HEALTH SELECT COMMISSION
19th January, 2017

Present:- Councillor Sansome (in the Chair); Councillors Albiston, Andrews, Brookes, Cusworth, Elliott, Marriott, Short and Williams, Robert Parkin and Vicky Farnsworth (Rotherham SpeakUp).

Councillor Roche, Cabinet Member for Adult Social Care and Health, was in attendance at the invitation of the Chairman.

Apologies for absence:- Apologies were received from Elliot, Ellis and John Turner.

64. DECLARATIONS OF INTEREST

There were no Declarations of Interest made at the meeting.

65. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

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

66. COMMUNICATIONS

(1) Information Pack
The pack contained:-

- November Health and Wellbeing Board minutes
- CQC overview
- Response from Public Health to Councillor Williams' question on data from the Sustainability Transformation Plan powerpoint
- Notes from the TRFT and RDaSH Quality Account sub-groups

(2) Consultations for CWTP and Learning Disability
The Chairman urged Members to get involved in the consultations. It was imperative that Councillors complete the consultation, whether agreeing to the proposals or not, and then needed to get the facts out to constituents.

The Vice-Chairman stated that at the previous meeting assurance had been given that the consultation documents had been sent to all GP surgeries. He had recently visited 2 local surgeries and found no evidence of any documents. He was concerned that either all the documents had gone or that there had been a breakdown in communications which may be indicative of the low response that had been received so far.

Tony Clabby, Healthwatch Rotherham, confirmed that the materials had been distributed to GPs and that Healthwatch had also been involved in distributing them through their networks.

Councillor Roche, Cabinet Member for Adult Social Care and Health, reported that with regard to the Learning Disability consultation, currently there had been 193 completed online questionnaires and 180 requests for hard copies. He agreed that there was a need for as many people as possible to be involved in the consultation and he would raise the issue of leaflets in GP surgeries with the CCG.

The Chairman reported that it was the plan that all Members would be provided with a copy of the leaflet at the next Council meeting.

67. MINUTES OF THE PREVIOUS MEETINGS HELD ON 27TH OCTOBER AND 1ST DECEMBER 2016

The minutes of the previous meetings of the Health Select Commission held on 27th October and 1st December, 2016, were noted.

Arising from Minute No. 43 (Response to Scrutiny Review: Child and Adolescent Mental Health Services), it was noted that:-

- there was an agenda item providing more information on the whole School Mental Health Pilot and considering Member involvement.

- the Scrutiny Officer had had a recent positive meeting with the CCG and RDaSH to discuss presenting future progress updates following issues raised at the previous meeting and to revisit timescales where needed with some realistic revised dates.

- the latest performance report produced by RDaSH for November was now available for circulation.

Arising from Minute No. 44 (CAMHS), the RDaSH Voice and Influence template was with the Youth Cabinet for comment.

Arising from Minute No. 45 (Response to Children's Commissioner's Takeover Challenge Review), it was noted that:-

- the new Transition Board would hold its first meeting this month.
- dialogue with regard to transition was still to take place.

Arising from Minute No. 54 (South Yorkshire and Bassetlaw Sustainability and Transformation Plan), it was noted that this had been discussed at 11th January Health and Wellbeing Board.

Cabinet Roche, Cabinet Member for Adult Social Care and Health, stated that he was still very concerned with regard to the consultation on the STP which NHS England was terming "awareness raising". He was in discussion with the Chief Executive as to the most appropriate way of gaining Members' approval/endorsement of the STP. There would be a meeting on 8th February regarding governance of the Rotherham Place Plan.

Tony Clabby, Healthwatch Rotherham, reported that NHS England had asked local Healthwatch's and Voluntary Actions across South Yorkshire and Bassetlaw to deliver engagement and communication sessions. Further information was awaited from NHS England as to the timetable and the messages they wished to be included.

Arising from Minute No. 55 (Adult Social Care Performance – Yorkshire and Humber Year End Benchmarking), it was noted that the quarterly reports were to link in with other reporting cycles and that the six monthly reports were to be submitted in July and December.

Arising from Minute No. 56 (Adult Social Care Performance – Local Measures), it was noted:-

- information supplied with regard to LM01-4 for October and November, 2016. With issues arising to be fed in and discussed in March.
- the performance clinic held in July was not a formal minuted meeting. However, there was now a Practice Challenge Group.

