HEALTH SELECT COMMISSION
Thursday 23 January 2025

Present:- Councillor Yasseen (in the Chair); Councillors Baum-Dixon, Bennett-Sylvester, Clarke, Duncan, Garnett, Rashid, Reynolds, Tarmey and Thorp.

Apologies for absence:- Apologies were received from Keenan, Ismail, Hall, Havard and Lelliott.

The webcast of the Council Meeting can be viewed at:-
https://rotherham.public-i.tv/core/portal/home

40. MINUTES OF THE PREVIOUS MEETING HELD ON 21 NOVEMBER 2024

Resolved:-

That the minutes of the meeting held on 21 November 2024 were approved as a true and correct record of the proceedings.

41. DECLARATIONS OF INTEREST

There were no declarations of interest.

42. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

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

43. EXCLUSION OF THE PRESS AND PUBLIC

There were no items of business on the agenda which required the exclusion of the press and public from the meeting.

44. SLEEP PATHWAYS

The Chair welcomed Alex Hawley, Public Health Consultant to the meeting and invited them to introduce the presentation.

The Public Health Consultant advised that they held the Best Start and Beyond portfolio within the Public Health Team at the Council which included pre-conception all the way through to transition into adulthood.

They introduced their colleagues who had contributed to the preparation of the presentation and who were supporting its delivery to the Health Select Commission. They were Sue Turner, Public Health Specialist who

was also a member of the Council's Best Start and Beyond team in Public Health, Jill Harper from the 0-19 Service, Vicky Whitfield from South Yorkshire Integrated Care Board (ICB) and Helen Sweaton, Joint Assistant Director of Commissioning and Performance.

The Public Health Consultant provided a broad overview of what was meant by sleep health, the factors influencing sleep health and why the preventative approach was preferred and considered more productive.

The Public Health Consultant offered thanks to the Health Select Commission for expressing interest in considering sleep health as it was held as an underacknowledged public health concern.

They explained that poor sleep health was strongly associated with morbidity and mortality and had a causal role in health outcomes including cardiovascular disease, obesity, poor mental health and neurodegenerative diseases. There were also economic impacts associated with poor sleep health.

It was acknowledged that the influences on sleep health were complex, all encompassing and linked to socio-economic inequalities, and therefore merited a holistic approach which treated the source and not the symptoms.

With respect determinants of sleep health, these were categorised as follows:

- **Biological**; Age, sex and chronotype.
- **Behavioural**; Alcohol, caffeine, fasting, diet, physical activity, sedentary behaviour, gaming and social media, cognitive activity, listening to music.
- **Environmental**; Disasters, air quality, ambient temperature, noise, light, green space.
- **Personal and Socio-economic**; Attachment style, sexual orientation, psychological disposition, ethnicity, work, psycho-social stress, social relations, socio-economic status, seasonal and cultural patterns.

The Public Health Consultant drew members' attention to the role of age as a determinant of sleep health, and explained that everyone's relationship with sleep changes through different stages of life. Adults tended to experience more sleep disturbances, were prone to lighter sleeping and subjected to changes in bed times and wake times.

With children, there were huge changes in sleep patterns from newborn, infancy and reaching school age and puberty/adolescence and it was very common for children to experience sleep difficulties. The Public Health Consultant explained that societal structures were not well aligned with natural sleep patterns, leading to expectations also contributing to poor sleep health.

They outlined a study that had been undertaken by Professor Russell Viner concerning adolescent health had concluded that adequate sleep was the strongest factor in the mental health and wellbeing of teenagers. Professor Viner had advocated moving the school day to start later to accommodate the natural sleep patterns of adolescents, which were driven by changes in the internal body clock during that stage of development.

Whilst it was acknowledged that smart phone usage was held to be a factor in sleep deprivation, that was an issue that affected teenagers before that technology was available. The same study by Professor Viner had also concluded that the adverse effects of poor sleep had around four times the impact of smart phone usage.

