HEALTH SELECT COMMISSION
28th July, 2016

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

Apologies for absence:- Apologies were received from Brookes, Elliot, Ireland and Roddison.

14. DECLARATIONS OF INTEREST

The following Declaration of Interest was made at the meeting:-

Councillor Andrews (non-pecuniary) – Mental Health Nurse working in the private sector.

15. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

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

16. COMMUNICATIONS

Janet Spurling, Scrutiny Advisor, reported that 8 Elected Members had participated in the recent work programme prioritisation session to shortlist potential items. It was agreed that an underlying theme would be to ask questions addressing health inequalities.

Key issues were the big transformational projects some of which would follow on from last year's work:-

- Sustainability and Transformation Plan including Rotherham Place Plan
- Housing and Social Care integration
- Adult Social Care development programme
- Mental Health transformation

Within the above major projects, specific issues/services were identified including Learning Disability/Carers/Older People's Housing.

There would also be the Quality Accounts, the final monitoring of previous reviews and monitoring the Children's Commissioner's Takeover Challenge review plus the regional work on the Commissioners Working Together Programme.

A more detailed programme would be circulated in due course.

17. MINUTES OF THE PREVIOUS MEETING HELD ON 16TH JUNE, 2016

The minutes of the previous meeting of the Health Select Commission held on 16th June, 2016, were noted.

Arising from Minute No. 5 (Director of Public Health Annual Report), there was an outstanding question regarding Making Every Contact Count (MECC) which had been included in the first version of the Health and Wellbeing Strategy but had proved difficult to progress. The issues raised were:-

- How would we achieve the balance between the worker carrying out the core purpose of their visit or interaction with the customer (which might be a very short appointment time) and finding time to ask the wider questions?
- If someone does disclose something that needs to be acted upon, how would this be dealt with when there may be waiting lists already?

Terri Roche, Director of Public Health, reported that there had been a couple of unsuccessful attempts in Rotherham to get MECC off the ground but now seemed to be the right time due to the Health and Social Care integration and the Sustainability and Transformation Plan having a big focus on the need for prevention, self-care and early help. It was a challenge when people were incredibly busy but the important message about MECC was that you developed it with the front line staff.

It was about helping people to make healthier choices but starting where they were at and helping them to achieve small sustained long term health changes.

The organisation that was buying into it needed to consider the whole culture in which their staff worked. It was about getting senior management buy-in so they understood that their staff needed time, training and consideration to the environment in which they were working so there was more health information, posters around etc. to get the person to start thinking about healthier lifestyles before they saw a health or social care professional.

As well as the change in the individual it was important to get organisational change, including your own staff's health and wellbeing. It was easier to have these conversations with others if you were making these changes yourself.

It was not about being an expert but about having the basic information that was available to the public and being able to ask that question which checked if they were ready to change and if so to give them a small amount of information and/or signpost to specialists.

That way it was believed it would happen. There were already some positive responses from the Rotherham Foundation Trust who definitely wanted to take it forward. It was hoped that proceeding in this measured way would not overburden staff.

Arising from Minute No. 7 (Quality Account Sub-Groups), it was noted that the sub-groups had now been determined with Members having been circulated with all the relevant information for the sub-group they were involved with. Meetings would take place in November and December, dates to be notified.

18. TRANSFORMING ROTHERHAM ADULT (18+) MENTAL HEALTH SERVICES

Alison Lancaster and Kerri Booker, RDaSH, together with Kate Tuffnell, Rotherham Clinical Commissioning Group, presented the recommendations for the future RDaSH service based on the work that had been carried out in Phases 1 and 2.

The Clinical Commissioning Group and RDaSH were working closely with the Authority and health professionals to explore the potential for shared services such as a Rotherham Hub as an initial single point of contact and co-location of services.

A number of public engagement events had been held during 2015-16 to discuss the proposals as they had evolved and been informed by consultation and feedback. This had culminated in the recommendations for the future Service set out in the attached report.

At the Select Commission meeting on 17th December, 2015 (Minute No. 60), option 3, the needs-led community based approach, had been supported. However, since then the model had developed further (Minute No. 9 of 16th June, 2016 refers).

Positive progress from Phase 1 of the transformation was highlighted and then details of the new model were outlined, including recognising the differing needs of young adults aged 18 compared with for example adults aged 70+.

