HEALTH AND WELLBEING BOARD
3rd December, 2014

Present:-

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

Also Present:-

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

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

S43. QUESTIONS FROM MEMBERS OF THE PRESS AND PUBLIC

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

S44. MINUTES OF PREVIOUS MEETING

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

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

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

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

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

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

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

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

S45. COMMUNICATIONS

NHS England Organisational Alignment and Capability Programme (OACP)

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

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

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

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

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

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

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

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

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

The website would link to the NHS Constitution.

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

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

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

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

S46. NHS 5 YEAR FORWARD VIEW

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

The NHS have achieved a lot

- Currently #1 healthcare system in the world
- More than 2/3 UK public believe the NHS "works well"
- Cancer survival is at its highest ever
- Operation waiting lists are down – many from 18 months to 18 weeks
- Early deaths from heart disease are down over 40%
- 160,000 more nurses, doctors and other clinicians
- Single sex wards implemented

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

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

Demand for care is rapidly growing

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

There are also new opportunities

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

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

- Health and Wellbeing
  Radical upgrade in prevention
  Back national action on major health risks
  Targeted prevention initiatives e.g. diabetes
  Much greater patient control
  Harnessing the 'renewable energy' of communities

- Care and Quality
  New models of care
  Neither ‘one size fits all’ nor ‘thousand flowers’
  A menu of care models for local areas to consider
  Investment and flexibilities to support implementation of new care models
- Funding
  Implementation of these care models and other actions could deliver significant efficiency gains
  However, there remains an additional funding requirement for the next Government
  Need for upfront pump-priming investment

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

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

New deal for Primary Care

- Funding
  Stabilise core funding for two years and increase investment in the sector over the next Parliament
  New funding for schemes such as the Challenge Fund
  New infrastructure investment
- Commissioning
  Increase CCG influence over commission of primary care and specialised services
  New incentives to tackle inequalities
- Workforce
  Increase the number of GPs in training
  Train more community nurses and other primary care staff
  Invest in new roles, return and retention
- Public Engagement
  Building the public's understanding of pharmacies and on-line resources to reduce demand

Multi-Speciality Community Providers

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

Primary and Acute Care Systems

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

At their most radical they could take accountability for all health needs for a register list – similar to Accountable Care Organisations

Other New Care Models

- Urgent and Emergency Care Networks
  Simpler and better organised systems achieved by
  - Developing networks of linked hospitals to ensure access to specialist care
  - Ensuring 7 day access to care where it makes a clinical difference to outcomes
  - Proper funding and integration of Mental Health Crisis Services
  - Strengthening clinical triage and advice
- Specialised Care
  Consolidating services where there is good evidence that greater patient volumes lead to greater quality
  Working with a smaller group of lead providers willing to take responsibility for developing geographical networks of specialised and non-specialised care
  Moving towards specialised centres of excellence for rare diseases
- Viable Smaller Hospitals
  Help sustain local hospital services where:
  - They are the best clinical solutions
  - They are affordable
  - They have commissioner support
  - They have local community support
  - Consider adjustments to payment mechanisms
  - Explore new staffing models
  - New organisation model including sharing management across sites, satellite provision on smaller sites and Primary and Acute Care systems
- Modern Maternity Services
  Explore how to improve our current services and increase choice by:
  - Commissioning a review of future maternity units for Summer 2015
  - Ensure funding supports choice
  - Make it easier for midwives to set up services
- Enhanced Health in Care Homes
  Developing new models of in-reach support and services by:
  - Working in partnership with Social Services and care homes
  - Building on existing success

Implementing new Care Models

- To deliver new care models we need a new type of partnership between national bodies and local leaders
- Working with local communities and leaders, NHS national bodies will jointly develop:
  Detailed prototyping of new care models
  A shared methodology for assessing the characteristics of health economies

National and regional expertise and support for implementation at pace
National flexibilities in current regulatory, funding and pricing regimes
A new investment model to help ‘pump prime’ and fast track the new care models

Delivering Innovation and Change
To deliver the scale and pace of change required we will also take steps to
- Align NHS Leadership
- Develop a modern workforce
- Exploit the Information Revolution
- Accelerate innovation