The Public Health Consultant explained the multiple levels at which it was possible to intervene to influence sleep health:

- **Societal**; Public policy, cultural leadership, regulations and incentives.
- **Community and Policy**; Community, religious, employment, health care systems, social networks and the built environment.
- **Interpersonal**; Family and group based interventions, via in person and web based social support.
- **Socio-demographic**; Demographically sensitive interventions based on age, sex, race and ethnicity.
- **Individual**; Sleep and circadian health interventions via in person, web based and mobile technology.

Factors relating to sleep safety rather than sleep health were outlined including factors affecting safe sleep in babies such as sleep positions, room temperature, breastfeeding etc, particularly during the first year of life. The Public Health Consultant described the importance of front line interventions through 0-19 services, early help and relevant others who worked with new parents to minimise the risks from SIDS (Sudden Infant Death Syndrome) through the promotion of safe sleep practices.

They drew members' attention to the SYMCA (South Yorkshire Mayoral Combined Authority) Safe Space to Sleep programme; a referral based scheme which aimed to ensure that all under 5's in South Yorkshire had access to good quality beds and bedding.

The Joint Assistant Director of Commissioning and Performance outlined that 40% of all children and young people experienced sleep issues disorders at some point in early life, and that percentage increased significantly for Looked After Children and Children with SEND (Special Educational Needs and Disabilities).

In Rotherham, approximately £400k was spent on melatonin prescribing in 2021/2022, so the development of the Sleep Pathway was a priority

which was reflected in the 2023-2025 Rotherham Place Plan and in the SEND Joint Commissioning Strategy 2024-2027.

The Joint Assistant Director of Commissioning and Performance described the four tiered structure of the pathway, including universal services such as the 0-19 service, midwifery, health visitors, early help and sleep charities at Tier 1. They highlighted that effort was made to communicate the support available at Tier 1 more effectively.

At Tier 2, this was where a problem had been identified that people were unable to resolve themselves. The offer included sleep programs delivered by health services, the local authority and early help, through specialist disability services and third sector organisations. A range of in person and online programs were in place to make them more accessible.

Tier 3 was a new strand of services which were aimed to verify that Tier 2 services and support had been effective. This offered a combination of home and clinic visits.

Tier 4 remained available where Tier 3 interventions were insufficient, and prescribing services were an option as part of the Tier 4 offer.

Jill Harper, a Team Leader within Rotherham Public Health's Nursing Services, explained that they were responsible for providing first line advice around sleep patterns, routines, positive sleep methods, foods to avoid and the sleep environment. Second stage interventions included home visits, assessments of sleep need and the implementation of support packages.

Sleep support was also available through the TRFT Children's Service App which was quite well used. Information available in the app related to:

- Sleep cycles in infancy.
- Pre-bedtime snacks.
- Night time waking.
- Bedtime environment.
- Bedtime routines.
- Teens and sleep.

The Joint Assistant Director of Commissioning and Performance gave examples the range of local resources available, including those on the SEND Local Offer. The services available were co-produced with children and young people through the 'With Me In Mind' service via CAMHS (Children and Adolescent Mental Health Service). Members were talked through a case study which explained how support was provided in practise and the outcomes that could be achieved.

Whilst it was not possible for the Child Development Centre (CDC) to be represented at the meeting, the Joint Assistant Director of Commissioning and Performance described examples of the support they offered which

included:

- Sleep Pathway information, advice and guidance.
- Sleep diaries.
- Telephone support.
- Sleep assessments and follow ups.
- Referrals to the Sheffield Sleep Clinic.
- Melatonin prescription (as a last resort).

It was stressed that the CDC spent a lot of time working with families and supporting strategies, which often ran over extended period of time prior to considering prescribing sleep medication.

