ORANGE BOOK FOR INFORMATION

Venue: **Town Hall, Moorgate Street, Rotherham.**

Date: **Wednesday, 25th January, 2017**

Time: **2.00 p.m.**

A G E N D A

1. Health Select Commission (Pages 1 - 40)

2. Improving Lives Select Commission (Pages 41 - 52)

3. Improving Places Select Commission (Pages 53 - 61)

4. Reports for Information (Pages 62 - 64)

HEALTH SELECT COMMISSION
27th October, 2016

Present:- Councillor Sansome (in the Chair); Councillors Albiston, Andrews, Brookes, Cusworth, Elliot, Elliott, Ellis, Fenwick-Green, Marriott, John Turner, Williams and Short.

Apologies were received from Councillors Ireland and Marles.

39. DECLARATIONS OF INTEREST

There were no Declarations of Interest made at the meeting.

40. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

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

41. COMMUNICATIONS

(1) Information requested from Foundation Trust at quarterly briefing

- A&E 4 hour target performance
  - This remained a challenge nationally but in August the trust had exceeded the 95% target. Over the last year, bar one month, performance had exceeded the national average.
- Where the Hospital was in terms of staff shortages for emergency consultants.
  - There were currently 5.7 WTE in post and still some use of agency staffing. This position was set to improve by December and there will be further work around rotas and staffing from January 2017.
- If meeting targets for agency staff use/spend
  - For the five month period to August the trust had spent £393,000 less than the planned spend on agency staff.

(2) Information Pack
The pack contained:-

- Outstanding issues with regard to the Director of Public Health's annual report
- Sustainability and Transformation Plan presentation
- Quarterly briefing notes from meeting with Health partners
- Locality Working presentation

The presentation on the STP had been included to set the context for the agenda item in December. The integrated locality pilot, discussed at the last meeting, was also in the work programme.

(3) An all-day training session concerning prevention to be held on 24 January with HSC Members encouraged to attend.

(4) Scrutinising Performance Information with Confidence
Working session for the Select Commission, facilitated by Dianne Thomas (Centre for Public Scrutiny) to be held on Tuesday 22 November 2016 from
1.00pm – 3.00pm. This linked with the Commission looking at Adult Social Care performance on 1 December when the Yorkshire and Humber benchmarking data 2015/16 would be scrutinised.

42. MINUTES OF THE PREVIOUS MEETING HELD ON 22ND SEPTEMBER, 2016

The minutes of the previous meeting of the Health Select Commission held on 22nd September, 2016, were noted.

Arising from Minute No. 32 (Commissioners Working Together Programme) it was noted that the third paragraph should read "options appraisals …." and not "operations appraisals".

Arising from Minute No. 30 (previous meeting), the additional information provided after the meeting was noted regarding performance clinics

Arising from Minute No. 31 (Rotherham's Integrated Health and Social Care Place Plan), it was noted that Councillor Short, Vice-Chair, would be joining the visit to the new Urgent and Emergency Care Centre on 11th November, 2016. The visit was now fully booked. New dates would be supplied for further visits in the New Year.

Members could keep up-to-date on developments through the dedicated website http://www.rotherhamemergencycentre.nhs.uk/. This included a short video giving a virtual tour of the Centre and the Trust were developing some characters and patient stories to add.

It was also noted that issues raised on the Rotherham Place Plan had been fed back to Nathan Atkinson, Assistant Director Strategic Commissioning, and colleagues at the Rotherham Clinical Commissioning Group.

Arising from Minute No. 34 (Health and Wellbeing Board), the additional information provided after the meeting was noted regarding digital roadmap.

Resolved:- That the minutes of the previous meeting held on 22nd September, 2016, be approved subject to the above clerical corrections.

43. RESPONSE TO SCRUTINY REVIEW: CHILD AND ADOLESCENT MENTAL HEALTH SERVICES - MONITORING OF PROGRESS

In accordance with Minute No. 96 of the meeting held on 14th April, 2016, Paul Theaker, Operational Commissioner, Children and Young People's Service, reported on the current progress of the Scrutiny Review's 12 recommendations.

The RDASH CAMHS Service reconfiguration had been completed at the end of June, 2016 with a new single point of access and locality workers in place. There had been positive feedback from partners on the changes made. However, a small number of posts were not recruited to until after that date due to a difficulty in recruiting appropriate staff to those posts. This had had an impact on the delivery of a number of the actions within the response to the Scrutiny review (detailed within Appendix 1 of the report submitted)

Consideration was given to the Appendix which contained the progress to the recommendations as at October, 2016. Discussion ensued with the following issues raised/highlighted:-

- The draft refreshed needs analysis would be going the following week to the partnership group.
- The performance framework would be for the full mental health system, so not only RDaSH but also other services including counselling in schools and Early Help counselling, formerly Youthstart. It was also being adapted and refined to meet national reporting requirements and would be tested fully in the new year.
- It was recognised that some of the timescales had been ambitious given the scale of the reconfiguration, consultation and recruitment but partners had really gone back to unpick the information and fully understand what services were doing.
- As some of the data was out of date, what impact did that have further down the line for partner agencies? – In terms of RDaSH CAMHS there was detailed information about young people who are in treatment. So there was good high level information but a need to unpick and get consistency in what was provided from partners.
- RDaSH provided more detail regarding training and awareness raising activities – revamped and more informal letters, meetings with schools to consider how they could work together better, refreshing the "top tips" documents, information packs distributed to all secondary and primary schools, working with South Yorkshire Eating Disorder Association, asking what training people want rather than assuming what they want.
- Had the CAMHS workforce development strategy been written? – Although a draft had been produced to the timescale it was still a draft. The plan had considered training needs at each level across the wider workforce e.g. from a playground supervisor needing

basic awareness through to a mental health practitioner, looking at where services' plans sit in the framework and then directing people to the training packages.

Schools mental health pilot

- Monitoring reports from the visits to the schools in the mental health pilot could be shared with Members.
- There seemed to be a low number of secondaries engaged in the pilot, so how were academies encouraged to have a certain level of staff training when there was no requirement for them to do so? – The need to get academies on board was appreciated which is why there was the approach to roll out from pilot schools to their peers and through the headteacher network. The schools involved were very engaged, including with training.
- Were we able to add schools to the pilot or would they have to wait until the next batch? There would be a meeting in December and schools were talking in terms of the network, but there was a need to start having that dialogue with the other schools.
- Would the full evaluation of the pilot in July be by an independent person, not someone involved in the work? – We need to take that forward and look at who will undertake the evaluation. In terms of the monitoring that is led by Public Health and Commissioning.
- Councillor Roche echoed concerns over the lack of influence over academies and the length of time it had taken to get suicide prevention on the agenda for the headteachers' meeting.
- What level of training did school staff have to have to be part of this initiative, as if they were not trained to a set level could they be doing more harm than good? If there is not a mandate to say staff must be trained to this level how would we mitigate against that? – As part of the pilot each school would identify a mental health champion and that tends to be the SEN or Safeguarding lead who would then roll the work out, as it is not directed by Council staff. In terms of training specifically this linked back to the action on workforce development and who could provide training at those levels.
- How many people in the pilot schools had been trained as the number who needed training would vary with the size of the school? Had they already been trained before the pilot started? – This information was not available but could be requested from schools as part of the monitoring. Schools and academies could not be directed regarding what training they undertook but could be made aware of what was available through the workforce plan.
- Are schools devising their own training? – Each pilot school undertook a mini needs analysis which led to them identifying their three priorities for this academic year, but not necessarily training. For example it could be peer mentoring with young people or staff wellbeing. The programmes are led by the identified mental health champion within the school.
- Are we saying there are possibly people working in schools with no mental health training? - It was understood that all the school

mental health champions had undergone mental first aid training but this would be checked. There is a school counselling service which could be provided by Rotherham and Barnsley MIND, MAST or by people directly employed by schools. So within schools there is a counsellor or a mental health professional or practitioner who is used to help develop these approaches in schools. As reassurance certainly in secondaries it is about those services such as counselling taking that lead alongside the mental health champion. In terms of primaries, for example in Maltby, that school is working proactively with the cluster around the mental health agenda, almost in a hub and spoke.

- So to clarify, all secondaries have some sort of counselling or mental health specialist in their schools but not primaries? Yes in secondaries. Within primaries there is a lead or designated person.
- Do those services than have priority access to second tier mental health services if those people then identify a child with greater need? – Access would be through the counselling service or through the designated lead contacting the Single Point of Access (SPA) and outlining concerns. Locality workers are coming into schools and they would be able to pick up those issues and advise and support - bespoke training/information.
- Regarding school lunch time staff it is more about raising awareness, taking a bit more time to notice but also knowing who in school to go to and say I've noticed this and could they watch out for it, rather than them going and doing some early intervention work themselves.
- Is responsibility for mental health being delegated to people working in schools? - It is about all the C&YP's workforce having responsibility, be that at a very basic level of awareness regarding who to speak to or refer on to. The role of CAMHS Locality Workers is to provide support, not just for schools but also for GPs, Early Help teams etc. so that is about supporting schools about techniques and enabling smoother referrals into CAMHS.

It was suggested that mental health teams needed to provide more support to work with schools on their plans.

Members emphasised the importance of the quality of the referral and were concerned that if people are not trained children could slip through the net. - Pathways to CAMHS had changed since the development of the SPA and this was enabling smoother access. RDaSH workers were alongside Early Help triage and schools and other workers could refer young people in to the SPA, where they would have a wider, more holistic assessment of their needs.

- Can parents or a young person still self refer and how is it publicised? – Yes they can although the joint sessions at Eric Manns had now ceased. Marketing is an area we need to work on, tied in with access through the Early Help hub once fully co-located.

- How many posts have not yet been recruited to and where are they? – Only one, based within the CSE team, even with three advertisements so RDaSH were now looking at this in a different way to recruit a locality worker who will be a CSE lead. Because of "*Future in Mind*" all trusts were trying to recruit mental health practitioners so RDaSH thought they would struggle but had a very successful recruitment campaign and recruited 12 really good calibre people. There are four additional staff in anticipation of work with unaccompanied asylum seekers, who are waiting to start following DBS checks. Recruitment started in January but it often takes three months for people to start with DBS checks and serving notice.

Waiting times

- Do we have a long waiting list given that people have not been able to access CAMHS successfully? Do we have targets about how quickly those young people will be seen? Do we have any threshold data or benchmarking with other similar LAs around anticipated numbers and access at the different tiered levels? Do we match staffing to identified need? – In the past there was a problem with long waits for assessment but that has improved. In May 2016 240 children were on the waiting list for an assessment appointment but that was now down to 50. The most that children were waiting now for an appointment date was four weeks and the average was 8 weeks to be seen for assessment against a target of 3 weeks, although we expect that to reduce significantly now staff are in place. Regular meetings have been held between RDaSH and RCCG regarding the waiting list and other issues arising from reconfiguration. Regarding C&YP starting treatment, we target 8 weeks but the national target is 18 weeks. Exact figures were not available and were requested.
- Four weeks might seem a long time but once a referral was made RDaSH were gathering information in advance e.g. from schools. A lot of people Do Not Attend (DNA) for their first appointment because people have not filled in the form. There were problems on information sharing between partners i.e. system error, which had to be sorted out. Because of the long waiting lists RDaSH had two teams, one working on the three week waiting list and the other bigger team bringing down the waiting list.
- Locality Workers see children at an earlier stage. Children with the right criteria are coming in to CAMHS and others are getting earlier support through Early Help, as before children might have waited for a few weeks but then not met RDaSH criteria once assessed. Our target, set by the CCG, is three weeks and nowhere else has this target and it is a problem. RDaSH would like it to be six weeks, as in the NICE guidance, so there is more time to gather the information. Reporting on both three and six weeks has been in place for some time.
- Is it time to review the three week target if it presents such difficulties? – This target was set to recognise the issue and to

recognise that radical change was needed to address it, so it probably was the right thing to do. Members' original scrutiny review recommendation was to retain the three week target in light of positive changes that were happening in RDaSH and then to review it. The CCG accepted that it was a challenging target but why not keep a challenging target if that was the right thing to do and system improvements allowed you to see people more quickly.

- Are we prepared for unaccompanied asylum seeking children coming, such as specialist training to deal with more complex needs? Has RDaSH now got the staffing in place to mitigate against surges in demand? We are taking on extra staff in preparation. Not 100% sure yet but as it is a new configuration we are still trying to respond to things as they emerge, for example there is greater demand in the South locality.

- Urgent cases are based on level of risk and mental health presentation and would be people expressing suicidal ideas, significant self harming, people on paediatric wards admitted from A&E or people with an acute psychotic presentation. RDaSH confirmed that children with an urgent need were seen within 24 hours and that they had met this target over the last three years, although this was questioned by Healthwatch on the basis of feedback from parents and young people. This is linked to awareness raising with referrers around criteria as they may make referrals saying they are urgent cases but as RDaSH gather information and through the early help triage that might be why there is misunderstanding. Long waiting times for assessment are around ASD and ADHD which RDaSH are working on alongside the other pathways. It also reflects differing perceptions of what is an urgent case and who makes the assessment.

- What types of referrals are we talking about? – RDaSH provides a broad range of services so it includes: diagnostics for ASD and ADHD for over 5s (which are neuro-developmental) and mental health ranging from low level anxiety and low mood, depression, eating disorder through to other common mental health conditions as in adults. Staff all have some level of professional qualification e.g. social workers, nurses, occupational therapists, psychologists and a bespoke CAMHS learning disability service, plus access to psychiatry as that is not normally the initial contact a patient has. RDaSH were developing a specialist eating disorder service.