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

- How local would the services feel to the Service user? Would they be accessing the services at their GP or would there be 2 central buildings, north and south?
  The In-Patient Services would stay where they were i.e. Woodlands (for Older Persons Services) and Swallownest Court (for Adult Services). The organisation was looking at what resources building wise it had in the north as it was recognised that was a real area for requirement. A number of patients had home visits and they would

continue. Staff did have agile working but staff bases were required and whatever community assets there were would be used in order to link in with making the services as accessible as possible

- Have you considered whether whoever did the 'signposting' actually made the first contact on behalf of the client?
  Work was taking place with a couple of Council Officers who had done a huge amount of work looking at what agencies were out there, what was offered, what had changed etc. and were putting together a directory. The mapping of all the assets would also include the way the services were accessed some of which were by the client only. However, all staff were being encouraged to make the first point of contact dependent upon the patient's wishes. It was also about signposting more accurately to the appropriate service, what they were being signposted for and how it would happen

- Would there be time frameworks for the transformational change especially for CAMHS?
  There was an absolute commitment to complete the transformation with the Trust stating their intention of October for having all the management structure in place which was where most of the savings were coming from. Some of the Service users would not necessarily notice a difference to their service as they would have the same care coordinator; the difference would be for the newer patients who would go through a different progress and process. There was a lot of work taking place around the transition from CAMHS to Adult Services. It was monitored by the CCG and was with regard to identifying those people earlier than they were currently

- Preventing inpatient stays. Was there sufficient funding to employ additional community nurses and therapists if the service increased? If successful, the budget would move to the community. Was there enough trained staff to cover the needs of the staff in the community?
  The budget was what it was and, together with the resources, had to be managed accordingly. At the moment inpatient beds were full and that was not envisaged to change but it was the length of stay that had to be managed. There was a huge demand for services in the community, far more than currently could be managed and sometimes it was about helping people to access the right services and working with primary care and other organisations

  The Service regularly met with the Police, the Vulnerable Persons Unit etc. The organisation was looking at the skill mix and what was required as it moved forward; it was not necessarily about qualified staff but support workers as well and linked into how Direct Payments were used and other community assets

- Are we working with GPs with regard to depression and those patients that required counselling? The GP was usually the first point of contact if a person had never had a mental health issue

As part of the programme the Service was working with Primary Care both in Dementia and the Improving access to Psychological therapies (IAPT) Service to support GPs. Additional funding had been invested in developing a Dementia Pathway so that GPs would start to lead more in the diagnosis and support of people within their practice. There was also a Dementia Care Resilience Service which supported carers of those with Dementia

There had been some challenges for IAPT in the past year relating to waiting times. There was a whole set of national targets that the Service had relating to decreasing people's wait for IAPT services. One was that 75% of people have to receive an appointment within 6 weeks. A lot of work had taken place with the IAPT Service and there was the possibility of additional investment. Work had taken place with the national team and seen some significant decreases in the waiting times. The IAPT service was based in GP practices so there was a strong link and the organisation was currently reviewing the service as to further improvements. There was a lot of work around depression and anxiety and that aspect of the Service

- With regard to the Service configuration and framework how would you monitor the anticipated benefits to make sure that you achieved the measures laid out
  There was a performance team that monitored measures such as referral rates, complaints and compliments, PALS etc. and were reported on a quarterly basis

- Had Learning Disabilities been included within Phase 1?
  The document submitted related to Adult Services (those 18+ years). A whole host of additional transformational processes were being undertaken at the moment and Learning Disabilities were undergoing transformation and was a separate programme of work. Over the past couple of years service changes had led to an enhanced Community Service which had reduced the need for inpatient and ATU beds. The Services was also, as part of a national requirement, working with colleagues from across Doncaster, Sheffield and North Lincs CCGs and local authorities as part of the Transforming Care Partnership which was a programme of work around improving services for people with learning disabilities and linked with the Winterbourne. It was acknowledged that the CAMHS, Learning Disability and Adult transformations needed to be aligned due to the crossover between the Learning Disability and Mental Health Services and about how to make sure those transitions were smooth

  Some work had been taken place, the Green Light Agenda, where Adult Mental Health Services worked closely with Learning Disability Services. They met regularly in terms of strategic development and to identify service users that potentially would drop between the gap between Services. They also looked at what reasonable adjustments Adult Services could make and what support from Learning Disability

