Surge Plan sets out how the local health community can manage demand, the responsibilities of individual organisations and how they can best work together.

To be able to monitor the impact across primary care there is a FluCon reporting system that could be adopted for other events. This monitors capacity and demand across Rotherham GP Practices, Pharmacies, Walk in Centre and Out of Hours Services. For familiarity across partners the report will continue to be called FluCon but will be reporting on any other outbreaks or incidents that result in a significant surge in workload.

Practices have organised 'buddy' arrangements that enable them to offer cover and support across practices. Where possible GPs will primarily provide cover in their buddy groups. However there may be occasions where a GP supports a practice outside of these arrangements due to exceptional surge in a particular area. On triggering the Surge Plan NHS Rotherham will nominate an officer responsible for setting up buddy arrangements with alternative practices. If effective buddy arrangements are not in place or if all practices within a buddy network are affected by the surge then NHS Rotherham will co-ordinate an alternative buddy arrangement.

NHS Rotherham holds an up to date GP locum list. These locum GPs can be called upon to provide additional support to primary care.

To support the RAID process practices will be notified of patients that undergo accelerated discharge from hospital. Practices are advised to flag these patients, so in the event that if the patient contacts them within 72hrs of discharge they are triaged as a priority by a doctor.

Scenario 3: Strategy to cover two consecutive 4 day bank holidays over Easter

The current arrangements for providing cover during bank holiday periods are adequate for most local health organisations. Commissioners have considered strategies for ensuring that the Walk in Centre is able to remain open throughout the bank holiday period. The following measures have been put in place to ensure service continuity;

- The WIC will operate an appointments system during periods of high demand. This will enable the Centre to manage patient flow and improve patient experience
- Work with the WIC to increase patient flow by more effective use of triage and shorter GP appointment times.
- Care UK are already meeting with managers and IT/business managers to review the holiday period and plan for the Bank Holiday periods in April 2011.
- Care UK has also recently sent out a mail-drop to patients to explain the role and function of the WIC to try and address public education about appropriate use of the service.

NHS Rotherham has considered commissioning a GP Practice in the town centre and one in the south of the borough to run surgeries during the bank holidays. The town centre GP Practice would have acted as an overspill for the WIC. The GP Practice in the south of the county would have been a referral point for patients who have been referred by the OOH service. However it is recommended that these options are not adopted for this bank holiday period. The measures put in place to control patient flow at the WIC are believed to be sufficient to ensure service continuity.

NHS Rotherham intends to conduct an exercise (Exercise Hornblower) under the Civil Contingencies Act 2004. This which will ensure that each Directorate can contact its commissioning staff. It will test new staffing structure contact details and consolidate the lessons learned from the severe weather incident in Nov/Dec 2010.

ADULT SERVICES AND HEALTH SCRUTINY PANEL
10th February, 2011

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

Also in attendance were Jim Richardson (Aston cum Aughton Parish Council), Russell Wells (National Autistic Society), Mrs. A. Clough (ROPES), Victoria Farnsworth (Speak Up) and Mr P Scholey (UNISON).

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

Apologies for absence were received from Councillors Goulty, Middleton and Evans.

75. DECLARATIONS OF INTEREST

No declarations of interest were made at the meeting.

76. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

There were no members of the press and public present at the meeting.

77. UPDATE ON ASSISTIVE TECHNOLOGY REVIEW

Further to Minute No. 40 of 7th October, 2011, the Policy and Scrutiny Officer, reported on the considerable amount of work that had been undertaken on the findings and recommendations from the Scrutiny Review.

Following consultation with Adult Services, it was understood that further developments had taken place in relation to the Review's recommendations. It was, therefore, proposed that a further report be submitted to the Panel's March meeting setting out details of what work had taken place and to approve the final Scrutiny Review report.

Resolved:- That a further report be submitted to this Panel's March meeting.

78. 2011 HEALTH AND SOCIAL CARE BILL - SUMMARY

The Policy and Scrutiny Officer reported on the Health and Social Care Bill, introduced into Parliament on 19th January, 2011. The Bill took forward the areas of Equity and Excellence: Liberating the NHS (July 2010) and the subsequent Government response Liberating the NHS: Legislative Framework and Next Steps (December 2010) which required primary Legislation.

It was part of the Government's vision to modernise the NHS so that it was built around patients, led by health professionals and focussed on delivering world class healthcare outcomes. It also included provision to strengthen public health services and reform the Department's arms length bodies.