The Parent/Carer Forum were doing a very good job leading the Family Support Service. They were facing a high level of demand: by quarter 2 they had supported 38 families and 50+ children, mainly aged 5-11, and a significant number with issues around ASD. Earlier in the week a news story highlighted the benefits of interacting with families and parents at an early age with children with suspected ASD. We were ahead of the curve and there was evidence of helping to avoid admission to CAMHS, in what was a positive example of true prevention and early intervention. Support

was not just around CAMHS but also with Education, Health and Care plans and school and home as well. The CCG was proposing to increase funding for 2017-18 by £15k. Contact was available via phone, email, facebook or face-to-face.

Discussions took place at RDaSH regarding what was meant by a SPA and as the local authority was also developing its own SPA that seemed the right option through a partnership agreement with staff going there and sitting with the Early Help team. This has produced a lot of learning about what is or is not CAMHS. There are still details to sort out in terms of networking, infrastructure and cover for annual leave but that will not stop the work taking place.

- How will you measure ease of access to the SPA and will the criteria be visible to all partners? It is not yet fully in place but we are trying to get to having one phone number for Rotherham for all to use into Early Help and from there it would be decided who is the best person to meet needs. Top tips documents for GPs and for universal services, plus the directory of services, set out the criteria and where to refer e.g. low level anxiety to school nurse.
- Are there financial contributions to Early Help? Can we be assured that people will meet criteria and receive a service? – Locality workers were aligned to the Early Help localities and the intention was not for others to undertake RDaSH's business for them but to prevent people bouncing around the system as had happened in the past. Looking at referrals together and having access to local authority information means it will be easier to know if other workers were already involved with a family and so the Locality Workers can support those other workers, so services are more streamlined. Work was also underway to look at the overall skill set within localities.
- Is the SPA now live? - RDaSH duty team members have been working at Rotherham on Thursdays, almost "testing out" what has been developed in terms of the SPA pathway and looking at going live from November. That will be reviewed, including if any bottlenecks appear.
- My Mind Matters web hits – over the last 6 months average of 341 hits per month, 57 of whom were new users, so some repeat visitors. 57% hits from YP, 25% from carers and 18% from practitioners. There is ongoing work to raise the profile and keep promoting it.
- IYSS Young Inspectors were involved with an unannounced inspection of CAMHS and were very positive regarding a "Rotherhamised" website rather than only the generic sites. A very detailed review has been done of the My Mind Matters website recently – review of every page in all three sections with extensive notes made regarding the wording and to ensure up-to-date statistics.
- National work will affect how services are paid for by commissioners. At present it was a block contract, but for a few

years now work has been done looking at a currency, which was already in place in adults and older people's with 21 clusters designated around types of medical condition e.g. cluster 5 is non-psychotic (very severe), 14 is psychotic (crisis). This was a way of monitoring activity and understanding where patients were going. Proposals for CAMHS were a bit different, still clusters but based on level of need, for example "getting help for ADHD" or "getting more help for eating disorders" which is more severe.

- CAMHS was overspent and there were a lot of agency staff that were costing more but now the trust has recruited permanent staff it is coming in at break even. Some of the work with the new pathways will be to see what each pathway is costing but how do you define value for money? Is it early help or is it preventing someone going in a Tier 4 bed if we can put in intensive support instead, which is costlier but more quality support for the child and their family, so it is a balance.

As general points for future reports Members requested:

- If time delays were indicated reports should say what action was being taken to get back some of that lost time, or similarly if budgets were not on track. If there were issues at national level that had affected timescales for work locally, this should also be covered.
- That clear demonstrable evidence and facts/data be built into the response template in future reports.
- More detailed narrative as this would be helpful for new Commission members to understand the context for the review recommendations.
- That as there has been concern over the number of actions rated as red more explicit narrative could also replace the RAG ratings.
- Revised clear dates and timescales for actions to be completed by.

Further information requested:

- Numbers of people trained in each pilot school and when they were trained.
- To check if school mental health champions have all undergone MHFA training and if there are any gaps how these will be filled.
- Validated figures for waiting and assessment times for both routine and urgent cases.
- Effective outcomes and seeing the impact of the work being done

Officers and partners were thanked for their attendance and responses.

Resolved:-

1. That the monitoring of progress against the responses to the Scrutiny review of Child and Adolescent Mental Health Services be noted.

2. That clear demonstrable evidence and data be built into the response template in future reports.

3. That mental health workers should be more involved with the schools in the mental health pilot on their plans.

4. That the regular monthly performance reports for waiting and assessment times for both routine and urgent cases be submitted to the Commission and performance data validated.

5. That the stretching 3 week target for assessment following referral should remain.

6. Future progress updates to include more evidence of improved outcomes for C&YP following the interventions put in place.

7. Following discussions, new dates to be agreed for actions in the recommendations.

8. That there should be independent evaluation of the whole school approach mental health pilot.

9. That the next progress update would be in March 2017.

44. ROTHERHAM CHILD AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS) - REVIEW OF CHILDREN AND YOUNG PEOPLE'S VOICE AND INFLUENCE

Nigel Parkes, Rotherham Clinical Commissioning Group, presented a briefing note on the independent review of the nature and extent of children and young people's voice and influence in Rotherham CAMHS.

The independent review had been commissioned by the Rotherham Clinical Commissioning Group, using non-recurrent funding for CAMHS transformation, with the aim of:-

- Strengthening children and young people's voice and influence
- Increase the responsiveness of services
- Improve mental health outcomes

The first stage of the review had scoped what children and young people had said about their experiences of Mental Health Services, of being listened to and about their participation priorities. The second stage had drawn on the findings to frame guided conversations with 4 focus groups and some individual interviews with children and young people all of whom had personal experience of Mental Health Services. Members of the Parents and Carers Forum had participated jointly with the children and young people in 1 focus group.

The review had considered 9 participation priorities covering experience, personal care and public involvement:-

- Feeling good – personal experience of being listened to and involved in decisions about own care
  1. Assessment
  2. Routine outcome monitoring
  3. Complaints procedure and advocacy
- Doing the job right – being able to take part in helping develop the Service (contributing to management)
  4. Staff training
  5. Supervision and appraisal
  6. Recruitment and selection
- Running the Service well - having a voice and influence with the leadership of the organisation
  7. Involvement in commissioning
  8. Influencing senior managers
  9. Mission statement

Both positives and concerns had been raised in the focus groups with most participants not having been involved in helping to develop the Service or influence the leadership of the organisation.

The review had made 1 overall recommendation: to embed the use of the mapping and planning tool of participation priorities in order to integrated participation more systematically as part of wider organisational and cultural change.

RDaSH had been tasked by the CCG with taking the recommendations forward by undertaking a baseline study to assess the work they did with different groups, such as the Youth Cabinet and the Young Ambassadors. This linked with the review of the Public and Patient Engagement Strategy by RDaSH.

The report author had visited RDaSH to talk with staff about the findings in the report and also about the tacit information from young people, with discussion focused on what could be done. RDaSH had found the report very insightful and the fact that it was independent gave it extra weight. It generated a lot of reflection on what it was like for people using RDaSH services.

Actions being taken forward included:

- Monthly training in place that included record keeping and safeguarding but also used “in their shoes type training” i.e. What is it like for a family coming into our services? What is our welcome like?
- Youth tube
- Work at Rotherham Show

- Improved supervision and percentage of staff having had an appraisal now nearly 90%
- Recruitment and selection

The following issues were raised:-
Where were RDaSH in terms of completing the template and how was this now being taken forward? - RDaSH were undertaking their self-assessment and would welcome some challenge with that, so they suggested taking it to the Youth Cabinet meeting on 17th November to see how robust the self-assessment was from a young person's perspective.

The Chair requested that the template be shared with the Commission so that Members could see how this would be taken forward and to gauge its success.

Resolved:-

(1) It was noted how the recommendations from the Voice and Influence review would be taken forward and in particular how this would support the recommendations from the Children's Commissioner Takeover Challenge review.

(2) That the completed self-assessment template be shared with the Commission.

45. RESPONSE TO CHILDREN'S COMMISSIONER'S TAKEOVER CHALLENGE REVIEW BY ROTHERHAM YOUTH CABINET

Janet Spurling, Scrutiny Officer, presented a report containing the response from partner agencies to the 11 recommendations arising from the spotlight review undertaken by the Youth Cabinet regarding Child and Adolescent Mental Health Services in Rotherham. The Youth Cabinet were also keen to scrutinise wider working and links between partner agencies especially through the School Nursing Service.

The review was carried out under the Children's Commissioner's Takeover Challenge initiative with the young people taking over a meeting of the Overview and Scrutiny Management Board.

The 11 recommendations were set out in full in Appendix 1 of the report submitted together with the detailed responses from partner agencies. The recommendations covered the following areas:-

- Involvement of young people – to inform practice and service development
- Reporting progress – on implementation of the new models/services
- Improving information – promoting and maintaining websites and addressing stigma

- Closer multi-agency working – in localities and with schools
- School Nursing Service – higher profile and accessibility
- Enabling informed choices by young people – regarding their treatment

Consideration was given to the Appendix which contained the initial responses to the recommendations. Discussion ensued with the following issues raised/highlighted:-

A detailed plan was needed with dates and times plus clarity over reporting routes from partners back to RYC and then to HSC if necessary. When would agencies be reporting back to RYC on the actions or with an explanation if there has been no action? – Some will take time, some are easy or already done such as the waiting area – music channels or tv and putting iPads in on stands. RDaSH will liaise with RYC and their input would be welcomed into action plan. This also linked with recommendation 5 for an annual update to RYC which could be more frequent if required.

Opening hours for the Single Point of Access (SPA)? – RDaSH want to move to an 8am to 8pm service so that it does not affect young people's school time and so they can be seen after school. As much as the trust wants to provide services in schools that is not always acceptable to all young people, so appointments will not always be in schools and it is important to talk to young people about where they want to be seen. 10-12 noon on Wednesdays seemed to be a popular slot for some reason. Families did say they wanted to be seen on weekends and between 4-6pm. Views on preferred locations for appointments differed but in general Rotherham town centre was seen as better than Kimberworth Place or people wanted an appointment in a locality base, but not always in a school. Again some were happy to be seen in the home and others not. The consultation report could be shared with HSC. Details around staffing were still to be worked out if parents want 8am appointments as usually mornings are more for people who have been admitted to hospital the previous night.

Out of hours will be through working with the Adult Mental Health out of hours service on call to cover 8pm-8am. Work and training with adults' services would ensure safe transfer. This would be cost effective and reduced demand for services has been seen in other areas with an 8am-8pm model.

TRFT confirmed that they had been successful in being awarded the 0-19 health services contract and thanked RYC for their participation in the commissioning process. Official feedback to the group by Public Health would be on 17 November.

Draft principles for the new RDaSH CAMHS web site were going out for discussion with young people. Much of the information on the current website would move across. The delay had been due to the

reconfiguration into place based care groups and all children's coming together. A completion date would be forwarded to the commission for the website and for the voice and influence policy.

Now the 0-19 contract has been awarded there is some work to do in rolling out locality working and there is the willingness and commitment to do that. Meeting dates have been set and a joint communications pathway will be developed between RDaSH and the SNS.

The importance of the monthly provider to provider meetings was emphasised. These had taken place for several months and were well attended by TRFT and RDaSH colleagues and had led to some of improvements seen, particularly the A&E response by RDaSH and the children's ward response by RDaSH.

Juliette Penney, TRFT attends the secondary headteachers meetings so she will be leading on raising the profile of the SNS in schools and involving headteachers in how to market the SNS. HSC agreed to maintain a watching brief and to receive information on any outstanding issues.

Part of the work on marketing the SNS will also be going out to young people to encourage them to work with the service and contact has been made with a RYC member to get their input as well.

Can academies opt out of the School Nursing Service? – No as it is a universal service available to everybody. Some academies are more open to partnership working than others but they cannot opt out

The School Nursing Service was locality based and RDaSH had been reconfigured around the same localities so that would enable joint working from there. Although there were some anomalies in the number of localities used by different agencies, for example adult health and social care based on seven and Early Help based on nine there is an overlap so areas are covered.

The Family Support Services work on stigma was important and it was agreed the update to RYC on 17 November would include this to capture the wider range of activities.

Concerns were raised regarding transition from CAMHS to AMHS and Cllr Roche informed the commission that a new transition board was being set up chaired by the Director of Adult Services and he was confident this would lead to improvements.

Could young people be involved in the work on transition, as it is happening to them so they are the best ones to talk about what needs to be put in place? – The new board was officer led and the date of the first meeting would be forwarded to the commission. The terms of reference may include details of plans to engage with young people but

communication with young people to ask them how the service could be improved could be arranged.

Was the transition tool kit that was recently launched in Leeds being used? – RDaSH had carried out an initial draft of scoping against the toolkit which had been shared with CCG. This is a CQUIN target.

Members requested that RDaSH and partner agencies discuss the concerns regarding transition following the meeting to ensure young people receive support even if they do not meet thresholds for AMHS.

Recommendations 1, 3, 4, 8 and 11 from this review also linked to the Voice and Influence review recommendations and priorities for participation being taken forward in minute 45 below.