The Public Health Consultant highlighted a video resource that had been included in the slides shared with the Health Select Commission as part of the agenda pack. The video was produced by Early Help along with Rotherham Children. Whilst it was not possible to show during the presentation due to the length of the video, Health Select Commission members were encouraged to access the video which contained useful advice and information, which drew on the experiences of local children. Issues covered in the video included:

- Smart phone use before bed.
- Narcolepsy.
- Sleep Apnoea.
- Nightmares.
- Caffeine's effect on sleep.
- The affects of sleep deprivation on school life.
- Self-help.

The Chair thanked the Public Health Consultant and colleagues for the presentation and invited questions or comments from members.

Councillor Thorp queried whether the information available regarding sleep issues was routinely shared by midwives, or whether this was only offered when an issue was identified.

It was explained that information about sleep was included in 'The Red Book' and there was a specific line that parents could contact in relation to sleep issues. It was also acknowledged that it was broadly accepted that sleep issues in babies was commonplace, but nonetheless challenging. Whilst parents were at liberty to proactively contact services where they were experiencing difficulties, there was a universal offer of midwifery and health visits which could provide support, advice and guidance as required. The topics discussed during visits were led by parents' needs and concerns.

Councillor Thorp wanted to understand whether there was any data relating to sleep issues suggestive of a correlation between incidence and

levels of deprivation.

It was believed that at Tiers 1 and 2, there was no intelligence regarding access to services with the level of sophistication described. Whilst the current position was likely the same for Tier 3 and 4, due to the nature of the services provided, it was theoretically possible to generate that data, but this would need further exploration with those involved in the delivery of service. It was agreed that the Joint Assistant Director of Commissioning and Performance would seek to establish what data could be provided.

Councillor Bennett-Sylvester noted the link between Councillor Thorp's query regarding sleep issues and levels of deprivation and the SYMCA Safe Space To Sleep Program. They wanted to understand whether details of the program were being shared via the Baby Packs that were launched recently.

It was confirmed that Baby Packs were issued universally, whilst the SYMCA Safe Space To Sleep program was accessed based on need, and midwifery services were used to identify vulnerable families that needed support from the scheme. However, as the scheme was open to older children as well as babies, family hubs, schools and nurseries were aware of their ability to refer to the scheme.

Councillor Bennett-Sylvester was also mindful of the impact of the quality of housing on sleep health, and the impact of issues such as overcrowding, group living etc and sought reassurances that there was collaborative working between professionals involved in the sleep pathways and housing services so that there was consideration given to the medical implications of housing issues where appropriate.

It was explained that where there was involvement with Early Help or Social Care, housing needs were considered and there would be appropriate discussions around allocations, which would give due regard to risks identified.

Councillor Thorp sought clarity about the use of sleep diaries and the reference within the presentation to children being removed from the pathway where these were not returned. They were concerned that this failed to address the child's issues and sought reassurances that checks and balances were in place before a child was removed from the pathway.

It was confirmed that sleep diaries were one part of the intervention process and were augmented by the involvement of others. Where there was the expectation that sleep diaries were completed and returned, there was always follow up before any action was taken.

Councillor Reynolds queried the length of time between first contact and sleep diaries being issued, and wanted to understand whether there was

any triage process in place to ensure that those with greatest need were 'fast-tacked' to access the support required in a timely manner to prevent issues becoming engrained.

It was agreed that sleep issues could become incredibly difficult for children and families if they were not 'nipped in the bud'. Whilst the system was fairly responsive, it was accepted that there was more to do to improve performance in that area. Significant efforts were invested to ensure that escalations through the staged approach occurred quickly where required.

Councillor Thorp noted that the CDC made referrals to the Sheffield Sleep Clinic, and queried whether it was possible for the services available though the clinic to be delivered at local level.

The services offered through the Sheffield Sleep Clinic were highly specialised services which were often provided regionally. As such, in this instance Rotherham residents were quite fortunate that this was located relatively nearby in Sheffield as those services were only available at a small number of locations across the country.