Arising from Minute No. 36 (Learning Disability – Shaping the Future Update), it was noted that the work of the People's Parliament at Speak Up should be taken into account.

Resolved:- That the minutes be noted.

(2) That the minutes of Practice Challenge Group be submitted to this Commission.

68. OVERVIEW OF THE ADULT CARE DEVELOPMENT PROGRAMME/BETTER CARE FUND

Keely Firth, Rotherham CCG, and Nathan Atkinson, Assistant Director Strategic Commissioning, presented a progress report of the Adult Care Development Programme and the Better Care Fund (BCF) as of Quarter 3 December, 2016:-

Nathan Atkinson reported on the Adult Care Development Programme - the overarching strategy to transform Adult Care highlighting the following:-

- Community Catalysts, a not-for-profit organisation, had recently won a tender to provide expertise as to the development of community groups to deliver preventative services and supplement the wider Adult Care offer

- The Village integrated health and care locality pilot had been running since July, 2016. A Key Performance Indicator suite was being developed to enable practical comparisons to be made with other localities in terms of performance and impact.

- Training commissioned to support operational workers with understanding and delivery of a strengths based approach to assessment.

- Formal consultation on the future offer in Rotherham for people with a Learning Disability.

- All eighty-four customers attending Charnwood Day Centre had been reviewed and moved to more appropriate support.

- Current offer by the Shared Lives Team had been reviewed with a view to the development of an effective expansion plan based on national best practice.

- Community Opportunity Pathway Programme continued to work with ten customers and their families. Support for the programme ended in December, 2016.

Keely reported that the Better Care Fund was made up funding from the CCG (approximately £20M) and the Local Authority (approximately £4M). There were thirty-six schemes which had now been categorised into six key objectives of the Fund.

During 2016/17 a review had been carried out of all the services for strategic relevance, whether there were strong robust contracts in place and ways of measuring success and the outcomes.

Seven of the eight national conditions were being fully met. The remaining condition was partly met; better data sharing between Health and Social Care based on the NHS number (fully met) and better data sharing including whether Adult Care could ensure that patients/service users had clarity about how data about them used, who may have access and how they could exercise their legal rights (partly met).

What had the Fund done for the people of Rotherham:-

- Defined, improved and increased the joint working with Social Care.
- Mental Health Liaison Services introduced where Mental Health Workers from the local Mental Health Trust now worked in the front end of the Hospital allowing people accessing A&E Services to have intervention before admission and if admitted, through the Mental Health Liaison Services, they could be targeted much faster.
- Social Prescribing – excellent feedback and had given real benefits to those in receipt. It had now been extended for Mental Health Services.
- Increase in the number of community beds which enabled patients to be discharged safely from Hospital where appropriate and had meant delayed transfers of care was less of an issue.

- Increase in the number of people that accessed Personal Health budgets.
- Community Occupational Therapy Service had been subject to a rigorous review resulting in some innovative practice that had reduced waiting times and enabled people to return quicker to their own homes.

The BCF had enabled changes but had also resulted in partners working well together, especially through the difficult period of winter pressures.

Discussion ensued with the following issues raised/clarified:-

- The Community Catalysts would be working in Rotherham for two years (February 2019) and would work with the Service to create different options and look at shifting the way of thinking and current practice models, especially for people with Learning Disabilities. It would run alongside the current consultation. A diagnostic exercise of looking at what was available in the community had commenced. It was hoped to create fifteen alternatives within Rotherham communities in the first year starting with some taster sessions to give people an opportunity to go and test different activities, options and things that were available in the community. It would also include looking at community assets and buildings and working with the Community Link Workers.

- The emergency re-admissions target was a contractual Indicator and included in the Foundation Trust's contract with the Trust being incentivised not to discharge patients before it was safe to do so. However, the problem with the BCF metrics, and was a national issue for both emergency re-admissions and non-elective metrics, was that it was counted differently using different activity and patient groups. It almost became a spurious figure. Consideration was currently being given to replace it locally with an equally strong measurement with the same aims of the BCF metric.