Resolved:-

1. That the response to the review undertaken by Rotherham Youth Cabinet be considered and noted.

2. That all dates be finalised for the actions in the response template.

3. That partner agencies discuss issues regarding improving transition from CAMHS.

4. That future progress updates include clear evidence and data, especially with regard to involvement of young people and improved outcomes.

5. That HSC would maintain a watching brief on progress in raising the profile of the School Nursing Service in schools.

6. That the next progress update would be in March 2017.

46. IMPROVING LIVES SELECT COMMISSION UPDATE

Councillor Cusworth gave the following update where the workstreams of Improving Lives linked to health:

Domestic Abuse sub-group was looking at support available in Rotherham:

- In the past referrals had not really been forthcoming from GPs and dentists and it was hoped this situation had improved since the last data was reported from 2013.
- Health visitors and GPs were required to provide support within 24 hours for children who witness high risk domestic violence.

Post abuse services for CSE – this involves health partners, including as commissioners

National transfer of unaccompanied asylum-seeking children:

- health assessments for the children might need interpretation services
- there was a regional approach across Yorkshire and Humber to health care as very specialised

Councillor Cusworth was thanked for her report.

It was noted that the next meeting of the Improving Lives Select Commission was to be held on 2 November, 2016 and all HSC members were invited to attend by Councillor Clark.

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

Janet Spurling, Scrutiny Officer, reported the following:-

- Consultation had now commenced on the proposed changes to the Hyper Acute Stroke Care and non-specialised Children's Surgery and Anaesthesia
- The final consultation documents had reflected some but not all of the feedback from the Joint Committee and Health Select Commission
- A Frequently Asked Questions document had been produced which answered some of the concerns and questions raised
- The Rotherham Foundation Trust needed to do things differently to be sustainable and had realised a few years ago the need for collaboration even as a standalone Trust.
- Proposed model for Stroke Care reflected that for Coronary Care which was a recognised as a good model. Manchester and London also had a centralised model of Hyper Acute Care
- No Rotherham patients would go to Chesterfield for Hyper Acute Stroke Care
- Children and young people would go to the nearest hospital to where they lived
- Discussions with staff would take place if changes took place and, due to shortages of skilled staff, the NHS would be looking to match expertise across the region to provide the services
- Planning and managing bed capacity for the extra numbers of patients in the proposed 3 hospitals were currently being discussed

The next meeting of the JHOSC was to be held on 21st November when there would be an update on how the consultation was progressing and the business cases for change. The Yorkshire Ambulance Service were to be invited to discuss the issues raised with them.

The Chairman would feed back at the next Health Select Commission.

Resolved:- That the report be noted.

48. HEALTHWATCH ROTHERHAM - ISSUES

It was reported that no issues had been raised.

The Chair requested that in future any issues or concerns from Healthwatch be raised prior to the meeting.

49. DATE OF FUTURE MEETING

Resolved:- That the next meeting of the Health Select Commission be held on Thursday, 1st December, 2016, commencing at 9.30 a.m.

HEALTH SELECT COMMISSION
1st December, 2016

Present:- Councillor Sansome (in the Chair); Councillors Andrews, Brookes, Cusworth, Elliot, R. Elliott, Ellis, Marles, Marriott, Williams and Short and Mr. R. Parkin (Speak-Up).

Councillors Mallinder and Sheppard were in attendance for Minute No. 54 at the invitation of the Chairman.

Councillor Roche, Cabinet Member for Adult Social Care and Health, was in attendance.

Apologies for absence:- Apologies were received from Councillors Albiston and Fenwick-Green and Vicky Farnsworth (Speak-Up).

50. DECLARATIONS OF INTEREST

Robert Parkin, Co-opted Member made a Personal Declaration of Interest at the meeting (involved in the Learning Disability Offer consultation) – Minute Nos. 58 and 59.

51. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

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

52. COMMUNICATIONS

(1) Information Pack
The pack contained:-

- Rotherham Clinical Commissioning Group Clinical Thresholds paper (raised with Members in draft Clinical Commissioning Group Commissioning Plan)
- Latest version of the Rotherham Place Plan which had taken account of the Select Commission's feedback
- Notes from the Learning Disability Offer Sub-Group
- September Health and Wellbeing Board minutes

(2) Update from visit to the new Emergency Centre
The Vice-Chairman reported that he had visited the new Emergency Centre on 11th November. The size and scope of the new unit was very impressive and would be a wonderful asset for the town once open. He had been assured that the facility would open on time and be on budget.

(3) RDaSH had confirmed dates for actions from the CCTOC response:-

- Consultation was taking place with young people on the website and a functioning website for young people would be in place in February, 2017
- The first meeting of the new collaborative network would be arranged for March 2017 and then quarterly

53. MINUTES OF THE PREVIOUS MEETING HELD ON 27TH OCTOBER, 2016

The minutes of the previous meeting of the Health Select Commission held on 27th October, 2016, would be considered at the January meeting.

54. SOUTH YORKSHIRE AND BASSETLAW SUSTAINABILITY AND TRANSFORMATION PLAN

Chris Edwards (Chief Officer, Rotherham Clinical Commissioning Group), Louise Barnett (Chief Executive, The Rotherham Foundation Trust) and Sharon Kemp (Chief Executive) gave the following powerpoint presentation:-

Our Ambition:-
"We want everyone in South Yorkshire and Bassetlaw to have a great start in life, supporting them to stay healthy and live longer"

Why we need to change
- People are living longer – and their needs are changing
- New treatments are emerging
- Quality, experience and outcomes are variable
- Health and care services are not joined up
- Preventable illness is widespread
- Shortage of clinical staff in some areas
- We have inequalities, unhealthy lifestyles and high levels of deprivation in South Yorkshire and Bassetlaw
- There are significant financial pressures on health and care services with an estimated gap of £571M in the next 4 years

Health in its wider context
- Being healthy is about more than just health services
- 80% of health problems could be prevented
- 60% are caused by other factors:
  Socio-economic status
  Employment
  Housing
  'non-decent' homes
  Access to green space
  Social relationships/communities
- Public service reform
  Personalised support to get people into work
  Support young people facing issues

Develop wraparound services
Structure ourselves better
Make money work better to achieve outcomes

Reforming our services
- We have a history of strong partnership working
- We want to work together in new ways
- Key to our success will be:
  Developing accountable models of care
  Building on the work of the Working Together Partnership Acute Care Vanguard
  Joint CCG Committee
  Local Authorities working together

Developing and Delivering the Plan
- £3.9Bn total Health and Social Care budget
- 1.5M population
- 72,000 staff across Health and Social Care
- 37,000 non-medical staff
- 3,200 medical staff
- 835 GPs/208 practices
- 6 Acute Hospital and Community Trusts
- 5 Local Authorities
- 5 Clinical Commissioning Groups
- 4 Care/Mental Health Trusts

Developing the Plan
- Built from 5 'place' based plans – Barnsley, Bassetlaw, Doncaster, Rotherham and Sheffield
- 8 workstream plans (now our priorities)
- Chief Executive and Chief Officer led

Our Priorities
- Healthy lives, living well and prevention
- Primary and Community Care
- Mental Health and Learning Disabilities
- Urgent and Emergency Care
- Elective and Diagnostic Services
- Children's and Maternity Services
- Cancer
- Spreading best practice and collaborating on support office functions

Shadow Governance – Strategic Oversight Group
- Collaborative Partnership Board – membership includes
  5 Clinical Commissioning Groups
  5 Local Authorities
  5 Foundation Trusts
  4 Mental Health Trusts
  NHS England

Voluntary Sector
Healthwatch
- Executive Partnership Board
- Joint Committee CCGs
- Provider Trust Federation
- STP Delivery Unit

Reshaping and rethinking Health and Care
Our focus will be
- Putting prevention at the heart of what we do
- Reshaping and rethinking primary and community-based care
- Standardising hospital care

Putting prevention at the heart
- Drive a step change in employment and employability
- Help people to manage their health in their community with joined up services
- Invest in a region-wide Healthy Lives programme – focussing on smoking cessation, weight loss and alcohol interventions

Reshaping Primary and Community Care
- Improving self-care and long term conditions management
- Social Prescribing
- Early detection and intervention
- Urgent care intervention and treatment closer to home
- Care co-ordination

Standardising hospital care
- Reshaping services
- Managing referrals
- Managing follow-up appointments
- Diagnostics and treatment
- Reviewing local and out-of-area placement in Mental Health Services
- Specialised services

Early Implementation
- Spreading best practice and collaborating on support office functions
- Children's surgery and anaesthesia
- Hyper Acute Stroke Services
- Acute gastrointestinal bleeds
- Radiology
- Smaller medical and surgical specialties

Financial Challenge
- We currently invest £3.9Bn on Health and Social Care in South Yorkshire and Bassetlaw
- If we do nothing we estimate a £571M gap by 2020/21:
  £464M Health gap

£107M Social Care gap

Putting the Plan into action - Our Objectives
We will:-

- Reduce inequalities
- Join up Health and Care Services
- Invest and grow Primary and Community Care
- Treat the whole person, mental and physical
- Standardise Acute Hospital care
- Simplify Urgent and Emergency Care
- Develop our workforce
- Use the best technology
- Create financial sustainability
- Work with patients and the public

Engagement
We will:

- Connect and talk with our communities
- Connect and talk with our staff
- Foundation is in place with:
  Partners' communications and engagement group already set up
  Strategy in development
  Local conversations in 'place' already happening

Our Timeline

- Collaborating on support office functions – 2016-2019
- Develop network approach to services – 2016-2021
- Review Hospital Services and resources – 2016-2017
- Develop accountable care systems – 2016-2020
- Implement GP Forward View – 2016-2020
- Improve self-care and long term management of conditions – 2016-2021
- Focus on employment and Health – 2017-2020
- Invest in Primary Care and Social Prescribing – 2017-2020
- Develop and invest in Healthy Lives Programme 2017-2021
- New model of Hyper Acute Stroke Services – 2016-2019
- New model of Children's Surgery and Anaesthesia Services – 2016-2019
- New model of Vascular Services – 2016-2019
- New model of specialist Mental Health Services – 2017-2020
- New model of Chemotherapy Services – 2016-2018

Discussion ensued with the following issues raised/clarified:-

- There had been a lot of the concern regarding the decision by NHS England to keep the STPs confidential. Some other areas had gone against NHSE advice and published their STPs early. Would it have been better for South Yorkshire and Bassetlaw if it had been

published early? All Plans would be available in the public domain by Christmas; Rotherham's had been published in November. Everything going forward would be in the public domain. With hindsight it was a misjudgement to have kept it private.

- What was the aim of the consultation or was it an information sharing exercise? The Plan contained a set of aspirations. Working together across South Yorkshire was something everyone would want with increased prevention, joined up services and integration across Health and Social Care. However, the devil would be in the detail as during the course of the next 4 years when the business cases that underpinned the Plan were submitted there would be deeper discussions.

- Would the consultation change anything? The Plan was an aspiration and if people thought the aspiration was wrong then it needed to be known. It was an evolving document.

- Was the "80% of health problems could be prevented" a snapshot of South Yorkshire and Bassetlaw or a national figure? It was a national statistic.

- With regard to governance, Sir Andrew Cash had recently stated to all the Chairs of Yorkshire Health and Wellbeing Boards that there would be an Accountability and Commissioning Board where any resources, be it staff or otherwise, would go. The Board would be Chaired by him and it would make decisions as to where the funding would go. The model set up did not take into account the key accountability of Members of any Council who were accountable to the electorate for any resources they spent. Currently there was very little information being communicated with regard to the key accountability of Members and that was a real concern – The only governance the 3 Chief Officers were aware of was that contained within the presentation i.e. the Collaborative Partnership Board whose membership included the 4 Chief Executives who were very clear that they had no mandate to make any actions/decisions through the Board and that they had to go through each of their organisation's decision making processes. That feedback had been consistent. The 4 Chief Executives needed to be part of the Partnership Board to influence and ensure key local issues were taken into account and make sure that whatever came out of the STP delivered the Rotherham Place Plan as that was what would make a difference to Rotherham residents.

  The Cabinet Member would receive briefings. However, there was a need to get complete clarity with regard to the governance and where the decision making rested. The 3 Chief Officers were firmly of the view that the Partnership Board was an officer working group that would feed back into the respective decision making processes.

- Children's and Maternity Services had been included as 1 of the Plan's priorities and mentioned how a particular challenge was staffing it 24/7. Was this solely down to the lack of workforce and if so what had led to that shortage? Was it national or just a challenge for Rotherham and South Yorkshire? There were a number of factors for The Foundation Trust but workforce was always a significant challenge and there were national workforce challenges. You also had to be cognisant of the size of services, the level of demand and complexity of need. As an organisation, the Trust was very clear and committed to the delivery of high quality Children's and Maternity Services. They were provided 24/7 and consideration was being given as to how to better provide those services going forward.

  A key part of the Place Plan would start developing around Children and working with all the partners across Rotherham to work through how to meet their needs well. From that basis the Trust would then be contributing into the STP to ensure that where the Trust may need collaboration with other acute organisations to perhaps improve on clinical input which could be delivered to support services for Rotherham, this would be secured to deliver the Place Plan.