Councillor Garnett noted the non-recurrent ICB funding being used at Tier 3 of the pathway, and sought clarity of when that funding would end, and how many Rotherham residents had accessed services delivered by that funding and who may be adversely affected by its withdrawal.

The non-recurrent ICB funding was allocated on an invest to save basis to test the Tier 3 service as it was believed that too many children that were provided with Tier 2 services, but there were no checks that advice and guidance provided had been implemented successfully. Where Tier 2 interventions were unsuccessful, children moved quickly to Tier 4 services and it was felt that this contributed to the level of prescribing. Tier 3 was intended to reduce the numbers escalated to Tier 4, where Tier 2 services may have proved successful if families were provided with additional support. Initial feedback indicated the enhanced support offered through Tier 3 was well received by parents and carers, and on conclusion of the pilot, the benefits of the introduction of Tier 3 would be reviewed and assessed in order to allow an informed decision on the long term future of Tier 3 services. The hope was that the reduction in medication prescriptions would service costs for a recurrent Tier 3 service, or clearly demonstrate that the additional support offered ultimately had no impact on the prescription rate. However, it was too early to say what would prove to be the case upon the conclusion of the pilot.

Councillor Duncan queried the extent to which the Sleep Pathway, and the introduction of Tier 3 services was expected to reduce medication dependency.

Whilst there were no specific targeted level or values, the intention was that any financial savings which generated through the introduction of the

Tier 3 service, would come from reduced prescribing, would be reinvested to continue that Tier.

Councillor Steele wanted to understand whether there were time limits associated with prescription sleep medications.

Extensive trials had demonstrated that melatonin was a very safe medication, however it was understood that some children used it for extended periods and in some cases, for several years. Medication was a part of a wider treatment regime, with planned medication breaks to review whether this remained necessary in individual cases.

Councillor Steele sought reassurance that where medication was prescribed in the long term, the effects of sustained use over time were monitored and know not to cause cumulative harms that might not have been associated with short term use.

It was explained that all children prescribed melatonin saw a paediatrician once a year and underwent health checks. Melatonin was known to affect growth to a certain degree in some cases, but that was well understood and considered in decision making processes. Practitioners were clear the prescribing sleep medication was a last resort, and concerns such as those raised by Councillor Steele regarding medication had contributed to the decision to operate the Tier 3 pilot.

Councillor Steele was curious how the various services identified and engaged with children and families who needed support to address sleep issues where parents were not contacting services directly, and more broadly how the pathway was promoted to potential service users and communities.

A large and varied workforce were involved in the delivery of the sleep pathway, with numerous interactions with parents and families at various stages of child development designed to build both exposure, awareness and trust. 80% of Rotherham schools had signed up to the 'With Me In Mind' service, which offered the opportunity for schools to refer children into the service based upon issues identified with and without parental involvement dependent upon age, and in some cases, self-identified concerns. Any suggestions concerning ways to improve awareness of the pathway and the source of advice, guidance and support available was welcomed.

The Rotherham Public Health's Nursing Services Team Leader added that practitioners completed area health profiles and held a good understanding of levels of deprivation and the issues that affected particular localities, such as healthy eating, sleep deprivation etc. School nurses in particular worked very closely with schools to identify levels of need, and ensure appropriate support was provided.

Councillor Baum-Dixon noted that prior to the presentation, they were unaware of the services associated with the Sleep Pathway. They sought reassurances regarding promotion of and engagement with the services delivered through the pathway, particularly in early childhood and for pre-school children.