The Bill contained provisions covering 5 themes:-

- Strengthening commissioning of NHS services
- Increasing democratic accountability and public voice
- Liberating provision of NHS services
- Strengthening public health services
- Reforming health and care arms length bodies

The report also set out a summary of the bill proposals listed by Section:-

Section 8	Duties as to improvement of Public Health
Section 13	Other services etc. provided as part of the Health Service
Section 14	Regulations as to the exercise by local authorities of certain Public Health functions
Section 18	Exercise of Public Health Functions of the Secretary of State
Section 19	The NHS Commissioning Board: further provision
Section 22	Commissioning Consortia: general duties etc.
Section 25	Other Health Service functions of local authorities under the 2006 Act
Section 26	Appointment of Directors of Public Health
Section 27	Exercise of Public Health functions of local authorities
Section 42	Charges in respect of certain Public Health functions
Section 50	Co-operation with bodies exercising functions in relation to Public Health
Section 167	Establishment and constitution
Section 170	Independent Advocacy Services
Section 176	Joint Strategic Needs Assessments
Section 177	Joint Health and Wellbeing Strategies
Section 178	Establishment of Health and Wellbeing Boards
Section 179	Duty to encourage integrated working
Section 180	Other functions of Health and Wellbeing Boards
Section 182	Discharge of functions of Health and Wellbeing Boards
Section 183	Supply of information to Health and wellbeing Boards
Section 190	Pharmaceutical Needs Assessments

From April, 2013, Public Health England would allocate ringfenced budgets, weighted for inequalities, to upper tier and unitary authorities in local government. Shadow allocations would be issued to local authorities in 2012/13 providing an opportunity for planning. Building on the baseline allocation, local authorities would receive an incentive payment, or 'health premium', that would depend on the progress made in improving the health of the local population and reducing health inequalities based on elements of the Public Health Outcomes Framework. The premium would be simple and driven by a formula developed with key partners, representatives of local government, public health experts and academics.

Discussion ensued on the report with the following issues raised/clarified by the Policy and Scrutiny Officer and Director of Public Health:-

- The Health and Wellbeing Board (HWB) would be set up by the local authority and would be a statutory board. There would be a minimum membership including 1 nominated Councillor, Director of Adult Social Services and Children Social Services, local Health Watch, representative from the GP Consortia and other members at the discretion of the local authority and Board members

- The Board would sit in a shadow form initially. A report was to be submitted to Cabinet shortly on how the Board may be constituted

- The Board would have to develop a Joint Strategic Needs Assessment

- Public Health would come into the local authority as their responsibility including the appointment of the Director of Public Health which would be a joint appointment by the local authority and the National body Public Health England

- The local authority would take on a number of functions which presently sat within the PCT including teenage public health, work with the Prison Service as well as pupils health within schools

- The local Health Watch would replace the existing LINKS partnership – details still unclear

- The Board would be responsible for bringing all the commissioning together and would look at all the commissioning plans across the different Services (Children Services, Adult Services, GP Consortia). The Services would have a duty to co-operate with the Board and must give regard to the Joint Strategic Needs Assessment as well as the Health and Wellbeing Strategy

- In the original consultation paper, "Liberating the NHS", there had been a suggestion that the HWB would take over the scrutiny role of health. Many authorities had argued that it did not make sense for the Boards to scrutinise themselves so there had been a u-turn although it was not absolutely clear as yet what the role of scrutiny would be

- It was extremely complicated and there was not a lot of detail as yet and needed working through as to what it meant locally. Essentially, the Government was to split off NHS provision from Health so the outcomes of health would be the responsibility of Public Health England and have a commissioning board responsible for health services through the GP Consortia. It was proposed to join that up at a local level by the Health and Wellbeing Board with responsibility to try and co-ordinate local health and social care and as well as the prevention of illness through Public Health. There would be some resources come to it but not sufficient

- The School Visiting and Health Visiting Service would initially be nationally commissioned through Public Health England. They would be handed over to a local level at some stage in the future

- There was a key role for Scrutiny in terms of scrutinising the governance arrangements within the GP Consortia locally and how they used public money to commission services on behalf of the Rotherham public

- Currently the PCTs were being clustered for 2 years to manage the process. Rotherham was being clustered with Sheffield, Doncaster, Barnsley and Bassetlaw. The responsibility for NHS Rotherham would pass to that South Yorkshire cluster

- Rotherham's GP Consortia had been set up and was Chaired by Dr. David Tooth

- It was hoped that staff from Public Health would transfer to the local authority and would come with some NHS funding. However, 45% of NHS funding would come from Public Health England not all of which would reach the Council. There would be a number of services that had to be commissioned, Sexual Health Services, Screening Services, Specialist Clinics etc., that would transfer either to the local authority or Public Health England

It was noted that the report was to be submitted to the Performance Scrutiny Overview Committee and Cabinet for consideration before a response to the consultation was submitted.