- Continuing Health Care (CHC) was where packages of care were put into place; that was not in the BCF at the moment. The Fund had been generated through local investment as BCF was not a national pot of money but derived from partners assessing which national conditions had to be met and agreeing on the funding to pool. There had been some additional investment in Social Care but the bulk of it came from the partners. When the Fund was set initially the focus had been on the areas that felt intuitive to deliver the objectives but there was nothing to prevent the inclusion of CHC.

  Both the Council and CCG were investing more in the CHC type packages. There was no cross-subsidisation but there was an increase in investment in CHC from a different set of funds.

- Consideration should be given to CHC becoming part of the BCF. There were CHC reassessments of adults whose health were not going to improve and then that funding was lost together with residential and nursing homes then competing for funding to care for the older people.

- There had been some marked improvements in the Integrated Health Village recently. An event was to be held on 24th January to refocus activity.

- The review of Breathing Spaces had been undertaken to gain an understanding the flow of patients and there was excellent feedback from outpatients. The issue for Rotherham was that patients were frequently accessing the hospital initially as an A&E attendee, admitted for short stay assessment and then generally referred/discharged to Breathing Spaces. An audit of cases had revealed that there were those that were in clinical need and appropriate to have gone to A&E in the first instance but there were also those incidents where 999 ambulance crews had not known of Breathing Spaces' existence as an alternative. Nationally Rotherham stood out on how much it spent on people with respiratory disease but also how many people then had a good outcome from the condition. Rotherham was an outlier i.e. appeared to spend more than others but the outcomes were not showing that immediate benefit. The review was trying to ascertain what was done there, what was working well and whether things could be done differently.

  The Foundation Trust was working with the CCG to review Breathing Spaces. There was an opportunity for more "step up" arrangements and a need to review the clinical evidence base on outcomes.

- The BCF performance metric relating to permanent admissions of older people to residential and nursing care homes was a two part measure reflecting the number of younger adults and older people. Part one was younger adults and part two was older people where their long term care needs were met by residential care. It was relative to the population group and measured by how many per 100K were going into provision.

- The emergency re-admissions Indicator was performing very close to the target. It was a symptom of how seriously ill people were when they were went into hospital, the care undertaken and the discharges carried out; there would be occasions when people needed to be readmitted. From a contractually perspective with the Hospital it was not a metric that was underperforming but rather due to the way the metric was calculated.

  There was with some complexity around the metric. It would refer to those patients re-admitted with the same condition and there was some detail about other types of re-admission. The aim was right

which was to ensure when patients were treated in the acute setting and that they were supported and discharged at an appropriate point; if things were done prematurely people would be re-admitted. Scrutiny of the metric was welcomed as it was something that the Trust focussed on to ensure that as the length of stay for patients was reduced, particularly for the non-elective patients, it could be tracked as to whether it created more problems and resulted in re-admissions. The Trust was finding that as it reduced the length of stay it was still performing and above average in terms of re-admissions level - approximately in the top 1/3.

- Concern that once local Indicators were selected that the emergency re-admission indicator remain until there was a better understanding of the situation.

- All of the eighty-four customers attending Charnwood Day Care resource had moved onto alternative provision except three that were still accessing day services but from a different day service. A review would take place with those customers six months post their new service. No issues or complaints had been received.

- Information would follow regarding consultation with Light Bite users.

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

(2) That the possibility of Continuing Health Care funding being included as part of the Better Care Fund be raised at the Health and Wellbeing Board Executive Group.

(3) That feedback be submitted to this Select Commission on the 24th January Integrated Health Village event and the review of Breathing Spaces.

(4) That a briefing be provided on Community Catalysts.

(5) That the Better Care Fund be submitted to the Select Commission for comment and pre-decision scrutiny prior to sign off by the Health and Wellbeing Board.

Lite Bites

A dedicated piece of work has been undertaken to look at the operation of the café Lite Bites which is based within the complex of the Trinity Hall in Wath Town Centre.

Lite Bites is under the operation of the Oaks Day Centre and is run by staff with the support of customers from Oaks Day Centre. The work undertaken has looked at the outcomes, cost and any opportunities/threats. The work has been carried out with Oaks Day Centre in conjunction with the operation of the café within the centre itself.

A briefing note is being finalised to consider what the options are that should be considered for the cafes. This will be discussed at Senior Management Team in the coming weeks.