Services may be needed from a mental health point of view. There was a lot of support from the Learning Disability Services and they would support RDaSH in the community. Transitions between the 2 Services was much better than it had been

- How were the discussions progressing with regard to the Care Co-ordination Centre becoming the single point of access?
  Discussions were continuing including looking at the amount of work that came into the Services through their points of contact and what would be required in terms of staff training, costings and algotherims. It was not close to happening yet but the conversations were progressing

- How did you envisage a new Rotherham hub including Adult Social Care?
  From a Mental Health perspective it was about helping people navigate the services as easily as possible. There were conversations about accessing anything from anywhere via one point of contact. In terms of the actual staff on the ground there was a real will to work towards that. It was about making the journey as smooth as possible for the people that wanted it

- How did that link with the plans that were in place regarding organisational development strategy and ensuring skills because the whole package around the hub would be specialist skills and how they fitted along the pathway of care
  The representative could only really comment on the transformation that was being worked on; the other was an aspirational idea that needed a lot of work

- Page 36 of the document made reference to the challenges and risks for 2017/18 including staff reviews. To what degree had this been planned for now before the new model was implemented to try and avoid further major change?
  The plan was for several years of savings and the changes in the service regarding the client group was equally a plan for the future. It was a long term plan

- Did the plan include early diagnosis of various conditions or potential conditions such as Autism and would this decrease the waiting time? Were there any facilities planned for Rotherham?
  With regard to diagnosis of Autism in adults, there had been training within the Disability Teams so there was now the ability within Learning Disability to carry out a diagnosis. The amount of activity for adults had also been increased in Sheffield. This was the normal pathway as it was a specialist service and there was not the specialism within Rotherham. The waiting times were reducing but it was an area that required further work and discussions were taking place with the Local Authority. Discussions were also to commence

around an Autism Strategy which would really start to look at what issues there were and how we might start to work on those issues

- Do we buy diagnostic tools for Autism in the Rotherham area? Was it all in Sheffield?
  It was still in Sheffield but 4 Rotherham members of staff had recently been trained in the ADOS techniques of diagnostic. Staff had now been asked to cost the purchase of the tool. It would feed into the Autism Strategy

- How would you build safeguards into the initial screening and prioritisation of staff at the point of contact to ensure patient safety and appropriate next steps?
  As part of a generic assessment, there were questions around Safeguarding and all the staff undertook mandatory training. There was supervision around Safeguarding so staff could access Lead Nurses and linked into the Local Authority. On top of the full Needs Assessment, each patient had a risk assessment which included Safeguarding

- When doing the appraisals there would be a percentage of people that were misdiagnosed and they could be channelled into a certain channel which was the wrong place. Would you guess at a percentage of misdiagnosis?
  The diagnostics were carried out by psychiatrists and not nurses. Unless done by a diagnostic person such as a psychologist, generally mental health diagnoses were delivered and determined by a psychiatrist. There were staff trained in Mental Health and Mental ill health and a recognition of the symptoms of that. In the last 10/15 years staff had been trained in more psychological approaches so it moved away from purely a medical model which was about treating symptoms with medication which did not always work because they were often based in social/historical/trauma issues. As the awareness of psychology and the psychological application to mental ill health was wider, more staff were aware and this informed treatment. Cognitive Behavioural therapists had a 2 year degree course to complete. The staff that were doing CBT informed therapy undertook a 5 day training course supervised by a CBT therapist to do anything more complex

  There was a way of working with an individual called “developing a formulation”. This was about understanding all the components of a person and that was psychologically informed but also informed by everyone around them such as the patient themselves and the carer. Staff were being trained to use that more and about mapping out the whole story

  Diagnostics came from psychiatrists and they did not always get it right because a person’s personality develops over time and how a person presented may not be the same when they were young as

when they were older. Some symptoms could be masked by other presentations e.g. quite depressed but in fact have Dementia

- Cognitive Psychology was a new approach to appraising people. Some staff were being trained in 5 days because of the shortage of psychiatrists/psychologists and the pressure on them
  The Service did train staff up to deliver Cognitive Behavioural Therapy (CBT) and had also trained psychologists in the Service. It was about developing the skill base of the staff and would look to develop the skill set because psychologists were very expensive and there were very few of them

- How was the ease of access to clinicians for advice for the administrative staff at the initial single point of access?
  This worked now and would carry on working in the CCG and would be the same for Older People Mental Health Services. The administrative staff tended to take the basic information and then passed it to a clinician to make a decision as to what happened next

The Chairman thanked the Alison, Kerri and Kate for their attendance.