Resolved:- That the implications arising from the Health and Social Care Bill be noted.

79. HEALTHY LIVES, HEALTHY PEOPLE: PUBLIC HEALTH WHITE PAPER CONSULTATION

Further to Minute No. 62 of December, 2010, the Policy and Scrutiny Officer submitted the key proposals and consultation questions which the Government were seeking views on by 31st March, 2011.

The proposals included:-

- Establishing a new body – Public Health England – within the Department of Health to protect and improve the public's health
- Responsibility for Public Health would transfer to local Councils from 2013 Directors of Public Health would be jointly appointed by the local authority
- Public Health England and work within the local authority
- Establishing Health and Wellbeing Boards to decide upon local public health priorities
- Using a 'ladder of interventions' to determine what action needed to be taken to address different public health needs
- Funding for public health work would be ringfenced and areas with the poorest health would receive extra funding

- Commissioning of public health activity would be the responsibility of Public Health England through directly commissioning certain services directly, asking the NHS Commissioning Board to commission Public Health Services and the provision of the ringfenced budgets for public health to local authorities
- GPs, community pharmacies and dentists would be expected to play a bigger role in preventing ill health
- A new Outcomes Framework would be produced against which progress on key public health issues would be measured

A powerpoint presentation was given to help the Panel in their deliberations as follows:-

- Government was consulting on the Public Health White Paper
- Deadline for which was 31st March, 2011
- Follows consultation which has already taken place on the NHS White Paper – which RMBC responded to

- **3 parts to consultation:**
  - Consultation questions referring to main white paper
  - 2 supporting documents:
    - Commissioning and Funding for Public Health
    - New Public Health Outcomes Framework

- **Consultation Questions**
  - The Department. of Health would work to strengthen the Public Health role of GPs by:
    - Public Health England (PHE) and NHSCB to work together to encourage GPs in their Public Health role
    - Incentives and drivers for GP-led activity concerning Public Health
    - PHE to strengthen the focus of Public Health issues in the education and training of GPs

  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?

  - PHE will promote information-led PH interventions
  - PHE will draw together existing complex information and intelligence performed by multiple organisations into a coherent form for ease of access
  - The National Institute of Health Research will continue to take responsibility for PH research on behalf of DH

  Question b: What are the best opportunities to develop and enhance the availability, accessibility and utility of Public Health information and intelligence?
  Question 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?

Question d: What can wider partners nationally and locally contribute to improving the use of evidence in public health?

- A detailed workforce strategy will be developed late 2011
- The DH will encourage PCTs and local government to discuss future shape of PH locally
- DH also publishing review of the regulation of PH professionals – they believe statutory regulation should be a last resort, preferred approach is to ensure effective voluntary regulation for any unregulated PH professionals

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?

- **Funding & Commissioning**
  16 questions relating to how PH is to be funded and services commissioned, key points to consider:

  - Ring-fenced PH budgets allocated to LAs by PHE
  - Will include Health Premium for authorities with greatest deprivation and inequalities
  - PH budget will not include functions which are already carried out by LAs such as housing, leisure, social care
  - HWB can pool other budgets as required
  - Shadow PH allocated to be provided April 2012
  - Local authorities and GP consortia will have equal obligation to prepare the JSNA through the HWB
  - HWB to develop local HW Strategy, based on the JSNA
  - Commissioners to have regard to the JSNA and HW Strategy
  - Ring-fenced budget to give opportunities for local government to involve new partners when contracting for services

- **Outcomes Framework**
  12 questions relating to the proposed new Outcomes Framework, key points to consider:

  - The framework will be co-produced and nationally applicable without the Government dictating what is contained in the data set
  - There will be a need to reflect the breadth of contributions from all partners
  - Public health, NHS and Adult Social Care frameworks will all align with key areas of overlap where services share an interest
  - The framework will:
    - Use indicators which are meaningful to communities
    - Focus on major causes and impacts of health inequality
    - Take on a life-course approach
    - Use data collected and analysed nationally to reduce burden on LAs

- Will include 5 domains:
  - Health protection and resilience
  - Tackling wider determinants of health
  - Health improvement
  - Prevention of ill health
  - Healthy life expectancy and preventable mortality