Health Village

The Health village event on the 24th Jan 2017 was well received and led by the team. Learning and feedback from the event have been incorporated into the action plan which is monitored on a regular basis by the project team.

There has been improvement in the staffing levels across the integrated locality pilot, specifically community nursing and the appointment of an administrator to support the team with a particular focus on co-ordination of integrated working processes. A leadership team is now in place consisting of lead officer across the services. They have undertaken a review and refresh of the action plan with the priority to support work to reduce winter pressures in secondary care and have begun to develop key procedures to support integrated working practices. Work is also underway to identify an appropriate external agency to support in the evaluation of the pilot over the summer 2017.

Breathing Spaces

The contract intentions for 2017-18 with TRFT include a review of Respiratory pathways including Breathing Space. This review will focus on quality and performance of the pathways, strategic relevance of services and value for money.

Community Catalysts

Community Catalysts are now working within Rotherham and have successfully appointed a Catalyst worker who commenced in post on the 6th February 2017. There has been an initial project group meeting which brought together key partners of the project.

The Catalyst will support and compliment the work that has already begun around collation of information and advice and building on the work that Community Link Workers and other individuals have undertaken to build community capacity. The project is focussed around the work for Learning Disabilities and will support the modernisation of the Learning Disability Offer for Rotherham.

The Community Catalysts Project forms part of the Adult Social Care Development Programme as a workstream. Therefore this has a requirement for regular updates into the internal and external board meetings to ensure progression.

69. TRANSFORMATION OF ACUTE AND COMMUNITY CARE

Louise Barnett, Chief Executive of the TRFT, and Dominic Blaydon, Associate Director of Transformation, gave the following powerpoint presentation:-

Overview of the Trust's vision for the next five years
- We will continue as a stand-alone district general hospital
- We will build a reputation for innovation and quality care
- We will achieve a CQC rating of "good" or better
- We will deliver financial sustainability
- We will have a strong emergency and urgent care function
- We will develop sub-regional specialist care centres
- We will provide a strong community health service offer
- We will integrate with health and social care partners

Community Transformation Programme
- Integrated Health and Social Care Teams
- The development of a Reablement Village
- A multi-disciplinary Integrated Rapid Response Service
- A joint approach to care home support
- An enhanced Care Co-ordination Centre

Acute Care Collaborations
- Hyper-Acute Stroke Services
- Breathing Space

Children's Transformation
- Integrated Locality Teams
- Review of Children's Assessment Unit
- Rapid access to a Community Paediatrician
- Reconfiguration of Inpatient Bed Base
- A joint approach to Workforce Development

Discussion ensued on the presentation with the following issues raised/clarified:-

- Currently if a Rotherham resident had a suspected stroke they would be taken by ambulance direct to the Stroke Unit at the District General Hospital and assessed for thrombolysis (an immediate treatment to enable to reduce the possibility of having a secondary stroke). If, due to the capacity of the Stroke Unit, a patient would be taken to A&E and receive the medical intervention or wait in A&E for a bed in the Stroke Unit. They would then spend the first seventy-two hours on a local Stroke Unit and then moved to stroke rehabilitation either at the Stroke Unit, intermediate care or rehabilitation.

- Under the new model, dependent upon where the patient lived, they would either go to the Hallamshire or Doncaster Hospitals for the first seventy-two hours. After that time they would be repatriated to Rotherham Hospital.

- Currently Rotherham residents would be taken to Rotherham Hospital to receive care unless their needs were particularly specialist/had very severe needs when they would then go to Sheffield.

- There was concern with regard to the response times, changes to the journey and what affect that would have on a patient if there was a delay in getting the right treatment. The CCG would be making the decision about what happened to Stroke Services in Rotherham and one of the key principles to making the decision was whether the quality of care to Rotherham patients was going to be better. The Governing Body would be looking very closely at if outcomes for patients would be better or worse. Travel factors would be taken into account.

- The commissioners collectively across South Yorkshire looked into whether the new care pathway would improve the quality of care. They also looked at the evidence base available which showed that where you potentially centralised the care you could provide high quality care irrespective of whether the place that a patient went to currently was providing it at the moment so there was the expectation that that would increase. It was on that basis upon which they were putting forward the proposal.