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

(2) That any comments to inform the final model would be submitted to the RDaSH Trust Board for approval.

(3) That the phased implementation by April, 2017 be noted.

(4) That a report be submitted in September, 2017.

19. ADULT SOCIAL CARE PROVISIONAL YEAR END PERFORMANCE REPORT 2015/16 - FOLLOW-UP RESPONSE

In accordance with Minute No. 6 of 16th June, 2016, Nathan Atkinson, Assistant Director, Strategic Commissioning, submitted the additional information requested by the Select Commission.

Scott Clayton, Interim Performance and Quality Team Manager, and Stuart Purcell, Performance Officer, were in attendance to answer any issues raised.

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

- Reassurance was needed that the improvement in data was leading to changes/changes of approach
  There was a challenge with the benchmarking of Yorkshire and Humber data due to the availability of data to benchmark as it tended to be on an annual basis. There were other mechanisms available via the real time data from the Authority's Social Care records and day-to-day activity

The mechanisms by which the Mental Health Employment Indicator were calculated had changed very recently in terms of their platform for informing the Authority how they had calculated and therefore produced the current rate of performance. The performance for the year end as per their publication was close to 6% whereas it had dropped in the first cycle of the new published figure nearer to 2%. There was no current 2016/17 handbook of definitions but it would be unpicked when released later in the year and followed up with RDaSH regarding their performance if this had deteriorated once there was clarity on the measure. Supporting people into employment was a priority and required co-ordination with partners and a more corporate approach to employment and skills as at present there were a number of initiatives

- Given that it was about how the data trends actually improved the service, who do we ask about that to make sure they actually were doing something with the data that you collected?
  You can only run an effective organisation by using your data wisely to inform whether you were on the right track. The data was used and aligned to the budgetary position as well. It was the key to good performance

  The data was fed into the Senior Management and Directorate Leadership Teams and into the Corporate reporting mechanisms. Issues would also be discussed with Service Managers to see if the performance data reflected how they felt about what was actually happening within their Services.

  An update was submitted to Cabinet but there was no reason why progress reports could not be submitted to the Select Commission

- What was the decision making process for accepting an expression of dissatisfaction as an actual complaint
  Customers filled in a complaints form or contacted the Complaints Team through a number of channels. There was no decision making process as such - if a customer had filled in a complaint form it was a complaint. In the majority of cases if someone wanted to make a complaint there was no barrier

- There had been 75 complaints which were a slight increase to last year. Did that relate to those forms filled in or complaints accepted at Stage 1?
  These were formal complaints where someone had taken the time to write or contact the Complaints Team to say they wanted to make a formal complaint

- What was the decision making process on whether it was escalated through to Stage 2 and Stage 3 and who made those decisions?
  It was a customer driven process. If a customer made a request to go

to Stage 2 it would proceed to Stage 2. There may be individual circumstances based on the complaint where it may be suggested that it would be better to go straight to the Local Government Ombudsman. There were a certain amount of decision making processes within the Complaints Team through experience but if a request been made we escalate the complaint

- Complaints about the quality of service had increased by over 50%. What action would be taken in context of the wider service changes?
  Given the amount of changes that have taken place affecting customers and family members a greater increase in complaints would have been expected. However, it was credit to the staff/team managers on the ground who had been able to deal with customers' dissatisfaction/concerns before it turned into formal complaints.

  The learning from complaints and management oversight of complaints had strengthened over the last 12-18 months. If a complaint was upheld or partially upheld Managers were requested to specifically identify what they had done about it, what their learning had been and reported to the Departmental Management Team. It was an opportunity to share good practice across the whole Directorate, therefore, giving the Management Team good oversight. Where learning was identified by a manager it was shared

- How large was the sample of people each year in the annual user survey? Was there other means of obtaining service user feedback?
  1,400 surveys were issued which equated to a 40% response rate. It was very prescriptive in the way it had to be operated in terms of identifying who the cohort was and based on the sample of your Service users told you how many surveys you had to post out and put people into that sample

  There were a number of different ways for specific teams and services who had their own satisfaction type customer surveys which were analysed to ascertain the satisfaction rate. They were submitted on a regular basis to the Directorate Management Teams