  Staff shortages were not particular to Rotherham. Like many organisations, the Trust struggled to recruit and was trying very hard currently to ensure that it created an environment where it could retain the staff it had and reduce turnover whilst at the same time creating an attractive place to work for other colleagues. The Trust had recently recruited some quite exceptional individuals to help lead elements of those but continued to have vacancies in some areas.

- Rotherham should not dilute the great services it had to its detriment for the wellbeing of other places – If done correctly, the STP should be a huge opportunity for Rotherham. The Foundation Trust was very self-aware but there were several specialities that needed collaboration to be sustainable. Hopefully the process would allow hospitals to collaborate with Rotherham patients treated in Rotherham unless there were good reasons, clinical or financial. The default position was work behind the scenes to manage the workforce and the patient being offered treatment on the same site. The majority of services should be provided from the same site.

- The interim governance arrangements would remain in place until April 2017 during which time a review would take place. What was currently operating? Where was the review and what was it moving to? What we have now was the arrangement on the slide with the 17 organisations having met once as the Collaborative Partnership Board. The review was to take place by April, 2017. It would be the expectation that the Collaborative Partnership Board would receive the review. The questions posed would be raised at the Partnership Board.

- Had work taken place on the specialist areas possibly being brought together with regard to patients' families travelling to visit and the associated costs? Work was commencing on the 8 workstreams and would result in business cases and proposals for change. If there were major changes it would have to go to full consultation and mapping of the impact for patients and family but had not reached that stage as yet.

- In the recent Autumn budget the Chancellor had stated that there was no monies for prevention. How was it intended to be able to deliver the standards desired and to meet the challenges when there was no extra funding? Realistically there was no funding and making prevention part of everyone's day job was essential. Making Every Contact Count should not cost anything; if every health professional made a smoker aware of the Smoking Cessation Services on offer that intervention could make a big difference. The Healthy Lives Programme, focusing on the "big three" of smoking cessation, weight loss and alcohol, and trying to measure how all Rotherham professionals could communicate that and ensure that the Rotherham population had the best access and made informed choices. Rotherham partners were trying to ensure that prevention would be one of the early workstreams.

- Would the increase in GP budgets be for increased Health Checks? In the plan there were 2 areas that received investment – GP and Mental Health Services. In terms of GP Services it was 2-3% investment which would tackle the management of patients with Long Term Conditions and access to GP services. However, there were not as many GPs so Primary Care would be looked at to provide, for instance, a pharmacist in the practice or more trained nurses to allow the GPs to spend more time with those patients with complex needs. Prevention would be core to everything they did.

- Are you looking at providing more training for staff who worked in GP surgeries? It was expected that every professional who came into contact with a patient to train them in the priorities.

- If members of the public will be able to speak to other professionals at GP surgeries would anyone be refused to see a GP? Every practice worked differently but patients would always be directed to someone who could meet their need. The practice would judge that – it may be the pharmacist, physiotherapist etc. If patients, after seeing those professionals, were not getting what they needed, they would need to see the GP. It was about trying to get the maximum benefit from the GP appointment and saving people's time.

- How confident are you that GPs with the pressures that were on them and other clinicians for timescales and the time spent with patients that they could Make Every Contact Count? GPs were a tiny portion of MECC. It was hoped that people would get the message 2/3 times every time they came into contact with a health professional, Council Officer etc.

- There was a complexity with the partnership working within and outside the South Yorkshire and Bassetlaw footprint. The Transforming Care Plan for Learning Disability and Autism included 3 of the 4 South Yorkshire CCGs and North Lincolnshire. Was there some train of thought as to how it would be tackled and how the Select Commission would be able to scrutinise it or would it be done on a singular basis? The rationale for North Lincolnshire being in the cluster for learning disability clients was that RDaSH provided services there. The 2 areas that you would normally see partnership with were North Derbyshire and Wakefield because of patient flow. Although there was the STP boundary there would have to be partnership work with a number of STPs.

The Chairman thanked Chris, Louise and Sharon for the presentation.

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

(2) That Rotherham Clinical Commissioning Group discuss with Public Health the possibility of providing local statistics regarding health problems.

(3) That the Chief Executive of Rotherham Foundation Trust would raise the issues regarding the formal governance process with Sir Andrew Cash.

(4) That the Rotherham Foundation Trust submit their action plan to the quarterly briefing.

(5) That consideration be given as to how the Transforming Care Plan for Learning Disability and Autism would be monitored/scrutinised.

(6) That it be noted that reports would be submitted to the Select Commission on a regular basis with regard to STP priorities reaching decision phase.

(7) That if Members had any further questions on the presentation these should be forwarded to be raised at the next Health and Wellbeing Board.

(8) That the comments made at the Select Commission be communicated to the Health and Wellbeing Board for inclusion in the formal consultation feedback.

55. ADULT SOCIAL CARE PERFORMANCE - YORKSHIRE AND HUMBER YEAR END BENCHMARKING

In accordance with Minute No. 6 of 16th June, 2016, Nathan Atkinson, Assistant Director Strategic Commissioning, and Scott Clayton, Performance and Quality Team Manager, presented the final published year end performance report for 2015/16.

The Council had seen continued improvements across the range of 22 national Adult Social Care Outcomes Framework (ASCOF) measures reported in 2015/16. 19 out of 22 comparable measures were recording an improvement since 2014/15.

The direction of travel was beginning to evidence that implementation of new Service delivery models led to better outcomes for people and increasing satisfaction levels sustained over the year:-

13 measures had improved their Yorkshire and Humber and national rankings
4 measures had retained their Yorkshire and Humber rankings
4 measures Yorkshire and Humber rankings declined and 8 measures national rankings declined
1 measure was not able to be ranked in 2014/15 so no comparison was applicable.

However, it should be recognised that some of the areas of improvement when compared to the now published national data, showed that the Council had either not always in the transitional year kept pace with other councils' performance or the improvement had been from a low baseline. Possible reasons identified that may have contributed to the negative shifts seen in some rankings were detailed in the report submitted.

Current 2016/17 performance update on the 8 declined national ranking measures were shown in Appendix 1 but in the main had improved since year end or an additional comment had been added.

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

- The information for customers needed to be presented in a way that all understood – This was the challenge and had to ensure that the advice offer was good, met the needs and able to answer what the customer was enquiring about so they could find the services that met their needs. That would not always be by the Council.

- Did the Service consult with other authorities that were performing better than Rotherham to see what they were doing differently? There was already a range of networks where officers met and could tie in with other colleagues to check out what they were doing differently to ascertain if it was a genuine difference and what steps they had taken.

- How did the Mental Health performance impact on the overall score? In terms of No. 3 (Proportion of adults receiving long term community support who receive services via Self-Directed Support), through the Care Act everybody could approach the Council to be assessed and see how their needs could be best met. That experience was across the board. What was found that, if look at activity across the Directorate, excluding Mental Health, almost 98% of Service users were able to have their needs met through a Self-Directed Support. Similarly, what was found on the Mental Health parts of the Service was that, because of some of the challenges, that some people with Mental Health issues have may chosen not to take that particular path.

  It was a similar story in terms of the carers. Historically there had always been a zero score because the nature of the services and provision offered to carers in Rotherham was predominantly badged up as information and advice which did not count to the score whereas the actual services went to the cared for person. This had now changed and was the reason for an increase from zero to 29%. In terms of the impact on Mental Health data they actually had a net reduction of bringing the score down as they were always offered services via the Direct Payment methodology, therefore, the current performance score was 100%. That would change by year end as it did not contain any RDaSH data who offered commissioned services.

- Performance showed that Direct Payments were good but also stated that they were flagged as 1 of the major budget pressures? It was due to how the data was collated. In terms of the statistics and measures, technically the more people in receipt of Direct Payments the better but it was about how you operated them. There had been many discussions regarding the applications and interpretation of Direct Payments which had created anomalies which in turn had financial implications. The data had to be reported to the Government but there was recognition at local level that this was an area for improvement.

  The total number of customers that benefited from Direct Payments was larger than the numbers accounted for in the figures. This was due to the majority being on Managed Accounts and did not count towards the Measure. When those customers had been revisited this year and asked if they wanted a full Direct Payment and take full control of their package they would move into a process that allowed that and increase the figures. Alternatively they could move into a more commissioned service and the cost element associated with Direct Payment would decrease.

- Was there an action plan as to how the situation would be improved? The Managed Accounts issue was part of the Budget Recovery Plan where there was significant activity attempting to rectify the situation.

Managed Accounts historically had been used as a way of finding alternative home care. There were standard home care rates i.e. 8 contracted providers to provide competitive prices but unfortunately the Managed Accounts process was individually negotiated with some of the prices being significantly higher.

- What would the future reporting process be through Liquid Logic? It was anticipated that there would be some issues with a dip in performance as operators became familiar with the new way of working.

- How would the information gathered from Liquid Logic be used? Were we confident about the quality of the data? It would be key to the validity of the data being reported mid-December and that the historical records had been transferred to the new system correctly. Liquid Logic was more structured than the current system and an increased number of mandatory fields that officers had to complete which would help with better quality data.

- Would there be question marks with regard to the end of year figures? A new reporting suite had to be developed which would allow the information to be transferred across specifically and capture Q4 activity correctly to facilitate the completion of national reporting and have confidence in the data.

- How was work progressing to secure and sustain NHS Continuing Health Care (CHC) funding where there was eligible need? It formed part of the Budget Recovery activity. Some of the care packages where it was believed the eligibility applied would be looked at.

- If the CHC funding was reduced was that because the NHS criteria changed or due to a change in the person's state of health? It would be due to a change in the person's needs.

- Why was CHC lost to a customer classified as a new admission? That particular Measure's definition of who counted as a new admission was centred around who funded the placement. Somebody who was in receipt of 24 hour provision but at the initial stage was fully funded by CHC the Council did not contribute to that placement and, therefore, would not be counted as a new admission. However if a person's needs changed and it became a jointly supported placement and, therefore, the Council began to pay a proportion of the costs, at that point it would be classified as a new admission in that financial year.

  In 2011/12 there had been a general decline in the number of admissions – down from 40 to 20. However, last year it had increased to 31. On examination, it appeared that the particular cohort of customers that now had to be taken account of was due to the loss of CHC funding. The current data for Q2 had seen

admissions increase from 7 to 10 and forecasting approximately 20 to year end.

The improvements made since the last report were welcomed.

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

(2) That future reports identify holistic improvements

(3) That the Select Commission receive written quarterly reports to have better visibility of how the action plans are addressing areas for improvement.

(4) That the Select Commission receive six monthly verbal reports on progress to see how the plans are moving forward on a gradual basis.

56. ADULT SOCIAL CARE PERFORMANCE - LOCAL MEASURES

Further to Minute No. 20 of 28th July, 2016, Nathan Atkinson, Assistant Director Strategic Commissioning, presented the Q2 Local Measures performance together with the 4 existing Corporate Plan measures.

The report set out the current performance challenges as at 30th September, 2016, which included:-

LM01 – Reviews
LM02 – Support plans % issued
LM03 – Waiting times assessments
LM04 – Waiting times care packages
LM05-07 – commissioning KLOE's
LM08 (CP2.B3) – Number of people provided with information and advice first point of contact (to prevent service need)
LM09 (CP2.B5) – Number of carers assessments (only adult carers and not including young carers)
LM10 (CP2.B7) – Number of admissions to residential rehabilitation beds (intermediate care)
LM11 (CPS.B9c) - % spend on residential and community placements new measure 2016/17

Discussion ensued with the following issues raised/highlighted:-

- How would the model currently being put together link into budget pressures and budget savings? If the performance improved what kind of budget savings would that give against requiring the same amount of investment? If so, would you be able to re-direct that investment across Adult Social Care or would it have to be shared across all the portfolios? In terms of re-investment, a purpose of the consultation was to look at where finances needed to be realigned. Investment would need to be moved around but there was not much slack in the system. The savings were challenging but were

deliverable, therefore, it had to be ensured that the intelligence and knowledge arising from the Performance Team and Liquid Logic were used to ensure that any issues were addressed quickly.

- If performance was falling where would that sit against the budget pressures within the model and into 2017/18 and beyond? The key for performance was improved assessments/re-assessments. In order to make any change in Social Care it was reliant upon re-assessment and the review process formed part of that. The Service needed to ensure there were good quality assessments that were strength based, considered all the options, and not just statutory services, and ensure that they had longevity and were of good quality. In the past there had been a tendency to look at numbers rather than quality.

  Care Act assessments were a much longer process than previously, if done properly, looking at the person centred approach with long conversations with the individual about what they required, what the person could do rather than what they could not do as well as a built-in time period for reflection. There was a need, from a workforce point of view, for considerable development in embracing and embedding the principles. Online Care Act training had been purchased as well as further workforce development initiatives.

  There also had to be good solutions and services for people. Some of the work being doing around the strategies was developmental but the challenge was that in some areas there was not a great amount of choice. There were things out there that may be a more community focussed than perhaps a statutory service.

- What was LM04 (waiting times care packages)? It was tracking those customers who were on a package of care and whether they had been reviewed at least once in a year. Currently it was tracking at just below 21% opposed to the target set of a minimum of 75%. Ordinarily there would be approximately 6,000 people on service during a year. LM04 looked at the sub-set of those 6,000 which had been on service for longer than 12 months and asked how many had been reviewed. The figures revealed that the Service was not getting through the pace of those numbers as it had been in the past some of which was due to the process of the Care Act and the length of time that took but also the changes in the Service and having the Teams and resources in the right place at the right time which had not happened as quickly as anticipated. Liquid Logic had also had an impact with staff having time out to learn the new systems.