The 0-19 Service was comprised of health visitors, nursery nurses, school nurses and staff nurses. There was a website for the service and efforts were made to promote this. With regards to sleep health, this formed part of questions asked during mandated contact visits, although it was acknowledged that there was a degree of expectation that parents would proactively contact the service where they held concerns. It was also notable that Baby Packs were universally provided, and ensured that all recipients had information concerning services at their fingertips without the need for them to go online or physically visit a family hub. Nonetheless, it was felt it may be necessary for the service to reflect on members' feedback and consider what more could be done to promote the services and support available but important to be mindful of the need to avoid creating unnecessary anxiety around normal fluctuations and disturbances in sleep patterns in early childhood.

Councillor Duncan wanted to understand how the general success of the Sleep Pathway was being measured and how effective it had proved to date.

When the introduction of Tier 3 of the Sleep Pathway was being discussed, it became clear that there were services involved in the delivery of the universal offer and Tier 2 services that were not previously understood or acknowledged. That considered, it was new for the borough to have robust and cohesive services in place to ensure that children were reliably and consistently referred through the pathway, which ensured that only those children with genuine need accessed the services provided at Tier 4. It was not possible to provide a view on the success of the pathway to date at that stage, and there were no specific success measures identified. The intention was to fully evaluate upon conclusion of the Tier 3 pilot, and data could be provided to the Health Select Commission at that stage.

Councillor Baum-Dixon expressed the view that they remained unclear regarding what success was in terms of the Sleep Pathway. They sought clarity on whether this was solely a reduction in the levels of melatonin prescribing, or whether other outcomes were sought, or if there were any defined KPIs (Key Performance Indicators) which would allow conclusions to be drawn regarding the success of the pilot or otherwise.

With respect to the Tier 3 pilot, there were 2 assumptions. Tier 2 services were intentionally delivered by different people and by different means to enhance accessibility, however, that made measuring collective success difficult. It was assumed that failure to use information, advice and guidance and implement strategies accessed through Tier 2 services to

prevent sleep issues was a factor in the numbers that accessed Tier 4 services. The premise of the Tier 3 service was therefore to bridge that gap. Critically, there was not one specific desired outcome, but rather, a range of possible outcome from the pilot which would direct the best long term approach.

Councillor Clarke queried whether there was any evidence of concerns amongst midwives and health visitors regarding thermal comfort, and those struggling with energy costs, or damp and mould issues. They sought reassurance that those who interacted with children and families who were in a position to make those observations were doing so, and were aware of the energy support schemes available.

Visiting practitioners were mindful of conditions within the home environment and referred into and consulted with other services and agencies as appropriate. It was noted that if there was any further information or resources it would be beneficial for visiting practitioners to carry or have access to, all suggestions were welcome.

Councillor Yasseen wanted to understand the level of referrals to the SYMCA Safe Space To Sleep program and how this had benefitted Rotherham residents.

The latest figures for Rotherham were not know. Referral rates were healthy in the Summer when the program commenced, however, there were some issues and the program had undergone a degree of remodelling which remained work in progress, and was expected to change the referral profile. It was agreed that the Health Select Commission could be provided with updated information regarding referrals in due course.

Councillor Bennett-Sylvester shared their experience of being affected by a sleep disorder, and highlighted the positive impact of obtaining appropriate advice, guidance and support had had for them and their family. They had also had experience of the services provided by the Sheffield Sleep Clinic, which were likewise beneficial.

Councillor Yasseen commented that she felt discussions had reflected that more could be done to raise awareness of the specialist skills, knowledge and services represented within the Council and through partner organisations.

Resolved:-

That the Health Select Commission noted the contents of the Sleep Pathways presentation.

45. ADULT SOCIAL CARE - DOMICILIARY CARE

The Chair invited Councillor Baker-Rogers, Cabinet Member for Adult Social Care and Health to introduce the presentation.

Councillor Baker-Rogers advised that the update relating to Adult Social Care Commissioning was requested following its last presentation to the Health Select Commission in January 2024.

The presentation focussed on the following commissioning themes:

- Domiciliary Care.
- Mental Health.
- Learning Disabilities and Autism.