- Transformation – were there plans to extend Social Prescribing further and increase the budget?
  Social prescribing was funded by the Clinical Commissioning Group (CCG) and included in the Sustainability and Transformation Plan bid. There was an ask for further investment in Social Prescribing. There was an evaluation report which the CCG were compiling about how effective the Mental Health Social Prescribing had been. Certainly the intention from the Council was to invest and to look at how it could support organisations in the communities that could supplement and add value to the CCG funded Social Prescribing

- Across the range of indicators different local authorities head the rankings but it was noticeable that East Riding were first on 7 including 1b (with control over daily life) and 1f (Mental health users in employment). Have we looked at some of their practices and was there something we could learn to improve our performance?
  This was something that routinely happened and tapped into the regionally Yorkshire and Humber sector-led Improvement Agenda where the 15 authorities regularly came together to look at what the data was saying across the piste and gave the opportunity to "buddy up" and learn from each other. Experience had shown that once the performance had been interrogated, authorities counted different things which influenced their performance rating

- When would see the benefits from applying the learning from where others were doing well?
  The Authority was a lot more involved in ADASS where a lot of best practice was shared and also bodies such as the Local Government Association

  In the setting of the targets on a yearly basis, management teams were made aware of where they were currently or at year end, where that pitched the Authority in accordance with benchmark data, the difference made and allowed the opportunity to say what the stretch target was going to be, if that was possible or the priority for that service. You should be seeing through the tracking what was being done differently whether those specific actions were having the impact they set out to achieve. Performance clinics were held to get underneath the data

- Appendix C - was there a link between decreasing ongoing low level support and increasing universal signposting to other services especially for people 65 and over?
  The SALT table was a new way of recording this. There had been an increase and the particular areas where the biggest changes and volume in terms of numbers identified in the appendix. What was not known yet was if it was due to the change in the model of service delivery and signposting people to universal services designed to meet their needs without them coming into services long term. There was insufficient data to give an answer to that as yet

Resolved:- (1) That a further report be submitted to the meeting on 1st December, 2016, showing final 2015-16 submitted results and benchmark comparisons against regional and national data.

(2) That the responses to the outstanding issues raised at the June meeting be noted.

20. ADULT SOCIAL CARE - LOCAL MEASURES PERFORMANCE

Further to Minute No. 6(3) of the meeting held on 16th June, 2016, Nathan Atkinson, Assistant Director for Strategic Commissioning, presented a report on the local measures that had been priorities to ensure that they reflected areas of Adult Social Care Service activity. They also linked to the Council's overarching strategic policies and strategies.

The Directorate Management Teams received regular updates of the current performance of the Local measures alongside the National ASCOF measures reporting. Local measure in-year performance would be included in future Cabinet Member reporting arrangements. This would align and run parallel to the agreed Corporate Plan and Improvement Plan reporting schedules.

It should also be noted that, in addition to the Local measures, a range of other measures of activity were also performance managed and reported via alternative reporting streams. Service level management information measures were also regularly reported internally to Senior Management Teams.

The report set out the current performance challenges as at 31st May, 2016, which included:-

LM01 – Reviews
LM02 – Support plans % issued
LM03 – Waiting times assessments
LM04 – Waiting times care packages
LM05-07 – commissioning KLOE's

Discussion ensued with the following issues raised/highlighted:-

- Was commissioning a problem for the Directorate or across the whole of the Authority? Who decided if it was across the board and so who should look at commissioning or whether it was just in this particular Directorate and the Select Commission would look at it?
  The Directorate had self-assessed itself as red in most of the category areas. The way that Rotherham approached commissioning was a little behind its peers especially in relation to Adult Services. In terms of the development plan commitments were around co-production for outcomes that we should be doing. There was evidence of recent activity starting to move in that direction and engagement and involvement of officers working with communities and members of the voluntary sector was helping that. The Directorate was very much at the start of the journey and a lot of work to do. The staffing structures had to be considered and the skills within the existing team which was doing very effective work but very much focussed on contract monitoring especially for care homes/statutory services, and the strategic side had been somewhat lacking. There was much work to

be done with Autism an absolute area that needed to be prioritised together with Mental Health and Learning Disabilities

Nathan had been asked by the Chief Executive to oversee the Corporate Commissioning Review which was part of the Improvement Plan and a fundamental part of the Authority's journey to regain powers and within that would be looking at Children and Young People's Services, Public Health and perhaps other areas where there was some commissioning. That work was in its infancy but had a deadline of January, 2017 to conclude the review and publish the outcome. Within that there were a number of gateways which were specified within the Improvement Plan