- Was there an action plan in place for LM04? It was clear that the Service would not reach the 75% aspiration target but it was hoped to achieve 40% by year end. It was hoped that some of the improvements being put into place referred to earlier, better demand management and meeting needs in other ways, would result in a

reduction in numbers. It was hoped 2017/18, when Liquid Logic had been embedded and the new structure settled, would see improved performance.

- We need to be assured it would happen and when it would happen? In terms of the slippage, there was now improved project management by the Adult Social Care Development Board where the majority of the data would be scrutinised. It did not mean that customers were not getting services but not ensuring people received the right service through the assessment.

- What was LM10 (number of admissions to residential rehabilitation beds (intermediate care)? It was a measure that looked at the activity throughput of intermediate care as a joint service with the CCG. The numbers were increasing but in line with what had been provided in the past. It would suggest that the provision rate was right for meeting the current level of demand.

- It had been stated that with regard to meeting assessment targets that there may be other ways used to conduct an assessment other than face-to-face. In the days of more and more people using Services that were not inhouse, using Direct Payment to employ someone or even reliant upon family to provide care, if there was not that face-to-face contact some quite serious safeguarding issues might be missed. What exactly was being done to address that? For clarity any opportunity for remodelling some of the delivery and not being face-to-face contact would primarily refer to people on review. For a new person coming into the Service it would almost certainly come from the single point of assessment, contact be made and be seen by a worker face-to-face. If moves were made to discontinue face-to-face contact, it would have to be ensured that the relevant safeguards were in place to avoid the situations highlighted.

- There were times when a person they might be able to say something to a Social Worker in a private context or a Social Worker might see something. The lack of face-to-face contact would take that away that opportunity – The Service would devise a range of different models to actually undertake the number of reviews. They would have to carefully select which target groups were suitable for that range of different models and also put in place the fallback positions of when people felt that they needed to refer back into Service that they were seen, followed up and receive face-to-face contact. Previously, when consideration had been given to options, the Service put mechanisms in place whereby sometimes either provider reviews or telephone reviews had been done. The next step would always be that the next year the person would be seen face-to-face so there was not a continuum of that particular model of delivery. It may have to be included in the quality assurance side of any model proposed if moving away from face-to-face 100%.

- That would be more acceptable if the person had a telephone review in November/December and was then seen face-to-face at the beginning of the new financial year rather than waiting a full year without seeing anyone. This would be fed into the Service as a suggested model for consideration.

- LM05 and 6 (commissioning KLOEs) – how were these measured and what evidence supported the improvements? It was a self-assessment so open to interpretation. In terms of the standards there were 3 themes and within that a number of domains:-

  (1) Person centred and outcome focussed provision
  - Is the work you are doing starting with your outcome and working backwards and is it person centred?
  - Is it being co-produced with Service users, carers and the wider community?
  In the past a lot of the focus had been devising a specification with a small select group of officers, not spending time co-producing it with those in receipt of services and interested parties and losing sight of the outcomes. Some of the recent activity around Learning Disability and the work embarked on Autism, Carers and start of discussions with Older Peoples' Groups about developing an Older Person's Strategy, all pointed towards a move to co-produced models and very much part of the mission within Commissioning to ensure that it was embedded in everything it did.

  The person centred approach was not only mandatory through the Care Act but also a moral duty.

  (2) Well-led
  The direction of travel on leadership was coming from Elected Members, the Chief Executive through the SLT, the Strategic Director of Adult Services and Housing, Assistant Director of Commissioning and the Head of Health and Wellbeing, and staff appreciated that there was a lot more clarity about what the Services was trying to do. Commissioning was more prominent in people's knowledge in terms of the role it played and what was required to get good quality services for people. It was a whole system approach about how it interacted with other services.

  Evidence bases – As funding became tighter it had to be invested wisely so consideration was being given to developing new services. If other authorities had something working well in their area, with evidence behind it, it would be considered.

  (3) Promotes sustainable and diverse market
  At the moment Rotherham did not have a diverse market and in some areas the sustainability was questionable.

Developing and providing for value for money. It was known that some of the Authority's legacy services did not offer value for money and needed to renegotiate prices and think about what to/what not to invest in.

The Authority had historically been good at engaging with providers and had been embedded within the Commissioning function for some time. However, it had been limited to certain disciplines and cohorts, mainly learning disability and older people. It would be looked to widening it out to all the people supported in the Borough.

- Concern that the Leadership Team in 2015 judged itself practically as being in the "red" and the Leadership Team in place as of now judged itself as being in the "green". It did not seem to be the best measure. – When the Assistant Director for Commissioning had first come into post, a self-assessment had taken place. At that time there had not been any current commissioning strategies, no market position statement and very limited information on the people it supported. Within the proceeding period quite significant progress had been made. It was a matter of debate whether "amber" or "green" but certainly in a much better place than when the initial assessment was conducted in June/July, 2016.

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

(2) That quarterly reports are submitted to the Commission for information and decision as to whether any immediate further scrutiny was necessary.

(3) That performance on measures LM01-04 for October to December be reported to the Commission in January as part of the update on the Adult Social Care transformation.

(4) That the minutes of the performance clinic held in July be circulated to Select Commission Members.

57. DEVELOPMENT OF A ROTHERHAM ALL AGE AUTISM STRATEGY

Nathan Atkinson, Assistant Strategic Director Commissioning, reported that Commissioner Sir Derek Myers on 10th October, 2016, had approved a proposal to implement a strategic approach to the commissioning and delivery of services for people with Autism within Rotherham. The approach sought to develop a set of strategic commissioning intentions that promoted independent, choice and control for people with Autism.

The Strategy would strengthen Rotherham's statutory commitments and the approach positively added to the direction of the Adult Care Development Programme and the Children and Young People's Special Educational Needs and Disabilities (SEND) agenda.

Since the proposal was approved:-

- Initial consultation event held to launch activity attended by a range of stakeholders from public services, the voluntary sector, users and carers. The timeline for further consultation was currently being devised
- The event had focussed on mapping current provision across all sectors and identified gaps in some Services areas including training for staff working in Social Care, lack of specialist accommodation and access to information regarding local support
- Presentation to Learning Disability Partnership Board where the approach was strongly supported
- Completion of the Public Health England Autism Self-Assessment Framework which enabled the Council to benchmark progression towards meeting the quality standard goals outlined in the Government's 2014 Adult "Think Autism" Strategy
- Grant awarded to SpeakUp for Autism to assist with strategy development and co-production using users by experience
- Submission of funding bid to the Housing and Care Technology Fund to support the development of specialist housing and assistive technology for people with Learning Disabilities and Autism in Rotherham

The consultation plan was currently being devised with full consultation commencing in January 2017.

Resolved:- That the report be noted with an update to come in the future.

58. LEARNING DISABILITY - SHAPING THE FUTURE UPDATE

Nathan Atkinson, Assistant Director Strategic Commission, referred to the report, 'Learning Disability Commissioning – Shaping the Future', approved by Commissioner Sir Derek Myers on 10th October, 2016, to implement a strategic approach to the commissioning and delivery of services for people with Learning Disabilities within Rotherham through a market position statement. The approach sought to adopt a set of strategic commissioning intentions that strengthened independence, choice and control and supported the wider Audit Care Development programme.

Since approval of the report, the market position statement had been updated with the final version to be published on the Council's website in December. Speak Up had been awarded a £50,000 grant and had commenced a programme of work which would support the overall direction of travel for Learning Disability Services.

Two meetings had now been held with Sheffield City Council to progress activity on a Supported Living Framework which would lead to a formal work programme to facilitate the required tender activity and provider

selection process during 2017. A draft specification would be available for consultation in January with feedback from the Commission invited.

A bid had been submitted to the Housing and Care Technology Fund administered by the Department of Health on 28th October. The bid was to support the development of specialist housing and assistive technology for people with Learning Disabilities and Autism in Rotherham.

The tender for John Street and Oak Close had been published on YOURtender. It was envisaged that the Service provision would be awarded to a new provider in February, 2017, with a view to the transition taking place in March and handover on 1st April. Customers, carers and families would be actively involved in the provider selection process.

Sally from SpeakUp gave a verbal update on the Learning Disability offer consultation and the work they had undertaken:-

- Work had taken place with the Council as well as with people with Learning Disabilities and family carers with regard to how the consultation would work for people
- Development of a range and variety of methods in which people with Learning Disabilities, family carers, members of the public and staff across the Clinical Commissioning Group, RDaSH and the Council could have their say
- 4 different questionnaires that would be available through the Council's website along with an easy read version for people with Learning Disabilities and Autism
- Range of sessions that people could attend - 1:1 and drop-in sessions and focus groups for members of the public and family carers to have their say on the Learning Disability offer
- Made sure that carers have had their say in terms of thinking about some the questions that would be going into the consultation and making sure that people with Learning Disabilities across the Borough had the options to have their say
- Look to working with REMA and BME communities because conscious that very few BME communities access Learning Disabilities Services in Rotherham as well as organisations such as KeyRing and NASS to make sure people with Autism have their say on the Learning Disability offer
- The last Peoples' Parliament had focussed on road safety and hate crime. The Hate Crime reporting officer came to that session and took back peoples' views and voices to the Vulnerable Person's Unit

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

- When undertaking the consultation were you able to look at location bases? If there was a particular location where there was no response it may not be effective to go to the Borough-wide organisation but location-based community projects - Work was

taking place on ensuring all the information was available e.g. GP practices, across community services, posters displayed for the general public to know about the consultation. The information that would come back in through the online questionnaire would specifically ask for the location so it could be mapped across the Borough. Any issues in certain areas of the Borough would be picked up on a weekly basis. It was proposed that short reports be prepared for Members to update on progress with the consultation.

- A lot of people did not view such consultation work as a Service paid for by the Council. With all the funding being put forward it was important that people saw how the Council spent the money and who gained from it.

- Communications Team need to explain what was trying to be achieved, how it would be funded and the quality of the service.

- Were the drop-in sessions just in Rotherham or certain areas of the Borough? They were across Rotherham. Anyone could attend the drop-ins but there was a dedicated telephone line to book in on the 1:1 sessions or focus groups.

Resolved:- That the report be noted.

59. LEARNING DISABILITY - THE TRANSFORMING CARE PARTNERSHIP

Kate Tuffnell, Rotherham Clinical Commissioning group, presented a report on the South Yorkshire and North Lincolnshire Transforming Care Partnership (TCP) which comprised Rotherham, Doncaster, Sheffield and North Lincolnshire Clinical Commissioning Groups. The Partnership would transform care for people with a learning disability and Autism by working collaboratively to deliver the key principles from the national Building The Right Support Framework.

The TCP had been set the challenge to remove the need for permanent hospital care for people with a Learning Disability, people with complex and challenging care needs and/or Autism by March 2019. The plan set out how the Partnership aimed to achieve reducing the need for hospital beds whilst moving to a more proactive community-based care model which was in line with Building The Right Support core values and principles.

In 3 years the TCP would have:-

- Lowered the number of inpatient hospital beds for people with Learning Disabilities and Autism to between 10-15 beds
- Re-invested in new models of care such as expanded care teams, greater use of personal health budgets and a more coherent response to offender and forensic health

- Developed a coherent engagement strategy to ensure that Service users -and their families were genuine co-producers of models of care
- Development of the workforce, not just for statutory services, but also supporting the independent and private sector to access training across the system

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

- When someone who had been in hospital for a lot of years and was going to live in the community, it was essential that local Ward Councillors were notified to help ease other residents' concerns, prevent rumours getting out of hand and engaging the community in a positive manner - This was happening nationally. A challenge for Rotherham was that a lot of the homes that supported people with a Learning Disability did not always notify agencies. The CCG was working with providers across the Rotherham footprint and talking to them about their plans and how they worked locally. There had been instances where people had been placed locally, not known to the Services, and that was where things went wrong. It was also noted that in a number of the homes there were no Rotherham people in them.

- The public were concerned about the changes that were taking place for example support following the death of a family carer – It was really important that people fed into the consultation (Minute No. 58) and put their views forward because it would influence how the Council would take it forward. The work through the Transformation affected a very small number of people. Work was commencing to talk to them and find out where they wanted to live, what they wanted to do and it was hoped to do a piece of work with Speakup regarding Person Centred Planning for those individuals.

- Important to note that although the consultation was badged for Learning Disability it was for anyone in the Borough.

- If someone who lived in the community required a secure bed did we have the capacity to provide that person with a secure bed? If someone needed a hospital bed because they required treatment they would not be denied a bed. There was a staged approach; people who were working with someone in hospital to support them to move out of hospital. Then there was an At Risk of Admission Register which was an early warning and flagged where it was thought they may be problems with an individual and who may need additional support. Workers would meet as a team and provide that additional support and hopefully, with that support, stay in the community. If needed the individual would be admitted to hospital.

- If someone had to access Mental Health Services as an alternative was there capacity to support that person so they could access the Services that would help? A lot of work had been carried out over the last couple of years to look at the Mental Health Hospital and to make sure if someone with a Learning Disability needed to be admitted it was appropriate. Speak Up have done a lot of work with the hospital and training to ensure they understand the needs of a person with learning disability or autism. If somebody who needed to be admitted into Rotherham Mental Health Hospital that would happen if that required and the staff had had additional training to enable that to happen.