It set out progress against a number of dynamic purchasing systems, which were at varying stages of maturity, and the ways in which these had positively impacted the lives of Rotherham residents.

The Cabinet Member for Adult Social Care and Health advised that Scott Matthewman Assistant Director of Strategic Commissioning, Jacqueline Clark, Service Manager, Adult Care, Housing and Public Health and Garry Parvin, Joint Head of Learning Disability and Autism Commissioning were assisting with delivery of the presentation.

The Assistant Director of Strategic Commissioning provided background and context to the frameworks that were in place to support the wider commissioning process and the important outcomes that were seen from commissioning activity over the past 12 months.

Commissioning adult social care services involved planning, identifying and monitoring services required by Rotherham's residents. It was essential to ensuring that the appropriate support was in place to meet the needs of local communities, and enabled residents to live fulfilling lives as independently as possible.

The following were cited as key considerations when services were commissioned:

- Assessment of need.
- Priority setting.
- Service planning.
- Service procurement.
- Service monitoring.

Co-production was highlighted as an essential part of the process, as was ensuring sufficiency within the market and ensuring that the quality of services delivered was at the highest possible standard.

The legal framework that covered services delivered was outlined:

- Duties under the Care Act 2014:
    - Prevent, reduce and delay needs.
    - Market shaping.
    - Managing provider failure.

The purpose of Dynamic Purchasing Systems was explained. This was a vehicle to support providers to achieve the highest possible service standards in order to bring them to the local market, which enabled the Council to draw on those services as and when required.

This resulted in providers being brought onto the framework but at that stage there were no purchasing commitments from the Council's perspective. It afforded flexibility and responsiveness of service delivery in line with the needs of service users and ensured value for money.

The Service Manager, Adult Care, Housing and Public Health described the dynamic purchasing system that was in place for home care and support services.

There were a total of 21 providers appointed, which remained the same as when last reported in January 2024. Tier 1 providers were obliged to take requests for service under contract arrangements, and 9 of these were appointed with three in the North, Central and South areas of the borough respectively, which ensured capacity.

There were a further 8 Tier 2 providers, who were called upon in the event of capacity issues from Tier 1 providers.

Whilst one small provider had exited the market from Tier 2, as dynamic purchasing systems were open frameworks, it was quite simple to appoint a new provider.

There were 4 specialist care providers in place. These were subject to additional training to address learning disabilities and mental health issues.

Since last reported, there was an upward trend in the number of hours increasing by approximately 1000 hours to 19,600 hours of activity per week, however capacity was consistently meeting demand.

By quarter 2 of 2024/25, 15 of the 21 appointed providers had completed the quality assurance process. Quality was constantly monitored and systems and processes were in place via which concerns were reported and investigated.

The position at the time of reporting was as follows:

- 2 providers were rated excellent.

- 8 providers were rated good.
- 6 providers were completing the quality assurance process.
- 4 providers were rated as requiring improvement.
- 1 provider was rated poor.

For those that were rated as poor or requiring improvement, there was a process in place to ensure that the issues identified were resolved, however the last grading remained in place until those providers had undergone a further full assessment process. All affected providers had achieved the improvement plans that they were issued and had satisfied the Council that safe service was maintained.

The Service Manager, Adult Care, Housing and Public Health explained the position regarding key performance indicators. KPI 1, which related to utilising assistive technology was at 58% against a 75% target, which was lower than was previously reported in January 2024. KPI 2 which related to strengths based approaches training had increased to 92% against the 100% target. KPI 3 relating to level 2 professional qualifications was at 55%. It was noted that nationally, level 2 achievements rates were 22%, so whilst 55% was pleasing it was the intention to push for further improvement. For KPI 4, 90% of care staff had completed the care certificate and the remaining 10% were undertaking the certificate.

Results from a telephone survey conducted with services users was shared with members, which indicated positive experiences which had enabled service users and delivered quality services. In the event that concerns were shared through the survey, they were addressed via the contract compliance team.