Discussion ensued on the report with the following issues raised/clarified by the Policy and Scrutiny Officer and Director of Public Health:-

- It was essential that the GP Consortia recognised that it was responsible for health services as well as commissioning. Part of the proposals in both White Papers were that part of the payments to GPs in terms of the Quality Outcomes Framework would be based on the basis of some of the services they provided. Previously 20% of the payments were based on Public Health initiatives such as prevention of heart disease, screening for diabetes etc. at GP practice level

- The Government had stated its intention to market health so there would be an onus on those bodies commissioning services to comply with European Legislation and competition from the private sector

- With regard to voluntary registration, there were a large number of people working in Public Health that had a Public Health qualification as currently recognised. It was how those working in other aspects of Public Health were brought together under the "Public Health family" in terms of qualifications and standards in relation to practice. An example was Environmental Health Officers who were qualified in their own right and within their field may have specialism in Food Standards. They would come under Public Health. There were also Town Planners etc., professionals who took into account the health impact when submitting proposals for Council decision

- The Outcomes Framework would be a number of Indicators like Teenage Pregnancy rates, death rates etc. that the local authority's performance would be judged against. The Government was not stating that an authority had to reach a set target but that it had to make progress against the Framework and if it did it would get a reward in the form of "Health Premium"

- In terms of the competition, it did not necessarily mean the cheapest option. The specification around service had to be right so that it provided both quality and value for money in terms of the service commissioned on behalf of the people of Rotherham

- If a contract went wrong and it was part of Public Health it would fall to the Council; if it was health services it would be the GP Consortia

– The basis for the public health science at a local level was to understand the pattern of disease locally and then apply the measures to prevent those illnesses and diseases. Together with the information from the census it would be essential to understand which communities suffered most, what the problems were and how, under the new system, the Health and Wellbeing Board designed those services to meet those needs

– The financial impact of the new regime on councils was not known as yet. There would be a small amount of funding for Public Health divided out between the local authorities although the basis for the division had not been decided as yet. The bulk of the funding would be with the GPs so there was a need to work with the GPs to promote Public Health and secure the best deal possible

Victoria Farnsworth read out the following statement:- "Speak Up has developed the training package "My Health". I hope the GPs Consortia will continue to commission it. We train over 500 health workers last year across Rotherham and Sheffield to train health carers and workers to communicate better with people with learning disabilities and remind them that people with learning disabilities and other vulnerable people should be treated with dignity and respect. This training is also assisting professionals fulfil their obligations under the Equality Act."

Resolved:- (1) That a copy of the questions be circulated to Panel Members for consideration.

(2) That Panel Member feed any comments they wish to be incorporated into the response to the Scrutiny Office by 18th February, 2011.

(3) That the report and Panel comments be submitted to the 25th February, 2011, meeting of the Performance and Scrutiny Overview Committee.

80. ADULT SERVICES AND HEALTH SCRUTINY PANEL

Resolved:- That the minutes of the previous meeting of the Adult Services and Health Scrutiny Panel held on 6th January, 2011, be approved as a correct record for signature by the Chair with the additional apology of Russell Wells

81. CABINET MEMBER FOR ADULT SOCIAL CARE AND HEALTH

Resolved:- That the minutes of the Cabinet Member for Adult Independence Health and Wellbeing held on 22nd December and 17th January, 2011, be noted and received.

CABINET MEMBER FOR ADULT INDEPENDENCE HEALTH AND WELLBEING
31st January, 2011

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

Apologies for absence were received from Councillors Steele and Walker.

H49. TRANSITION FROM ALIVE BOARD TO HEALTH AND WELLBEING BOARD

Dr. John Radford, Director of Public Health, gave a brief outline background to the Public Health White Paper and consultations taking place. He gave a presentation and highlighted points from the submitted report covering:-

- Healthy Lives, Healthy People : Department of Health Strategy for public health in England
- Health Lives, Healthy People : Consultation Overview
- Consultation process
- Consultation questions
- Outcomes framework for public health : consultation questions
- Funding and commissioning for public health : consultation questions
- Consultation process for outcomes framework
- The Health Background
- The New Approach
- Health and Wellbeing throughout life
- A New Public Health System
- Public Health England
- Proposed Role – The Director of Public Health
- Public health funding and commissioning
- Defining commissioning responsibilities - examples
- Public Health and the NHS
- Allocations and the health premium
- Accountability
- Public Health Outcomes Framework : Vision
- The Indicators
- Public Health Outcomes Framework : Alignment with NHS and ASC
- Summary Timetable
- Overall Transition
- Healthy Lives, Healthy People – A Consultation