Resolved:- (1) That the work of the Transforming Care Partnership to transfer care for people with a Learning Disability or with Autism be noted.

(2) That future reports on Learning Disability – Shaping the Future and the Transforming Care Partnership, be submitted at the same time.

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

The following verbal report was given on the above Programme:-

Consultation

- 900 hits on the website and interest via Twitter but these were not being converted into consultation responses as yet even though the information was getting out to the public
- As at 21st November there had been:-
  78 responses on the Hyper Acute Stroke proposals with 46 disagreeing with the proposals
  60 responses on Children's with 30 disagreeing with the proposals
- Very low attendance at public meetings with no-one attending the 18th November meeting at MyPlace in Rotherham or the meeting at the Source in Sheffield the following week
- NHS England were now looking at a gap analysis across all the communities and engagement so far to ensure they were reaching into communities and welcomed any suggestions from Members
- There had been feedback from all areas on both Services, Hyper Acute Stroke and Children's, but mainly from Barnsley (49 Stroke/26 Children)

Ambulance Service

- East Midlands – already had the specialist centre model in place for Stroke Care, Coronary Care and major Trauma and were achieving better outcomes and reduced mortality
- Yorkshire Ambulance Service Staff Training – all frontline staff (Paramedics and Technicians, call handlers for 999 and 111 as well as Community First Responders), were taught to assess the patient suspected of Stroke using the FASt. Patients at point of call had a fast assessment which was repeated at the time of the face-to-face

assessment. If it was a suspected Stroke staff followed the Yorkshire Stroke Pathway and referred the patient to the nearest Hyper Acute Stroke Unit

Children

- Data to come on the number affected by the proposals on the 6 sub-specialities

The Chairman and Vice-Chairman would continue to be involved, feeding in Members' issues and concerns and reporting back from the JHOSC.

61. IMPROVING LIVES SELECT COMMISSION UPDATE

Councillor Cusworth gave the following update from the 2nd November Improving Lives Select Commission meeting:-

- Post Abuse Services – significant investment put into the development and commissioning of Child Sexual Exploitation support Services by both Council and the Clinical Commissioning Group. They identified that this investment had resulted in a very different support offer both for victims and survivors to that identified in the Jay report. There was now a very comprehensive range of services existed.

- Unaccompanied Asylum Seeking Children that Rotherham committed to welcoming – the main concern expressed by the Select Commission was the possibility of an extra burden on services particularly CAMHS. The Clinical Commissioning Group did say they were fully prepared for this and appreciated there may be some extra service required. They did see the more locality plans and joint working as prepared to alleviate that and did commit to Looked After Children being prioritised as part of the assessment process.

Councillor Cusworth was thanked for her report.

62. HEALTHWATCH ROTHERHAM - ISSUES

No issues had been raised.

63. DATE OF FUTURE MEETING

Resolved:- That the next meeting of the Health Select Commission be held on Thursday, 19th January, 2016, commencing at 9.30 a.m.

IMPROVING LIVES SELECT COMMISSION
14th December, 2016

Present:- Councillor Clark (in the Chair); Councillors Allcock, Beaumont, Cooksey, Cusworth, Elliot, Fenwick-Green, Jarvis, Keenan, Khan, Marriott, Napper and Evans and Joanna Jones (GROW).

Councillor Hoddinott, Cabinet Member for Waste, Roads and Community Safety, was in attendance for Minute No. 39 (Domestic Abuse Service Provision in Rotherham).

Apologies for absence were received from The Mayor (Councillor Pitchley and Senior. Councillor Roche, Cabinet Member Adult Social Care and Health, submitted an apology for Minute No. 38 (Rotherham Adult Safeguarding Board)

34. DECLARATIONS OF INTEREST

Councillor Jarvis declared a non-pecuniary interest in Minute No. 39 (Domestic Abuse Service Provision in Rotherham) as she was a Board member of the Rotherham Rise Trust.

35. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

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

36. COMMUNICATIONS

Councillor Cusworth gave a brief verbal report on the business conducted at the recent meeting of the Corporate Parenting Panel. The agenda included:-

- Looked After Children and Care Leavers' Strategy 2017-2020
- Ofsted Activity Report – Children Looked After
- CCG Commissioning Compliance Tool for Looked After Children and Care Leaver Health Services
- LACC Report July to end of October, 2016 presented by 3 young people who were either current LAC or Care Leavers
- "The Care We Receive as Children Colours our Whole Life" (CQC 2016)
- Rotherham Fostering Service Performance Report 2015-16

Any Member wishing further information on the items discussed should contact Councillor Cusworth.

37. MINUTES OF THE PREVIOUS MEETING HELD ON 2ND NOVEMBER, 2016

Resolved:- That the minutes of the previous meeting of the Improving Lives Select Commission, held on 2nd November, 2016, be approved as a correct record for signature by the Chairman.

38. ROTHERHAM ADULT SAFEGUARDING BOARD 2015-16 ANNUAL REPORT

Sandie Keene, Independent Chair of Rotherham Safeguarding Adult Board, presented the Board's 2015-16 annual report in accordance with the Care Act 2014.

Whilst good progress had been made there was still much to do. It was the Board's aim to ensure that everyone in the Borough shared its zero tolerance of neglect and abuse of individuals with care and support needs whether in a family, community or care setting.

The key priorities for 2016-18 were:-

- All organisations and the wider community work together to prevent abuse, exploitation or neglect wherever possible
- Where abuse does occur we will safeguard the rights of people, support the individual and reduce the risk of further abuse to them or to other vulnerable adults
- Where abuse does occur, enable access to appropriate services and have increased access to justice while focussing on outcomes of people
- Staff in organisations across the partnership have the knowledge, skills and resources to raise standards to enable them to prevent abuse or to respond to it quickly and appropriately
- The whole community understands that abuse is not acceptable and that it is 'Everybody's business'

Sandie highlighted:-

- The Board had been reconstituted and relaunched in 2015 and had reviewed its membership and agreed its priorities
- There had been 2,556 concerns/alerts received in 2015. Of those 579 concerns were investigated further and a plan in place to protect the individuals concerned to prevent further abuse and ensure that the outcomes desired by the individual were met
- The need for proper performance management and to look at the quality of the work across agencies
- Refocussing of resources had enable a new Safeguarding Service Manager from within the establishment to be allocated
- Good attendance and commitment from all agencies at the Board
- Strategy, Constitution and Mission Statement published

- Emerging Safeguarding Adult Reviews of historical cases – 3 Reviews commissioned
- Discussion regarding creation of a budget for 2017-18 with possible contributions from agencies
- Abuse occurred in care settings as well as in people's homes
- Future contribution to the national work taking place looking at people with Learning Disabilities who died an untimely death

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

- Was performance information available in a timely way to support the work of the Board? This had been raised with the Chief Executive and there was now a much more timely response.

- What measures and interventions led to an improvement in standards of care and safety? This was with regard to the Council's Contract Commissioning Team and contract quality rather than Safeguarding. If there was a Safeguarding enquiry it would be followed up as Social Worker intervention to make sure that things were resolved.

- Why had 306 individuals not been assessed under the Mental Capacity Act and Deprivation of Liberty Safeguards? The issue of the backlog had occurred because of a change in the interpretation of the Law and exponentially increased the numbers for the Local Authority. This had led to a backlog in assessments. The Board had requested that some work be carried out to reduce this. National guidance had been published by ADASS on prioritisation of assessments and the Board had been assured that all the cases had been through an initial assessment to identify risk and to make sure that the most appropriate people were prioritised. However, from the Board's perspective, it was unsatisfactory that the numbers were not coming down and needed to be reduced.

- Why had no-one from the Police or Probation Services attended any training in 2015/16? The training within the Police Force was quite robust and they felt that, because of their shift patterns and the specific training that Police Officers undertook, their training was sufficient.

  The Probation Service had its own training programme. The Board's Training Sub-Group had examined training courses that would be particularly applicable to a multi-agency approach and when it would expect the Police or Probation involvement.

- How do agencies work with people who were 'self-neglecting' but may have capacity to make decision to try and stop them from slipping through the net? From a practical point of view, if someone had the capacity to make the decisions there was very little that could be done other than an agency attempting to get alongside that person and perhaps influence the decisions they were making. As far as

agencies were concerned they needed to come together regularly to discuss the situation/risks and examine what might be able to be done in order to ensure that they had given it every consideration possible. There needed to be robust case management when the individuals were known to agencies.

Little could be done with regard to influencing people's decisions if agencies had made sure that the individual had full awareness of the consequences of the decision. Predictably there were some cases nationally that fell within this category that had been subject to Safeguarding Reviews and the learning therefrom put into practice for the people of Rotherham.

- Did the Local Authority and its partners have things in place that could deal with self-neglect? There were things in place at the moment. A piece of work was being conducted around tracking people into Service, what they could do to support themselves or go to the community for extra support if needed. Work was also taking place with Mental Health with regard to what could be done e.g. people learning new skills to give them the opportunity to talk about their issues. It was hoped to align workers with the Mental Health Trust to boost capacity.

- Was there a reason for the high percentage of medication concerns in the residential nursing setting? The Authority had been carrying out some bespoke work with organisations and individual homes about how to raise the quality from a contract commissioning point of view.

- Was there a reason for the high percentage of staffing vacancies in the residential nursing setting? The figures quoted in the report were national statistics. There was a national shortage of qualified nursing staff in nursing homes with a number of homes deregistering due to the lack of staff.

  Because of the issues, the Board felt it would be more than helpful to have a representative on the Board from the independent sector, either residential, nursing or domiciliary care which would strengthen the participation.

- Was there a representative from Housing on the Board? Yes however it did not include the private sector at the moment.

- How confident was the Board with regard to the level of Learning Disability and Autism training within Adult Social Care? As a Board it did not share the level of training and specific elements of either Health Care or Social Care. There had been concern within the Council about Learning Disability and Safeguarding and some restructuring had been undertaken in terms of addressing some of those concerns.

- How confident was the Board that the Making Safeguarding Personal Agenda across the Safeguarding Service would be fully implemented and embedded? There had been considerable work done across Rotherham and there was a specific sub-group looking at it which was very much around the principles of making Safeguarding transparent and asking people at the beginning of the process what they wanted to achieve and at the end of the process ascertain if it had been achieved.

  The aim was to make Safeguarding personal and roll it out across Adult Social Care. All Social Care assessors and staff, including all staff that were employed by the Council, had not only undertaken e-learning but also the e-learning for the Corporate Safeguarding. Presentations had been made to RDaSH, The Rotherham Foundation Trust and all provider services invited to participate in the training.

- Was there a commitment to retain the Vulnerable Persons Team? The individuals who were clients of the Team were the most chaotic of society with some being victims of CSE. Work was being undertaken to look at how the Service could be extended.

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

(2) That a representative from the independent care sector on the Rotherham Adult Safeguarding Board be supported.

(3) That work underway to improve the provision of performance and audit information to support the work of the Adult Safeguarding Board be noted.

(4) That the Chair conveys to the Chief Executive this Commission's wish that the improvements in the provision of timely performance information to support the Adult Safeguarding Board be maintained.

(COUNCILLOR ALLCOCK ASSUMED THE CHAIR FOR THIS ITEM AS HE HAD BEEN LEADING THE WORK ON THIS ISSUE.)

39. DOMESTIC ABUSE SERVICE PROVISION IN ROTHERHAM

Councillor Hoddinott, Cabinet Member for Waste, Roads and Community Safety, and Chair of the Safer Rotherham Partnership, referred to the recent history of the Safer Rotherham Partnership and the criticism it had received in the Casey report regarding its operation and the lack of challenge.

The previous Cabinet Member, former Councillor Kath Sims, who had had responsibility for the Partnership, had spent a lot of time restructuring and reinvigorating the Partnership and had started the work on a plan which included domestic violence.

Progress had been made but the Partnership was not where it wanted to be as yet. There was a lack of strategic overview and it was not known where the gaps in service provision were. The report submitted set out the current domestic and sexual abuse offer in Rotherham and responded to the key lines of enquiry identified by the Commission:-

- What services are in place in Rotherham?
- How well do agencies work together at a strategic and operational level and how is this evidenced and evaluated?
- On what basis are services commissioned?
- How is the effectiveness of services evaluated for children and adult victims of domestic abuse and perpetrators?
- What is the funding available for services and is this resilient?
- How does provision compare with statistical neighbours?

Some funding had been secured from the Police and Crime Commissioner's Community Safety Fund to fund work going forward. An independent Peer Review had also been requested which would inform the revised Domestic and Sexual Abuse Strategy. Discussion at the Select Commission would help inform that revision.

There was now a Domestic Abuse Co-ordinator, Amanda Raven, in post. The multi-agency Domestic and Sexual Abuse Priority Group would be re-established consisting of officers and partners which would co-ordinate the work that needed to take place.