- Rotherham Trust's performance had been poorer than the Trust would have liked but had improved recently and providing much better care than previously in terms of the Sentinel Stroke National Audit Programme (SSNAP) Indicators (national metrics upon which the Trust was measured) and seeking to improve further. The case for change was there in terms of the clinical outcomes and the Trust needed to ensure through consultation that there was real input and feedback. All of the issues could be thrashed out in terms of patient experience and the lack of clarity over patients that mimicked a Stroke so that the commissioners in Rotherham and other commissioning bodies were absolutely clear on the basis on which they were making the decision and that it related to outcomes.

- There was a set of indicators that was used nationally around stroke and were gathered by SSNAP which included how quickly a patient got into a Stroke Unit, received thrombolysis and how much time they spent on a Stroke Unit when in hospital. When aggregated Rotherham performed very well even when compared to Doncaster and Sheffield. As part of the consultation process feedback had been provided that Rotherham was already a relatively high performing Stroke Unit and asked the question as to what the criteria was being used to decide who the specialist unit was. In principle the Trust did

not have a problem with centralising the resource in terms of sustainability and quality of the Service but the information submitted to the Trust and CCGs as part of the consultation process had not evidenced that. The Trust needed them to look in more detail about the impact of transporting those patients and then work through the detail of the precise plans so as to be confident that the quality of the outcomes would manifest if it happened in South Yorkshire.

- Information available regarding outcomes following a stroke such as chances of survival and maximising recovery e.g. speech, movement as well as the metrics on the stroke care pathway.

- In terms of clinical evidence around the number of individuals that the Hospital supported in terms of stroke, it was important because there was a threshold and it was helpful for clinicians to see lots of people in terms of their practice and outcomes for patients. However, since this process had begun Rotherham was slightly above the threshold that had been identified.

- Sustainability of the Trust as a standalone hospital if services were removed – Whilst the Trust would support stroke patients post-72 hours or all the way through depending upon the outcome, it needed to ensure that overall it had a breadth, depth and range of services that held together as a high performing organisation in Rotherham for patients. It was looking internally and across the place on community and making sure that integration was strong and effective but also what was needed in terms of acute. The Trust had recognised that it did not have the workforce resilience to deliver what it needed regularly, was quite vulnerable in certain teams with small numbers of clinicians and there were national shortages and so needed to work in partnership with other organisations. The aim would be to get the sustainability required with the service configuration based on population need. There was a case for specialist centres such as for spinal care, but there were still many conditions and complex needs that needed to be provided at home in the community looking at in-reach.

- The transformation of Acute and Community Care model would look at patient safety, ensuring that people were better off in terms of how the Trust did things and the need to reduce harm in terms of falls and pressure ulcers. Another area was patient and family experience and patient expectations; it was recognised that whilst medical advancements had been made, people wanted things more quickly. It was a big piece of work that the Trust needed to carry out and ensure they were able to be part of shaping what future provision would look like and do it together rather than imposing on the public. It was acknowledged that, as an organisation, it needed to get better and listen to people's opinions. The Trust had the clinical expertise but did not experience it the same as a patient and their family.

- No alternative model was being considered other than localised specialist acute model; the Trust needed to decide whether it was going forward on that particular model as part of the consultation. Should the CCG decide it did not want to proceed with the model the Trust would need to look at how it would deliver it locally. Locally there was a fully integrated Stroke pathway and there would have to be a very strong argument to fragment it and take out Hyper Acute and move to another centralised centre. There would need to be absolute assurance that the additional travel time and inconvenience for relatives and patients would achieve better outcomes and better quality service.

- The importance of easy read information and ensuring effective communication with patients and their families so everyone knew which hospital a person was being taken to following a stroke.

- It was really important that people were able to access local services that were easy to get to. There may be certain situations where it was better for the patient and family to move services further from Rotherham but the decision would not be taken lightly and every attempt made to ensure the right balance taking into account the importance of delivering services locally and the impact on patients and relatives.

- The Foundation Trust and CCG were stating that if proposals, in their view, resulted in a Stroke Care pathway that was not viable then they would not agree to it.

- Staffing and bed capacity in Sheffield and Doncaster and sharing information between services to manage additional capacity?