Also submitted were:-

- HM Government Leaflet : Healthy Lives, Healthy People – The Government's plans for public health
- Department of Health Factsheets : Local Democratic Legitimacy
  : Commissioning for patients

Discussion and a question and answer session ensued and the following issues were covered:-

- consultee range
- importance of Health and Social Wellbeing Board
- Joint accountability of local authorities and the Secretary of State
- Surgery follow up work by GP's.
- Migration from the Alive Board to the Health and Social Wellbeing Board
- Need to review the JSNA
- consultation deadline and resulting proposals timescale
- support for carers
- composition of Health and Social Wellbeing Board
- holding the GP consortium to account

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

H50. ROTHERHAM AIDS AND ADAPTATIONS POLICY

Consideration was to given to the submitted report detailing proposals for the Council's Aids and Adaptations Policy within the Borough. It highlighted key implications for customers living within the Borough.

The Aids and Adaptations (A&A) Team currently operated the statutory function of the Council to administer the Disabled Facilities Grant (DFG) and arranged relevant adaptations to properties within the Borough.

The Policy was principally aimed to help people remain in their own homes through the provision of equipment and adaptations. However, adaptations were a last resort and as such all alternatives would be reviewed. The Council must therefore decide whether the applicants' needs could best be met through:

- Adaptations within reasonable cost boundaries
- Issue of equipment, **or**
- Re-housing to an alternative adapted accommodation

Adaptations were split into three categories:

- Minor fixings (non means tested and under £1000 in value)
- Minor adaptations (non means tested and under £1000 in value, requiring some structural work)
- Major adaptations (means tested over £1000 in value)

A major adaptation could be made up of several minor adaptations.

The report set out more detailed information relating to:-

- Main Proposals
- Eligibility for Customers Requesting an Adaptation
- Agency Fees
- Decisions (customer choice)
- Grounds for Refusing an Adaptation
- Under Occupancy
- Mutual exchanges
- Reports not Submitted
- Split Households

Resolved:- That the Rotherham Aids and Adaptations Policy be noted.

H51. EXCLUSION OF THE PRESS AND PUBLIC

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

H52. BREASTFEEDING IN ROTHERHAM - UNICEF BABY FRIENDLY INITIATIVE

Anna Jones, Public Health Specialist, Children, Young People and Maternity, gave a presentation in respect of breastfeeding in Rotherham and the progress towards achieving the community Unicef Baby Friendly Initiative (BFI) in Rotherham (by 2013) and highlighted the risks of not achieving this quality standard.

Breast milk provided infants with the best start in life, it protected and reduced the risk of illness for both mother and child, which in turn reduced dependence on health services, resulting in short and long term NHS Savings.

Breastfeeding rates (both initiation in hospital and continuation at 6-8 weeks) in Rotherham had been steadily improving over the last 8 years. A range of robust systems were now in place to support women to continue to breastfeed as long as they wanted to. Whilst additional support, services and interventions were starting to show an impact on improved breastfeeding rates, Rotherham still had the poorest breastfeeding rates in Yorkshire and the Humber (and was in the bottom quintile nationally).

The presentation covered:-

- The UNICEF Baby Friendly Initiative and its implications for Rotherham

- What is the UNICEF Baby Friendly Initiative?

- seven point plan for sustaining breastfeeding in the community

- Implementing the UNICEF Baby Friendly Initiative means following and applying the set criteria laid down in their staged programme

- the breastfeeding policy
- staff education
- steps to attain UNICEF Baby Friendly Stages 2 and 3

Discussion and a question and answer session ensued and the following issues were covered:-

- evidenced savings
- need to continue the positive momentum
- maintaining staff training
- reasons for Rotherham lagging behind nationally
- initiatives to change attitudes towards breastfeeding

Resolved:- That the information be noted and Anna be thanked for an informative and interesting presentation.