Phil Morris, Business Manager, Children and Young People's Services, and Amanda Raven, Domestic Abuse Co-ordinator, then gave the following powerpoint presentation:-

The Government definition of domestic violence and abuse
"Any incident or pattern of incidents of controlling, coercive, or threatening behaviour, violence or abuse between those aged 16 or over, who are or have been intimate partners or family members"

This is, but not limited to the following types of abuse
- Psychological
- Physical
- Sexual
- Financial
- Emotional

Harm to children who witness domestic abuse can be signified. It is often categorised as
- Emotional abuse
- Physical abuse
- Neglect

Impact is on every aspect of a child's life

- Education
- Emotional wellbeing
- Social wellbeing
- Cognitive development

What is the prevalence

- 130,000 children live in households where there is high risk of domestic abuse
- 64% of victims have children
- 62% of children are directly harmed by their abuser
- 25% of children in high risk households are under 3 years of age and the abuse has been present throughout pregnancy
- 39% of children had difficulties at school
- 60% of children feel to blame
- 52% have behavioural issues
- 25% exhibit abusive behaviour with others
- Domestic abuse is a significant behaviour factor in 2/3rds of serious case reviews
- Domestic abuse factor in 60% of Care Order applications

Rotherham Picture

- 23% of Children Services contacts (April to August, 2016)
- 1,178 contacts for domestic abuse (April to August 2016)
- Between 30-40% require Social Care support

What should we do

- Protect the child
- Empower the non-abusive parent
- Hold abuser to account

Domestic Abuse Pathway

1	Children <18 years Domestic abuse incident Police attend, self or agency reported	1	Adults 16+ years Domestic abuse incident Police attend, self or agency reported
2	DASH risk assessment High, medium or standard risk to victim Immediate action to protect	2	DASH risk assessment High, medium or standard risk to victim Immediate action to protect
3	Notification and referral to MASH	3	Referral through to Assessment Direct single point of access if required

4	Screening IDVA/MASH Manager screening History Current involvement	4	Screening IDVA and Adult Services History Current involvement
5	MADA (Multi-Agency Domestic Abuse) meeting 11.00 a.m. each working day All agencies High risk and some medium risk cases	5	MADA (Multi-Agency Domestic Abuse) meeting 11.00 a.m. each working day IDVA and Police only High risk and some medium risk cases
6	MADA outcome and actions Safety Planning Safeguarding MARAC Operation Encompass	6	Mada outcomes and actins Safety planning Referral to appropriate services MARAC

Discussion ensued with the following issues raised/clarified:-

- 3 years ago there was a Scrutiny Review undertaken in respect of Domestic Abuse. It was extremely disappointing that the progress had stalled. The Domestic and Sexual Abuse Priority Group had not met since December, 2014, and the post of Domestic and Sexual Abuse Co-ordinator had been vacant from July 2015 to October, 2016. Members had a role to play but if they did not know there were any gaps in Service provision how could they deal with it? The Cabinet Member fully concurred with the sentiment but that was not to say that the work was not being done by some officers. The Co-ordinator post now sat within the Community Safety Team and was monitored by the Partnership Board. Officers had been requested to look at the Scrutiny Review recommendations from the earlier Review.

  Part of the Peer Review would be to look at the governance arrangements of the Safer Rotherham Partnership Board as well as performance monitoring. Funding had been secured from the Police and Crime Commissioner and the Council to employ a data analyst.

  The Safer Rotherham Partnership's new plan identified domestic abuse as 1 of its key priorities together with community cohesion and hate crime. There was also a Performance Board which would receive the current data from the Police.

- It was anticipated that the newly reformed Domestic and Sexual Abuse Priority Group would meet in January 2017. The Group's Chair would be at Assistant Director/equivalent senior Police Officer level.

- From a children's perspective, the Local Safeguarding Children's Board had not had access to a Strategy that clearly defined the outcomes of the expected impact on the safeguarding and wellbeing of children which the Board could scrutinise and ask questions of. It was important that the Strategy emphasised what the services should be and how would one expect those services to make a difference to the safety and wellbeing of children where there was domestic violence. The Board would then be able to ensure that the services in Rotherham were delivering what they should be delivering.

- There had not been a major discussion in the Safeguarding Adults Board with regard to domestic violence. However, there was little reference to the position of vulnerable adults in the domestic violence arena and the need for a pathway and establish where exactly the identification of a vulnerable adult may come. The scope of the Adult Board was set in Legislation in that it was particularly concerned with adults that had care and support needs and, therefore, would want to ensure that those thresholds were well co-ordinated in terms of who was doing what and identify together those people that fell under that umbrella, managing the risk involved and supporting people.

- Were there any emerging issues in Rotherham with regard to domestic abuse? There were pathways in place but they were not as clear as they could be in relation to vulnerable people. The Board needed to investigate and not just deal with what was happening at the time but try and get in front and see what was coming over the horizon with mechanisms put into place for prevention rather than reliant on an enforcement type approach.

  Domestic violence now sat within the Vulnerable Persons Team in Adult Social Care and would make sense to include within the Domestic Violence Pathway. The MARAC had always been predominantly victim-led but as there became a more holistic and family led approach it may be that the voice of the child should be heard in that meeting. The MARAC considered what the victim was saying but what a child was saying may sway the way in which the MARAC may make decisions.

- A family holistic approach was a better use of resources – There were a number of ex-CSE cases being received which were passed to the Vulnerable Persons Team. These were people that were now making inappropriate choices of partners because of their history. The bigger picture should be looked at rather than victim led.

- Was the Perpetrator Programme happening and were people being referred into it? How was the Programme evaluated? Was a perpetrator re-referred if there were further incidents? If other issues such as alcohol, drugs etc. arose was the person referred to the other agencies for help? The Perpetrator Programme was an offender-based programme run through the Probation Service and delivered

through the Community Rehabilitation Company. In many respects it was too late as the perpetrator had already committed the offence(s). Referrals would be made to agencies as required.

A more bespoke Perpetrator Programme would be far more beneficial but there were costs associated with it. Discussions were taking place with regard to a County-wide Programme based on Doncaster's experiences over the last 12 months.

Rotherham Rise had been proactively looking at getting a pre-offender Perpetrator Programme for quite some time. There were a number of bids submitted with neighbouring authorities for such programmes.

- Had an analysis been conducted of any perceived savings that would come to the Authority from having a Perpetrator Programme? No. There were national figures stating its success.

- The document talked about more employers recognising and supporting victims. Were we looking to get as many employers as possible on board and would they be given information on how to support victims and who to signpost to? The training programme had recently re-started with invitations to the Probation Service, Elected Members, voluntary sector and the NHS Trust to participate. Other areas such as dentists would also be invited.

- What about employees' sickness records? Certainly within the Council itself they were very good at picking up on that and did use inhouse services and the Service to support. There had recently been sickness record training.

- Had there been any research/statistics that identified drug abuse as a contingent of domestic abuse? Within the MARAC there was a special MARAC which considered the more complicated cases. Approximately 70-80% of those cases were either drug and/or alcohol related. The Vulnerable Persons' Team would be involved to offer support to the victim and perpetrator.

  Mental Health was also a massive issue.

- If the funding was county-wide would it be allocated to areas with particular problems? The Police computer could pick out hotspots and consideration would be given to moving funding/support.

- Was there still a facility for men experiencing domestic abuse in Rotherham? Yes. Both Rotherham Rise and ISVA (Independent Sexual Violent Advocates) would work with both male and females. There had been an increase in male referrals to ISVA. There were also refuges for men which the Service had referred through to.

Men were considered to be part of the "hard to reach" groups.

- Was the Perpetrator Programme designed around the male or female? The Programme recognised both sexes. Some were very bespoke around each person.

- The LGBT community were seeing a rise in hate crime and accessing the very limited service – Victims needed to come forward at an early stage and report their concerns.

  There were increased reports of hate crime. There were great inroads being made in other parts of the community but the Authority and South Yorkshire Police were not having as much success in the LGBT community but were working hard to rectify the situation.

- Was there any help for the families of perpetrators? Sometimes they were as much at risk as everybody else and support had been offered to the family.

  From the children's perspective the Police did refer cases through the MASH where an immediate assessment of the level of risk to the child was undertaken.

- Was there any support to a parent that was subject to domestic violence from their children(ren)? An increase was being seen in the number of cases. It was difficult because they would follow the same referral route of the victim (the parent) going to Rotherham Rise or the ISVA Service and staying in a refuge. However, very few parents would go into a refuge and leave their child(ren) behind. The offer of support currently was not what they wanted; what they wanted was support around mental health, drug and alcohol issues. There were a lot of services but no co-ordination.

- The presentation stated the categories of types of abuse which stated physical abuse was one. Was the term "violence" still used or was the preferred terminology "abuse"? Would the terminology be consistent in the revised Strategy?.

- What would a therapeutic programme look like and why would it be aimed at boys/young men? It had derived from feedback from Children's Services earlier in the year. It was not known what it would look like and was part of the considerations for the future.

- Was the Joint Strategic Needs Assessment (JSNA) up-to-date and what did it say about domestic abuse in Rotherham? The JSNA covered a wide range of areas, however, there was no specific element looking at domestic abuse and was an area that required review.

Resolved:- (1) That the current position in respect of domestic and sexual abuse service provision in Rotherham be noted.

(2) That the recommendations agreed by the Safer Rotherham Partnership Board on 5th December, 2016, be supported i.e.:-

- The commissioning of a full review and refresh of the Safer Rotherham Partnership Domestic and Sexual Abuse Strategy 2013/17;
- That an action plan is developed to underpin the partnership delivery of the refreshed Strategy which includes input from partners working in the field of domestic and sexual abuse;
- Reconvene the SRP multi-agency Domestic and Sexual Abuse Priority Group chaired by Assistant Director (Council) or equivalent level senior Police Officer or senior officer from one of the partnerships responsible authorities;
- Commission an independent peer review of the Partnership's domestic and sexual abuse offer to include governance arrangements, identification of gaps in service, pathways, funding arrangements and support networks;
- Approve funding of up to £10,000 from the Community Safety Fund 2016/17 to facilitate the above.

(3) That, in light of the discussions, that the recommendations from the 2013 Scrutiny Review be reconsidered.

(4) That there be a cost benefit analysis of the Perpetrator Programme and that this be used to inform the future commissioning of Services.

(5) That the Rotherham Safeguarding Adults and Safeguarding Children's Boards be involved in the development of the Strategy and Pathways.

(6) That domestic abuse be included in the future refresh of the Joint Strategic Needs Assessment.

(7) That the Chair of the Safer Rotherham Partnership submit a further report in 6 months outlining progress made in respect of tackling domestic and sexual abuse in Rotherham.

40. DATE AND TIME OF THE NEXT MEETING

Resolved:- That meeting be held in 2017 as follows:-

Wednesday, 1st February

22nd March

all commencing at 1.30 p.m.

IMPROVING PLACES SELECT COMMISSION
30th November, 2016

Present:- Councillor Mallinder (in the Chair); Councillors Allen, Atkin, Buckley, Jepson, McNeely, Price, Reeder, Rushforth, Taylor, Julie Turner, Walsh and Wyatt.

Apologies for absence were received from Councillors Cutts, Jones, Marles, Sheppard, B. Walker and Whysall.

33. DECLARATIONS OF INTEREST

The following persons declared their personal interests in Minute No. 37 (Housing Allocation Policy Amendments), as they are existing tenants of Council housing: Councillor McNeely and co-opted members Mrs. L. Shears and Mr. P. Cahill.

34. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

There were no questions from members of the public or the press.

35. COMMUNICATIONS

The following items were discussed:-

(a) Members of this Select Commission were thanked for their attendance at the performance management training session.

(b) the Council's Corporate Plan – this will be an item included on the agenda of this Select Commission's next meeting, scheduled to be held on Wednesday, 11th January, 2017;

(c) Pre-meetings/briefings in advance of meetings of the Improving Places Select Commission – it was agreed that these informal briefings will continue to take place on the same day as the full meeting of this Select Commission, although a longer period of time will be allocated to them.

36. MINUTES OF THE PREVIOUS MEETING HELD ON 26TH OCTOBER, 2016

Resolved:- That the minutes of the previous meeting of the Improving Places Select Commission, held on 26th October, 2016, be approved as a correct record for signature by the Chairman.

37. HOUSING ALLOCATION POLICY AMENDMENTS

Further to Minute No. 11 of the meeting of the Improving Places Select Commission held on 24th July, 2013, consideration was given to a report of the Strategic Director of Adult Care and Housing stating that, on 6th August, 2015, a revised Housing Allocation Policy had been implemented

by the Council. However, one of the proposals regarding Council Tax arrears was deferred due to representations made after the publication of the Commissioners' 'minded to agree' decision on 6th August, 2015. Further analysis and exploration of the legal implications was required and a clear procedure would have to be developed if Council Tax arrears could be taken into account in deciding whether an applicant is eligible to join the Housing Register. This analysis has now been completed and the purpose of the submitted report is to update Elected Members about the findings. Due to the legal advice given on this issue, it is no longer being recommended that Council Tax debt be included in the Allocations Policy.

At the same time, six amendments are recommended which aim to increase Housing tenancy sustainability, take into account lessons learned during the past twelve months (2015/16), changes brought about by the Welfare Reform and Work Act 2016 and to prepare for the Homelessness Reduction Bill.