- Once the pathway was in place Yorkshire Ambulance Service would be fully involved and clear about where a patient was taken. The Trust had raised the point in their consultation response with regard to Doncaster and Sheffield Hospitals having the capacity and capability to be able to delivering the extended service.

- Where was the best medical team going to be?

- With regard to the proposed Children's Transformation, one area that had been rated "Inadequate" by the CQC was Safeguarding but there was no remedial action mentioned in the proposal – information to follow.

- A multi-agency project group was overseeing the Co-ordination Centre single point of access. There were three workstreams – how to incorporate the Mental Health element, how to encourage the Social Care element and also links with the Integrated Rapid Response Service. It was thought that the new extended version of

the Care Co-ordination Centre would be agreed within the next year with an implementation plan of six months.

- Under the proposal everyone who might have had a stroke would initially go to Sheffield or Doncaster not Rotherham. There was still some ambiguity about a person who presented with stroke-like symptoms. More sophistication was needed through the consultation to deal with those instances.

- Once a stroke patient had stabilised they would be repatriated to Rotherham. There had been discussion as to whether the whole of acute stroke would transfer but the consultation document just dealt with the first seventy-two hours. Rotherham Hospital would have a stroke unit to deal with everything after the first seventy-two hours.

- Concerns regarding the immediate family getting to and from Sheffield/Doncaster had been raised at the JHOSC.

- The proposed model would be advantageous to those patients that were more complex and avoid them having to be transferred to the Hallamshire Hospital for treatment.

- Governance and influence over future services if transferred from Rotherham would be through the CCG.

- It was unclear what would happen in the case of those patients who unfortunately then had secondary strokes.

- Feedback had been provided on the issue of travel times. Work had been carried out on Yorkshire Ambulance Service having the capacity to meet the travel target, however, the Service's response times were not performing well currently on their eight minute response time. The guidelines stated that a patient needed to receive thrombolytic treatment within an hour; the assessment from the consultation process stated it could be achieved by having two centralised units at Sheffield and Doncaster.

- Was the chance of having a second stroke more likely to happen within the first seventy-two hours? How did Rotherham treat patients differently in that period? An answer would be supplied.

- Transformation of Children's Services and the Locality Teams and ensuring adequate staffing given some of the recruitment and retention issues – Currently there was a lot of duplication and inefficiency in the way professionals worked with an individual coming into contact with a number of agencies, having to retell their story each time and some of the information not being joined up. If a team was brought together to support the child and family there may be less professionals but should create an ability to provide a better and more responsive support compared to the current fragmented service.

There would be still be national shortages in certain fields but there would be more attractive roles and give the opportunity to develop apprenticeship roles, Bands 2, 3 and 4, to those who had a wealth of skills and experience which would then free up others.

It was noted that Louise Barnett would seek the Trust Board's consent to supplying the Commission with a copy of its consultation response.

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

(2) That a future report on the evaluation of The Village pilot be presented to the Commission.

70. BRIEFING ON SCHOOLS MENTAL HEALTH PILOT

Further to Minute No. 43(8) Janet Spurling, Scrutiny Officer, presented a briefing on the pilot that had taken place on adopting a whole school approach to the promotion of mental health and wellbeing in Rotherham.

Six schools had been invited to take part in the scheme representing each of the Social and Emotional Mental Health school cluster areas in north, south and central Rotherham.

The whole school pilot was based on the eight principles outlined in a national guidance document produced by Public Health England and the Children and Young People's Mental Health Consortium:-

- Leadership and management
- School ethos and environment
- Curriculum teaching and learning
- Student voice
- Staff health, development and wellbeing
- Identifying need and monitoring impact
- Working with parents/carers
- Targeted support

Each of the six schools had been encouraged to benchmark themselves against all eight principles and then pick at least two to progress and written up into an action plan. The schools had until July 2017 to deliver their actions.

The report set out the six schools and their selected actions.

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

(2) That the following Members accompany officers on the one-to-one update meetings with schools:-

Rawmarsh	Vicky Farnsworth
Newman	Councillor Short
Wingfield	Councillor R. Elliott
Wales	Councillor Marriott
Oakwood	Councillor Cusworth
Maltby	Councillor Andrews

Following the meeting the changes below were agreed:-

Rawmarsh	*Councillor Marriott*
Wales	*Councillor J. Elliot*
Maltby	*Councillor Andrews and Vicky Farnsworth*

(3) That, subject to the approval of Commissioner Myers, Councillor Cusworth be nominated to represent the Select Commission on the Whole School Steering Group.