H53. ACTION ON INFANT MORTALITY IN ROTHERHAM

Anna Jones, Public Health Specialist, Children, Young People and Maternity, reported on infant mortality in Rotherham and gave a presentation which covered:-

- Infant mortality updated 2006/09
- infant mortality rate
- identifiable actions to reduce the 2002-04 gap in infant mortality
- key findings
- action plan and development
- further developments
- action on infant mortality in Rotherham

Also submitted was a background paper on action on infant mortality in Rotherham, infant mortality equity audit 2010 and an updated action plan regarding reducing health inequalities in infant mortality covering:-

- Knowledge of infant mortality and the current position
- Comprehensive Preconception Services
- Early Intervention/prevention for high risk pregnancies
- Comprehensive postnatal service support/interventions
- Wider determinants to be considered

Discussion and a question and answer session ensued and the following issues were covered:-

- infant mortality equity audit 2010 breakdown by Ward
- correlation between highest numbers of births and most deprived Wards
- improvements in breastfeeding
- stillbirth review significance
- targeting resources
- low birth weight
- percentage of mothers smoking
- percentage of mothers breastfeeding

Resolved:- That the information be noted and Anna be thanked for an interesting and informative presentation.

H54. FEE SETTING - INDEPENDENT SECTOR RESIDENTIAL AND NURSING CARE 2011/12

Doug Parkes, Business Manager, Neighbourhood and Adult Services, presented the submitted report which sought agreement to the increase in fees to Independent Sector Residential and Nursing Care Providers for 2011/2012 in accordance with the established inflation formula.

This inflation linked formula was a contractual commitment. Last year there was no increase in the contract price due to low rates of inflation.

The funding for these fee increases was included within the Directorate's budget requirements for 2011/12.

Resolved:- That the fee for Residential and Nursing Care Homes be increased, as now set out, with effect from April, 2011.

H55. LOCAL AUTHORITY CIRCULAR ON THE PERSONAL CARE AT HOME ACT 2010 AND CHARGING FOR RE-ABLEMENT LAC (DH) (2010) 7

Doug Parkes, Business Manager, Neighbourhoods and Adult Services, presented the submitted report which set out the potential implications to the Council and recommended actions following the issue of Local Authority Circular LAC (DH) (2010) 7 – Personal Care Home Act and Charging for Re-ablement.

Resolved:- That, with effect from April, 2011, re-ablement be provided free of charge for the first six weeks.

CABINET MEMBER FOR ADULT INDEPENDENCE HEALTH AND WELLBEING
Monday, 14th February, 2011

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

An apology for absence was received from Councillor Steele.

H56. MINUTES OF MEETING HELD ON 31ST JANUARY, 2011

Consideration was given to the minutes of the previous meetings held on 31st January, 2011.

Resolved:- That the minutes of the previous meetings held on 31st January, 2011 be approved as a correct record.

H57. ADULT SERVICES REVENUE BUDGET MONITORING 2010/11

Consideration was given to a report, introduced by the Finance Manager, (Adult Services) which provided a financial forecast for the Adult Services Department within the Neighbourhoods and Adult Services Directorate to the end of March, 2011 based on actual income and expenditure to the end of December, 2010.

The forecast for the financial year 2010/11 was an overall underspend of £390,000 (i.e. approximately 0.5%) against the revised approved net revenue budget of £71.3 million.

Reasons for the forecast underspend included:-

- overachievement in the savings associated with the merger of the Wardens and Care Enablers Service
- higher than anticipated response from staff to voluntary severance
- additional savings through holding vacancies to facilitate redeployment of staff in support of the various structural reviews
- tight financial management within the service

However, during 2010/11, a number of significant budget pressures had emerged across the wider Council, and as part of meeting the in year budget pressures, Adult Services had contributed a total of £868,000 savings from its original approved budget.

The latest year end forecast showed that there were a number of underlying budget pressures which were offset by a number of forecast underspends. These were set out in detail in the report submitted.

Also reported, for the period April to December, 2010, was the total expenditure on Agency staff for Adult Services compared with an actual cost for the same period last year. Non-contractual overtime for Adult Services was also detailed.

The report set out the current position for the Department with a summary of the overall financial projection for each main service area/client group both

against original approved budget and the revised budget approved by the Cabinet.

It was reported that to mitigate any further financial pressures within the service budget meetings with Service Directors and Managers were continuing to be held on a monthly basis to monitor financial performance against the revised approved budget and ensure expenditure was within this revised budget.

Reference was made to additional income from NHS Rotherham in respect of additional funding announced by the Government for the support of social care both in 2010-11 and 2011-12.

Members present raised and discussed the following:-

- certainty of the additional health funding, inclusion into the 2011/2012 budget and package of services to promote better services for patients upon discharge from hospitals
- social worker recruitment
- Direct Payments
- supporting people returning home from out of district hospitals delaying the implementation of community based alternative to residential care within Physical and Sensory Disabilities
- year end opportunity to bid for a proportion of any overall corporate underspend

Resolved:- That the latest financial projection against budget for the year based on actual income and expenditure to the end of December, 2010 for Adult Services be noted.