The Select Commission received a presentation from Mrs. Sandra Tolley and Mrs. Sandra Wardle (Housing Services) about the Council's review of the Housing Allocations Policy. The presentation highlighted the following salient issues:-

- Housing Allocations Policy – the review timetable

- Proposals for further amendment (a report is to be submitted to the meeting of the Cabinet and Commissioners during February 2017);

- Council Tax – tenancy-related debts are relevant to the Housing Allocations Policy, therefore the recommendation relating to Council Tax arrears will not be included in the Policy

- The six proposed amendments to the Policy:

  Tenancy Sustainability – Recommendations

  1. The mandatory requirement for applicants who have no experience of running their own home, or where a previous tenancy has failed, to attend a pre-tenancy workshop.
  2. The mandatory requirement for all applicants to undertake a housing options interview before joining the housing register

  Reduction in spend – Recommendation

  3. New tenants should not be allowed to apply to transfer within the first two years of their tenancy.

Reduction in spend – Recommendation

4. No rent allowances are issued to new tenants or existing Council tenants. Recommended option
Option 1: Reduce the fourteen days' allowance to seven days (lowest amount of budget savings achieved)
Option 2: Reduce the fourteen days' allowance to a maximum of five working days.
Option 3: No rent allowances are issued (higher level of budget savings achieved)

Housing Options (Under age 35) Recommendations:

5. Bedsits are let to single people or couples giving preference to single people under the age of 35 years:
Option 1 – No change
Option 2 - Priority to single persons aged under 35 years

6. Include homeless applicants owed a reasonable preference to the list of applicants who are exempt from the Local Connection Criteria rules.
• Homeless, but not in priority need
• Homeless, but owed a duty by another authority
• Living in unfit or unsatisfactory housing, have a medical or disability or pressing welfare reason to move.

- Impact of the forthcoming Homelessness Prevention Bill;

- Brief details of the consultation process on the amendments to the Housing Allocation Policy.

The Members of the Select Commission raised the following matters during debate:-

(a) an explanation was provided of the different housing bands (criteria of the Housing Waiting List);

(b) the need for flexibility in relation to the rent allowances for tenants, reflecting the condition of some properties which are being let; contract arrangements are in place with regard to the interior and exterior decorating of some properties; the 'lettable standard" of properties;

(c) the allowance of two weeks, without payment of rent, in respect of the death of existing tenants (Members requested further information about this matter);

(d) pre-tenancy workshops and ensuring that tenants are fully informed of this process; it was noted that the system is to be used by many housing authorities and that every endeavour will be made to learn from and implement the best practice available; specific workshops are available

from several providers (eg: Mears); it was noted that prospective tenants are required to attend the workshops, although the courses do not require participants to take an examination or test; (a customer/tenant dvd training film is available to view);

(e) consideration of applications for tenancies from customers who are homeless – the Policy recommends that a reasonable preference is given to people who are homeless;

(f) Tenancy sustainability and the use of fixed-term tenancies – Government legislation insists upon the use of fixed-term tenancies;

(g) Transfer of tenancies – 10% of properties are currently advertised for tenants wishing to transfer properties; this amount could be reduced to 5%;

(h) reasons for termination of housing tenancies – there are many and varied reasons why tenants choose to terminate their tenancies (Members requested further details of the statistics included within the submitted report);

(i) the role of the Income Team is being reviewed and will be completed in the early months of 2017;

(j) action taken against tenants in breach of conditions – various interviews and checks are undertaken, as well as pre-tenancy inspections;

(k) it is probable that the Policy will be considered by the Cabinet and Commissioners at a meeting to be held during February 2017;

(l) options available for tenants under the age of 35 years – accommodation of a suitable size; possible use of shared tenancies which will be cheaper for the individual;

(m) the Policy intends to focus upon the housing requirements of those tenants most in need;

(n) the Key Choices website includes some background information about the local area in which a property available for rent is situated; this useful information will also be discussed in the interviews with prospective tenants;

(o) information about the process relating to void properties, to try and ensure that empty properties are available for letting as soon as possible;

(p) the timetable for this Policy review – ensuring that the necessary consultation takes place and that the review is comprehensive; the Policy has to be reviewed regularly in response to any changes in Government legislation.

The officers were thanked for their informative presentation.

Resolved:- (1) That the report be received and its contents noted.

(2) That the Improving Places Select Commission supports the implementation of the proposed six amendments to the Housing Allocation Policy, as set out below and as detailed within the submitted report:-

(i) Mandatory requirement for applicants who have no experience of running their own home, or where a previous tenancy has failed, to attend a pre-tenancy workshop.

(ii) Mandatory requirement for all applicants to undertake a housing options interview before joining the housing register.

(iii) New tenants should not be allowed to apply to transfer within the first two years of their tenancy.

(iv) No rent allowances are issued to new tenants or existing Council tenants.

(v) Bedsits are let to single people or couples, giving preference to single people under the age of 35 years.

(vi) Include homeless applicants owed a reasonable preference to the list of applicants who are exempt from the Local Connection Criteria rules.

(3) That a progress report be submitted to a future meeting of the Improving Places Select Commission, during 2017 and such report shall include details of:-

- further information about the allowance of two weeks, without payment of rent, in respect of the death of existing housing tenants;

- Elected Members (Scrutiny) are to be involved in the development of the workshops and in the eventual reporting on the effectiveness of the pre-tenancy workshops and the mandatory training for prospective tenants of Council housing.

(Councillor McNeely and co-opted members Mrs. L. Shears and Mr. P. Cahill declared their personal interests in the above item as they are existing tenants of Council housing)

38. DIGNITY/ROTHERHAM MBC CONTRACT PERFORMANCE UPDATE

Further to Minute No. 18 of the meeting of the Improving Places Select Commission held on 14th September, 2016, consideration was given to a report presented by the Assistant Director – Community Safety and Street

Scene, stating that on 1st August, 2008, the Council had entered into a 35 years' contractual agreement with Dignity Funerals Ltd. for the provision of bereavement services to the people of Rotherham. This unique partnership led to the transfer of significant risks from the Council to Dignity Funerals Ltd., with the Company taking on the responsibility for the capital works and maintenance of the East Herringthorpe Cemetery and Crematorium, together with the maintenance of the eight other Municipal Cemeteries located throughout the Rotherham Borough area. The Council retained the risk in relation to cemetery chapels, associated buildings and boundary walls on some cemetery sites. Dignity Funerals Ltd. had sub-contracted the grounds maintenance elements of the service to Glendale Countryside Management Ltd (but Dignity Funerals Ltd. had retained the overall responsibility for the delivery of the service). The following salient issues were highlighted:-

- the 35 years' contract produces annual incomes for the Council, with the amounts being linked to inflation;

- the requirement for crematoria to comply with mercury abatement legislation and new environmental legislation;

- improvements to the East Herringthorpe crematorium facility; proposed extension to the car park;

- possible availability of land for extensions to the existing municipal cemeteries around the Borough area;

- ensuring that progress reports are available about the cemeteries and crematorium service and that an annual report is provided by the Dignity Funerals Limited company;

- hours of opening of the facilities and the time available for burials (a review of this issues is continuing, including the specific requirements of Muslim burials);

- use of kerb sets and borders around grave spaces, which are not always suitable for cemeteries designed and operating as lawn cemeteries (eg; Greasbrough Lane at Rawmarsh);

- the Dignity Funerals Ltd. company establishes its own level of service pricing, which are lower in comparison to other local authorities regionally; further bench-marking would be undertake in respect of this issue;

- the cost of memorial benches and the availability of benches made from different materials; the review of pricing of such benches.

The Members of the Select Commission raised the following issues during debate:-

(a) the significant investment which Dignity Funerals Ltd. have made in the Est Herringthorpe Crematorium and the possible investment elsewhere in the other cemeteries around the Rotherham Borough area;

(b) Cemetery Chapels – the costs to the Borough Council of the continuing and future maintenance of these Victorian Chapels and whether the establishment of 'friends' groups would be feasible;

(c) the benefits of establishing a Bereavement Services Forum involving representatives of the Local Authority, Dignity Funerals Ltd., funeral directors and the local clergy;

(d) dog fouling in cemeteries and the use of Environmental Enforcement and Penalty Notices;

(e) the balcony area at the East Herringthorpe Crematorium and the need for structural repairs;

(f) the costs of maintenance of closed cemeteries which have no available space for further burials;

(g) improvements to footpaths and roadways within cemeteries – further details will be reported at a future meeting;

(h) further monitoring of the performance of Glendale Countryside Management Ltd., in respect of grounds maintenance at the Maltby cemetery;

(i) details were required of the timescale for the repair of the boundary wall at the Greasbrough Lane cemetery at Rawmarsh.

Resolved:- (1) That the report be received and its contents noted.

(2) That a further progress report be submitted to a future meeting of the Improving Places Select Commission, such report to include the following information relating to the cemeteries and crematorium service:-

- monitoring of the performance of Glendale Countryside Management Ltd., in respect of grounds maintenance at the Maltby cemetery;

- the various options available in respect of the provision of memorial benches within cemeteries (including a pricing structure);

- the fees and charges for the cemeteries and crematorium service – benchmarking and comparison against other local authorities, both regionally and similar local authorities throughout the country;

- further consideration of the opening hours of cemeteries and crematorium and the hours available for burials (including the requirements in respect of Muslim burials);

- an update in respect of the availability of land for a possible extension to the Maltby cemetery.

39. EMERGENCY PLANNING TASK AND FINISH GROUP

Further to Minute No. 31 of the meeting of the Improving Places Select Commission held on 26th October, 2016, Councillor Wyatt (Chair of the Task and Finish Group) provided the following progress and update details:-

- it was still the intention to complete this scrutiny review of Emergency Planning by April 2017;

- the review will include assessment of the duties of the Emergency Planning Forward Liaison Officers and of the Borough Co-ordinator of the Emergency Plan, with this assessment taking place at the time these officials are on-call, as required by the Emergency Plan;

- the review will include the testing of the resilience of the Emergency Plan, in a simulated emergency exercise, with a full evaluation after completion of the exercise;

- Members of the Task and Finish Group have visited the Stockton-on-Tees Borough Council, where a shared service arrangement exists for Emergency Planning, involving four local authorities; Members had been able to participate in a workshop about community resilience and community involvement;

- the scrutiny review will also examine the effectiveness of communications and the use of social media;

- it was also the intention to invite Parish Councils to a workshop for discussion of the effectiveness of the various Parish resilience plans (it was agreed that the appropriate Ward Councillors should be invited to attend this workshop).

The Select Commission thanked Councillor Wyatt and the Task and Finish Group for their continuing scrutiny work on this issue.

40. TENANT SCRUTINY

Co-opted member Mrs. L. Shears reported on the following matters:-

- Rotherfed representatives had attended the Young Tenants Conference at Trafford House on Tuesday, 15th November, 2016;

- research is being undertaken into the best practice in other local authorities with regard to tenant involvement, especially younger tenants;

- Rotherfed is undertaking another survey into ways of communicating and engaging with younger tenants (16 to 35 years age range) – copies of the survey document were provided for Elected Members;

- representatives of RUSH House had been invited to assist with the Rotherfed telephone help-line for tenants;

- concern has been expressed about the proposed reduction in the number of beds provided by RUSH House.

Resolved:- That the information be noted.

COUNCIL SEMINAR
29th November, 2016

Present:- Councillor Yasseen (in the Chair); Councillors Beaumont, Brookes, Clark, M. Elliott, R. Elliott, Jarvis, Khan, McNeely, Mallinder, Russell, Short, Walsh and Williams.

An apology for absence was received from Councillor Marriott.

ROTHERHAM COMPACT

Councillor Yasseen, Chairman, welcomed Waheed Akhtar, Voluntary Sector Liaison Officer, Janet Wheatley and Shafiq Hussain from Voluntary Action Rotherham, and Carole Haywood, Rotherham Partnership Manager, and explained the purpose of the seminar and how it was vital to forge good working partnerships with the voluntary and community sector, which had been highlighted in the Improvement Plan.

The powerpoint presentation highlighted:-

- What is the Voluntary and Community Sector.
- Voluntary and Community Sector Size.
- The Voluntary and Community Sector People.
- The Voluntary and Community Sector Income.
- The Voluntary and Community Sector Impact.
- The Voluntary and Community Sector Networks.
- Rotherham Compact and its Context.
- Status of the Compact and what needed to improve.
- Where are we doing now with the Compact.
- What do we need to do with the Compact.
- How services are using the Compact.
- Timeline.

Discussion ensued with the following issues raised/highlighted:-

- Financial fragility of the sector with reserves and the Charity Commission guidelines.
- Promotion of the Community Leadership Fund.
- Use of Voluntary Action Rotherham as an organisation able to conduct DBS checks.
- Potential for the Compact in Rotherham.
- Opportunities and challenges for the Voluntary and Community Sector.
- Bringing together cohesion and a sense of belonging.
- Partnership initiatives and communication and feedback.
- Funding streams and viability of the Voluntary and Community Sector.
- Huge resource and access potentials.
- Circulation of the Voluntary and Community Sector bulletin.

The Chair thanked Members for their attendance and officers for their informative presentation.

APPOINTMENTS PANEL
8th December, 2016

Present:- Councillor Read (in the Chair); Councillors Beck, Cowles, Steele and Yasseen.

APPOINTMENT OF ASSISTANT DIRECTOR, HOUSING AND NEIGHBOURHOOD SERVICES

Following a national advertising and search campaign, preliminary interviews and an assessment centre involving Elected Members and Stakeholders, the all-party selection panel chose Mr. Tom Bell as their preferred candidate at final interviews on Thursday, 8th December, 2016.

Mr. Bell has been undertaking the interim Assistant Director role since June 2016, having previously occupied the post of Strategic Housing and Investment Manager within the authority. He has worked for Rotherham Council for 24 years in various roles within Housing and Neighbourhood Services.

Resolved:- That Mr. Tom Bell be appointed Assistant Director, Housing and Neighbourhood Services.