The Service Manager, Adult Care, Housing and Public Health summarised the Mental Health Recovery Focussed Community Services framework. Lot 1 was a supported living service which supported individuals with mental ill health to live in the community. There were 3 distinct elements to the service:

- Tenancy.
- A registered housing provider responsible for managing the property.
- The care and support provider.

The 3 care and support providers were CQC registered as some service users needed personal care and medication management. There were 8 residential units of supported living accommodation occupied, 3 units were in the process of having tenancies finalised and a further 18 units were in development.

In relation to the 8 supported tenants, 5 had moved into the units from a hospital setting, 4 had reduced support needs through supported living and 2 were ready to move on to fully independent living.

The methods via which supported living was funded was explained, drawing links to the Care Act 2014, Section 117 of the Mental Health Act and

The Joint Head of Learning Disability and Autism Commissioning described the Learning Disability and Autism (LD&A) Supported Living framework. They explained that as was reported to Cabinet in September 2022, LD&A Supported Living was very well established in Rotherham, with an established base of national providers alongside a strong micro-enterprise presence which the Council were keen to develop further. However, it was noted that there was no dedicated support living specifically for people with Autism. It was further determined that market shaping was required.

Since that time, a Dynamic Purchasing System was implemented with 19 providers appointed, 14 of whom were new to Rotherham and all of whom were paying real living wage accredited or paying above national minimum wage in accordance with the Council's social value agenda. The framework allowed the Council to respond to need flexibly and responsibly.

With regards to next steps, it was explained that new dynamic purchasing system was due to be published at the end of January 2025. This was intended to enhance community opportunities and offer greater choice for service users.

The Chaired thanked officers for the presentation and invited questions and comments from members.

Councillor Clarke wanted to understand how many Rotherham households were supported by the 5 home care and support service providers who were rated as poor or requiring improvement, and queried whether that was a CQC rating or one determined by the Council. They also sought clarity on what processes were in place to improve their quality of service.

It was explained that the ratings applied were the Council's own. Whilst exact figures were not known, it was believed that approximately 500 hours of services were delivered by providers rated as poor or requiring improvement. The process in place to address identified issues involved the Council working with the Registered Manager for the service to implement an action plan which targeted the required improvements over a period of 6 weeks. Progress towards the achievement of action plans was closely monitored by the Council's Contract Compliance Officers. It was acknowledged that the decision to continue to apply the poor and requires improvement ratings after successful completion of an action plan potentially gave an unfair reflection of the actual quality of service that was being delivered, but the intention of this was for the Council to maintain vigilance until that improvement was sustained over a period of time. It was agreed that figures regarding the exact number of households

served by providers rated poor or requiring improvement would be provided to Health Select Commission at a later date. It was confirmed that all 5 affected were Tier 2 providers.

Councillor Clarke wanted to understand how scrutiny and oversight of the quality of services was undertaken, and how complaints were monitored.

It was explained that contact was predominantly via telephone, but where issues were raised there was direct contact. Contract Compliance Officers were responsible for monitoring complaints in conjunction with the registered provider. Individual services were expected to have a process in place and manage their own complaints, however, where these were not satisfied they did come into the Council. Internal controls were extremely robust and were applied in addition to the requirements of the CQC.

Councillor Duncan wanted to understand the contracting arrangements in place with regards to the home care services contract that had commenced in 2019 and appeared to be due to come to an end in 2025. They sought clarity around what the key considerations for procurement were.

It was explained that the service was due to end in March 2026. Service planning and co-production was taking place and the development of a different model would be considered if this was needed. This was expected to go to Cabinet in September 2025.

Councillor Duncan acknowledged that whilst the national achievement rate was 22%, they felt that a 55% achievement rate locally against a 100% target stood out as a potential cause for concern. They queried whether the contracts awarded incentivised improvement of qualification rates or sanctioned failure to achieve the target.