H58. ADULT SERVICES CAPITAL BUDGET MONITORING 2010/11

Consideration was given to a report, presented by the Finance Manager (Adult Services), in respect of the anticipated outturn against the approved Adult Services Capital Programme for the period April 2010 to January 2011. The projected final outturn for each scheme was detailed.

It was reported that the actual expenditure for the period April to 19th January, 2011, was £331,000 against a revised Programme of £800,000. It was explained that capital schemes were funded from a variety of different funding sources including unsupported borrowing, allocations from Capital Receipts, Supported Capital Expenditure and specific Capital grant funding. Appendix 1 showed actual expenditure to date against the approved budget together with the forecast outturn position.

The report gave a brief forecast Outturn position for each project including:-

Older People

- the balance of funding for the two new residential homes which related to landscaping and outstanding fees.

- the Assistive Technology funding from NHS Rotherham being managed jointly

and being used to purchase Telehealth and Telecare equipment.

- the Department of Health specific grant issued to improve the environment within residential care provision carried forward into 2010/11.

Learning Disabilities

- completion of the refurbishment programme at Addison Day Centre.

- the capital scheme to refurbish the respite centre at Treefields had now been completed from the Council's Strategic Maintenance Investments Fund.

Mental Health

- a small balance remaining on the Cedar House capital budget would be used for the purchase of additional equipment.

- large proportion of the Supported Capital Expenditure allocation rolled forward into future years whilst spending plans were finalised. Committed spend in 2010/11 related to the purchase of equipment of EMI clients within the 2 in-house residential care homes.

Management Information

- balance of the Capital grant allocation for Adult Social Care IT Infrastructure carried forward from 2009/10 to meet the ongoing commitments to fund the Adults Integrated Solution as part of introducing Electronic Social Care management.

- new Transformation in Adult Social Care Capital Grant announced in 2010/11. Spending plans were currently being finalised including the cost of transferring direct payments to the Social Care SWIFT system.

General

- the purchase and implementation of an electronic home care scheduling system by April, 2011, for care enablers.

The Cabinet Member referred to an area of un-maintained land to the front of Lord Hardy Court. It was reported that as far as the Service knew this was unattributed and there were revenue cost implications to keep the area maintained.

Resolved:- (1) That the forecast Capital outturn for 2010/11 be noted.

(2) That the Director of Health and Well Being speak to Green Spaces about the land in the vicinity of Lord Hardy Court and investigate, including with the Wentworth North Area Assembly and the Hoober Ward Councillors, how this area could be improved and brought into use.

H59. ASSISTIVE TECHNOLOGY - UPDATE

The Director of Health and Wellbeing submitted an update on the progress to date with regard to the recommendations of the Scrutiny Review of Assistive Technology carried out by the Adult Social Care and Health Scrutiny panel in October 2010.

It was reported that a number of significant changes had been made to the delivery of Assistive Technology that addressed issues raised within the Review. These included:-

- Appointment of a Dedicated Assistive Technology on a temporary secondment basis to raise the profile of AT and to address some of the issues raised and also to give a focal point to the provision of equipment so that staff found it easier to provide support easily and without blockages.

- A series of visioning events had taken place at which the process for recommending AT had been simplified. This had seen a significant improvement in the numbers of staff who were now considering AT as a viable alternative to reduce expensive care packages.

- Establishment of a system to monitor and demonstrate the savings that AT could bring. It was pointed out that when staff requested AT support they were also asked to detail the provision that they would have made under traditional care packages. The database showed the savings that had been made by the provision.

- Change in emphasis during the assessment process:- staff were being asked to give reasons why they had decided not to recommend AT provision. This had highlighted the importance of AT and engaged staff in greater deliberation about the provision of support.

- Identification of simple and direct access to equipment:- A series of cards had been developed (copies provided at the meeting) – Carer Package, Medication Management Package, Epilepsy Package, Environmental Package, Purposeful Walking Package and Falls Package – and allocated to staff. This was an innovative way of identifying the most frequently allocated packages and had been seen by one of the major providers as an excellent way of raising the profile of AT.

- Highlighting good news stories with an emphasis on outcomes:- A number of case studies had been circulated to emphasise the personal dimension to successful implementation of support. They also proved to be an effective vehicle for demonstrating the benefits to the customer.