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

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

Discussion ensued with the following issues raised/clarified:-

- People were living longer but an increasing number of people with long term conditions
- Ever increasing number of people that needed access to services because of lifestyle factors e.g. alcohol, obesity, lack of exercise
- Culture of change required and for people to take more responsibility for their personal health and lifestyle choice
- Need to be more innovative and creative in terms of creating care models locally reflecting the needs of the local population

- Still expectation that will deliver 3% savings every year for the next 5 years whilst recognising need for upfront investment and double running costs to be incurred
- £8Bn expected funding gap identified
- 2015/16 was the first year of the Plan – guidance would be published by NHS England on 23rd December
- Difference in opinion as to whether the changes to the funding formula was thought to have a negative effect for Rotherham
- Funding and framework was required to allow patients to be empowered to make their own choices and self-management as well as the vulnerable members of society requiring advocates to access the services
- Although the document was welcomed, the CCG was concerned about the risk to Rotherham with regard to the new formula

Resolved:- That the report be noted.

S47. CARE ACT 2014

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

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

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

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

Framework of the Act and its Statutory Guidance

- Underpinning principle
  Wellbeing
- General responsibilities and key duties
  Prevention
  Integration, partnerships and transitions
  Information, advice and advocacy
  Diversity of provision and market oversight
  Safeguarding
- Key processes
  Assessment eligibility
  Charging and financial assessment
  Care and support planning
  Personal budgets and direct payments
  Review

The Wellbeing Principle

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

New Responsibilities of Local Authorities towards all Local People

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

New Duties – Integration and Market Oversight

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

New duties – Advocacy, Safeguarding and Transitions

- A duty to arrange independent advocacy if a person would otherwise be unable to participate in or understand the care and support system
- New statutory framework for protecting adults from neglect and abuse. Duty on local authorities to investigate suspected abuse or neglect, past or present, experienced by adults still living and deceased

- Duty to assess young people and their carers in advance of transition from Children's to Adult Services where likely to need care and support as an adult

What might this mean for People needing Care and Support?

- Better access to information and advice, preventative services and assessment of need
- An entitlement to care and support
- A cap on care expenditure which an individual is liable for comes into effect from April, 2016
- A common system across the country:
  Continuity of care
  Fair Access to Care Services replaced by a national eligibility threshold

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

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

What does this mean for Carers?

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

What might this mean for Local Authorities?

- New duties and responsibilities
- Changes to local systems and processes

- More assessments and support plans
- Responsibilities towards all local people
- Better understanding of self-funders and the care market needed
- Training and development of the workforce
- Costs of reforms
- Preparation or reforms needed

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

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

Discussion ensued with the following issues raised/highlighted:-

- The Act came into force as from 1st April, 2015
- National eligibility criteria as from April, 2016
- Anticipated additional 5,357 requests for a care assessment in Rotherham as the eligibility criteria was reduced
- Local Authority would have to look on a case-by-case basis to ascertain eligibility
- Engagement with local resources/voluntary and community sector to work in partnership to support the needs of the community at a far greater level than present
- Belief that self-funders that will present themselves/eligible for support would be in the region of 667
- In 2015/16 Rotherham would see an increase in costs of £727,000 in terms of assessments and financial support
- Routine workforce meetings as well as the Association of Directors of Adult Social Services looking at the implementation of the Act to ensure continuity across the region

- A large amount of the Act was desperately needed but there were also great concerns regarding the equity of resources
- A lot of people would be caught by the changing of the cap to £100,000 given the average house price in Rotherham
- The rationale was set against a background of year-on-year budget cuts and greater increase in the population
- Consultation would commence shortly with the voluntary and community sector, however, the eligibility criteria had only recently been released and officers were working through what the implications would be
- Discussions had started with the Police regarding vulnerable persons and the processes required
- Innovative means of communicating the information to the public were being worked up
- Training would involve legal advisors and be accessible to partners and the voluntary and community sector
- It was anticipated that the forthcoming grant would not be sufficient to meet the additional burden

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

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

S48. COMMISSIONING FRAMEWORK

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

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

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

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

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

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

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

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

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

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

S49. HEALTH AND WELLBEING STRATEGY REFRESH

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

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

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

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

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

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

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

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

S50. ANY OTHER BUSINESS

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

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

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

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

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

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

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

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

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

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

S51. DATE OF NEXT MEETING

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