71. HEALTH SELECT COMMISSION SUB-GROUP: OLDER PEOPLE'S HOUSING

Janet Spurling, Scrutiny Officer, submitted a copy of the report to Overview and Scrutiny Management Board following the scrutiny session undertaken by a sub-group of the Select Commission regarding housing for older people in Rotherham.

The purpose of the session was to develop a clear understanding of the key issues involved in increasing the number of homes suitable for older people and to make recommendations to inform future plans for older people's housing.

The report summarised key issues identified and the ten recommendations which were as follows:-

(1) That an article be included in the tenant newsletter explaining how bungalows are allocated to different groups of people, not only older people, based on need.

(2) That discussion takes place with transport providers, including Community Transport, regarding:-

- Services for proposed sites before building commences
- Maintaining transport links to those sites in the future.

(3) That the importance of family pets for older people's health and wellbeing is considered in developing housing options.

(4) That consultation is undertaken with older people currently living in three storey buildings to capture their views on how suitable this housing is for their needs, to feed in to decisions about future models.

(5) That consultation is undertaken with older people to ascertain their views on the term extra care and how housing schemes should be branded.

(6) That the approach to branding and marketing housing options for older people should be a positive one such as promoting the third age rather than one of moving towards the end of a person's life.

(7) That new housing schemes are designed to look more generic rather than looking like they are only for older people:-

- To reduce the risk of older people being targeted
- To reflect mixed communities and reduce negative perceptions.

(8) That Shaftesbury House undergoes external renovation and is made more secure for residents.

(9) That action is taken to maintain high quality in current older people's housing to avoid the development of a "two tier" system with differences in quality and experience between current and new provision.

(10) That all multiple storey buildings for extra care housing should have lifts.

This was a good focussed piece of work and showed the role of scrutiny in policy development as opposed to its role in holding agencies and the Executive to account. It was positive to have all ten recommendations accepted with a clear response and timescales for implementation.

Resolved:- That the report be noted.

72. IMPROVING LIVES SELECT COMMISSION UPDATE

Councillor Cusworth gave the following update on the recent Improving Lives Select Commission meeting:-

- Independent Chair of Adult Safeguarding Board provided an annual review
- Domestic Abuse Service provision in Rotherham

The key link to Health was with regard to health partners responding to disclosures or signs of abuse and regional work on implementation of the Mental Capacity Act.

Should any Member require more information they should contact Councillor Cusworth directly.

Councillor Cusworth was thanked for her report.

73. JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE FOR THE COMMISSIONERS WORKING TOGETHER PROGRAMME

Janet Spurling, Scrutiny Officer, reported that NHS England had carried out their planned mid-point review of the public consultation in late December led by the Consultation Institute. The review had found that, although the Christmas period had been taken into account regarding the length of the consultation period, it had had a greater impact than planned as the response rate was lower than expected given the approach and methodology used.

The consultation deadline had been extended until 14th February to allow for further engagement. This meant that the final decision would now be made by the Joint Committee of CCGs in April, 2017.

In light of the concerns expressed by the Select Commission regarding the proposals for Hyper Acute Stroke Services, the Chair and Vice-Chair had met with a representative of the South Yorkshire Ambulance Service to discuss their ability to deliver the service, the number of vehicles they had at their disposal currently and how many more they felt they would need to carry out the new service.

The representative had been quite clear that the Service had no problems in maintaining the service whatsoever nor were there any issues with regard to the skilling of staff. The only issue was that the Service felt it needed an additional three ambulances bearing in mind the new proposed models of working.

Members reiterated the importance of having clear data and evidence when officers and partners were presenting information to the Commission.

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

(2) That the Commission submit a collective response to the consultation.

74. HEALTHWATCH ROTHERHAM - ISSUES

Tony Clabby, Healthwatch Rotherham, reported that the Autism Strategy was to be launched by the Autism Partnership

75. DATE OF NEXT MEETING

Resolved:- That the next meeting of the Health Select Commission be held on Thursday, 2nd March, 2016, commencing at 9.30 a.m.