- Better use of available information:- A piece of work was to be introduced that would give credible data to demonstrate the benefits of AT provision in one particular area.

- Prevention of avoidable admissions to hospital and the prevention/delay of admission to long term residential care:- The card scheme placed emphasis on a defined package matrix that clearly identified how assessment for AT equipment could be linked to delaying residential care, supporting the provision of domiciliary care and improving the support that

could be given to carers.

– Provision of information and signposting:– A campaign to raise the profile of AT in Rotherham had commenced with a dedicated AT week to take place in March

– Direct involvement of staff in developing AT:– The appointment of the AT Officer now gave an extra resource to research and benchmark equipment

– Better use of resources:– Financial savings that could be brought out be intelligent allocation of resources

– Better liaison with Rothercare:– closer working with Rothercare staff to solve issues relating to the fitting of equipment and identifying exactly how Rothercare would respond to any given alert

– Development of benchmarking opportunities:– the Regional Assistive Technology Manager for Yorkshire and Humber had provided excellent support

Members present raised and discussed the following:-

- provision of equipment and how much the client had to contribute and the Council's criteria
- bigger equipment needs considered by the Adaptations Service
- good media coverage
- simplified procedure to obtain Assistive Technology
- liaison with the Fire Service, Rother Care and the Council
- the wide catalogue of equipment now available
- provision of digital TV for people aged over 75

Resolved:- (1) That the Neighbourhoods and Adult Services' response to the scrutiny review, as now reported, be noted.

(2) That the progress that has been made in delivering assistive technology within Rotherham be noted.

H60. 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 (business/financial affairs.)

H61. SUPPORTING PEOPLE PROGRAMME

Further to Minute No. 46 of 22nd December, 2010, the Strategic Commissioning Manager submitted a report detailing the procurement process and subsequent evaluation undertaken for EU Classified Annex 2b services to provide housing-related and preventative support.

It was pointed out that 14 floating support contracts were taken to tender of which. 12 contracts were awarded by the Cabinet Member on 22nd December which left two remaining contracts not awarded.

Resolved:- (1) That the extension of the current contract for the Floating Support Service Providing Housing Related Support for BME Women Experiencing Domestic Abuse for a period of four months to 31st July, 2011 be noted..

(2) That the award of the tender for FS615 Home Improvement Service be approved.

Invitation to take part in a research study

Study Summary: Keeping Warm in Later Life ProjecT (KWILLT)

Background
Living in cold, damp housing is linked to health problems, high levels of avoidable winter deaths and low quality of life in older people. It is therefore important to promote keeping warm at home to reduce the burden on individuals and the health service. The Yorkshire and Humber region has the second highest level of fuel poverty in the UK. Fuel poverty is defined as a household which needs to spend more than 10% of its income on fuel.

Social marketing is an approach to develop interventions that promote healthy behaviour. It often involves trying to increase the public awareness and knowledge about something, but also how services are delivered. The aim is to make services easier to access. In order to develop information and services that work it is important that people are consulted and their views recognised. In this study we want to try to use social marketing methods to help older people keep warm, and overcome barriers to accessing things that could help, for example, Warm Front, housing or benefits.

Aim
This research study aims to examine the knowledge, beliefs and values of older people regarding keeping warm at home, and identify the barriers they experience that prevent them accessing help in keeping warm. It will then use this information to develop social marketing 'keeping warm' interventions, including brief intervention training materials for health and social care staff, assessment referral tools and social marketing public campaign insight.

Methods and progress so far
Different methods will capture the views of older people and professionals to ensure that we obtain an accurate understanding of factors that influence older people keeping warm.

1. Individual interviews and room temperature measurement with 50 older people and interviews with 25 health and social care professionals to explore the knowledge, beliefs and values of older people regarding keeping warm at home. Data was collection from older people in the winter months of 2009/2010 and 2010/2011. Staff interviews were completed in the summer of 2010.

2. 6 focus groups with older people, health and social care professionals and people in a policy or strategic capacity. These focus groups will verify, challenge and expand upon findings from the individual interviews. They are being conducted between February and April 2011. We are inviting you to participate in a focus group.

3. A consultation event with up to 50 lay and professional stakeholders to examine the findings and shape the social marketing 'keeping warm' intervention. This will be held in summer or autumn 2011.

The research is being led by Sheffield Hallam University.

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The details of the meeting are confirmed as;

- Friday 25th March
- Lunch at 1:00pm
- Discussion starting at 1:30pm
- Close of meeting at 3:00pm

If you are interested in taking part, please contact Kate Taylor
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