It was explained that any contract default notices were imposed based on a global review of providers, and would not consider qualification achievement rates in isolation. It was felt that incentivisation was more successful method.

Councillor Duncan queried whether rates or pay and other issues driving staff turnover in the sector were contributing to low levels of qualified staff, and whether future contracts awarded would seek to address that.

It was acknowledged that there was the need to review the terms and conditions of care workers, particularly around the secured hours, however there was the need to balance that with the cost of service delivery. It was certainly the ambition to improve that position and mature conversations were had with providers through forums, alongside significant investment from the Council to continue to improve that moving forward.

Councillor Garnett wanted to understand how the Council was contributing to market shaping required for Learning Disability and Autism Supported Living, and how it was advocating for Rotherham residents as part of that process.

There was active engagement with providers through forums and robust conversations, the housing needs assessment was completed on a South Yorkshire basis which the council fed into, which considered demography, transitions and need. There was also collaborative working with professional from Children and Young People's Services (CYPS) to further understand need and support market shaping activities.

Councillor Thorp wanted to understand the differences between Tier 1 and Tier 2 services, and which of those Tiers the 33% of providers that it was noted had failed the targeted standards of care fell into.

It was clarified that Tier 1 providers were obliged to take on care work when asked to do so, with 3 providers in each geographical area to ensure service capacity. Tier 2 providers could be offered work where there was no capacity within the Tier 1 providers. All of the providers that were rated poor or requiring improvement were Tier 2 providers. It was emphasised that whilst there were concerns at some stage, they were not considered to be failing.

Councillor Thorp queried whether there was transition planning between CYPS and Adult Care services and whether Housing were involved that planning to ensure that those needs were considered.

It was confirmed that transition planning was vitally important and there was close liaison with colleagues in CYPS. Where there were particular complexities of care, other services and professionals such as social workers were also involved in ensuring smooth transition. It was acknowledged that there was scope to improve further, and be more mindful of future need, and there was the aspiration to develop that level of sensitivity within service delivery and planning.

Councillor Clarke commented that Councillors were aware of the acute pressures on adult services and requested that Officers contact Councillors if there were any ways in which they could offer support.

Resolved:-

That the Health Select Commission:

1. Noted the Adult Social Care Commissioning Update.
2. Extended an offer of support to Officers in relation to involvement in co-production conversations and recruitment activities where it was felt that would be beneficial.

46. HEALTH SELECT COMMISSION WORK PROGRAMME - 2024/2025

Resolved:-

That the Health Select Commission:

1. Approved the work programme.
2. Agreed that the Governance Advisor was authorised to make any required changes to the work programme in consultation with the Chair/Vice Chair and report any such changes back to the next meeting.

47. SOUTH YORKSHIRE, DERBYSHIRE AND NOTTINGHAMSHIRE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Members were advised that the next South Yorkshire, Nottinghamshire and Derbyshire Joint Health Overview and Scrutiny Committee, was scheduled to take place 12 March 2025. Further details were due to be shared during the 1 May 2025 Health Select Commission meeting.

48. DIRECTOR OF PUBLIC HEALTH'S ANNUAL REPORT

The Chair drew members' attention to the Director of Public Health's Annual Report and encouraged the use of the document as a helpful source of information to drive future scrutiny activities.

Resolved:-

That the Health Select Commission:

1. Note the Director of Public Health's Annual Report and accompanying slide set.
2. Agreed to be cognisant of the contents of the report and accompanying slide set when considering future agenda planning and work programming.

49. URGENT BUSINESS

There was no urgent business to be considered.

However, the Chair took the opportunity to note that this was Ben Anderson, Director of Public Health's final Health Select Commission meeting as he was leaving the Council to take up a new role.

The Chair extended thanks on behalf of the current and previous iterations of the Health Select Commission that the Director of Public

Health had worked with for the valuable contributions made to the Commissions work over that period of time.