- Where was the appropriate place for the scrutiny of commissioning? Was it the Overview and Scrutiny Management Board or the Audit Committee?
  This would be raised at the Board meeting the following day

- At what stage would a review by ADASS be triggered or would it?
  It was a Peer Review. As commissioning on a Corporate level had to be reviewed in the first instance, support may be sought from ADASS to look at the Adult element or the Local Government Association to look at commissioning across the board but that was to be determined. Peer challenge was to be welcomed as that was how you learnt and progressed. At some point within the next 6 months it was hoped to have a Peer Review after the internal work had been carried out. The real test would be when the Authority perceived itself to be on the improvement journey and the reviews would establish whether it truly was

- When the Corporate Review was complete it would be an appropriate time to have the Peer Review to give comfort that someone had looked at the plan going forward
  Absolutely agree

- Had the performance clinic for LM01 been held yet?
  The performance clinic was held on 20th July with the lead officers that were accountable for reviews. A number of actions had been identified that required further consideration including looking at a whole range of activity across the care management teams to capture activity rather than the traditional model. The Care Act allowed the Authority to open up how reviews and self-assessments were carried out so that avenue needed exploring. There were also a number of actions that were being looked at in terms of activity that the teams were doing working with the customers which fell short of a review but did not necessarily take into account the holistic approach of the current assessments. The review activity allowed the Service to know whether the current package was working/whether or not things were improving or on a steady decline that would require further intervention

- Were you confident that from the performance clinic and the suggestions that you have given that we can start to pull back on the figure and the measure of LM01?
  It was a challenge and that had been recognised within the Senior Management Team by way of holding a performance clinic. That process had started and identification of what the actions were likely to impact upon it to get assurance as to how quickly it could be recovered through the remedial actions to get to the 75% and work toward towards 100% overall

  The service was still going through the Phase 2 of the remodelling and that came on stream in September which only left 6 months to pick up those who would be identified and reviewed through the additional processes over and above what was captured in the current data

- When performance clinics had first started there had been the opportunity for a Member to sit and observe/comment. Given the number of new Councillors could that invitation be extended?
  Discussion would take place with the Cabinet Member

- If extending the assessment were you completely changing the assessment tool and have you time and motion studied how long staff will take to do it?
  Part of the remodelling of the Service was looking at different ways of working where the actual input of staff time to get to the full assessment position could be reduced. It was currently a time intensive process but it was hoped to be able to strip out some of the Council staff time which in turn would improve the throughput to help the Service achieve the numbers. In terms of the detail, paperwork and methodology, that would be changing as the current recording system would move to Liquidlogic which would go live in December

- Where were/how positive results for individuals reported that resulted from their care package and support plans?
  Through Liquidlogic and the associated recording there would be the opportunity to capture with the Service user what they actually wanted to achieve as an outcome and during that process whether they felt it had been actually delivered

- The Corporate Plan contained some additional local measures. Were these being added to this document for future reporting?
  The Service reported on the Corporate Plan with the first quarter report due in September. The additional local measures had been included in the Key Performance Indicator suite which were submitted to the Strategic and Directorate Management Teams for tracking and informing decisions that were ultimately reported back into the Corporate Plan. If the Select Commission wished to extend the scorecard it was not a problem

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

(2) That the opportunity for a Peer Review be welcomed.

(3) That the outcome of the discussion with the Cabinet Member for Adult Social Care and Health be awaited with regard to an Elected Member attending performance clinics.

(4) That a report on Local Measures be submitted to the December meeting.

(5) That it be noted that once the further report had been submitted in December the Select Commission would be in a clearer position to make recommendations as to how it went forward.

21. CARING TOGETHER SUPPORTING CARERS IN ROTHERHAM

Elizabeth Bent, Crossroads Care, and Jayne Price, Carers Forum, presented the updated draft Strategy which emphasised the need to identify and support all carers, including hidden carers and young carers.

The following powerpoint presentation set the context for the Carers Strategy:-

Why do we need a Carers Strategy

- Approximately 31,000 carers in Rotherham
- Last Rotherham Carers Strategy expired in 2011
- Introduction of the Care Act 2014 – new rights for Carers
- Funding cuts throughout Health and Social Care

Co-production

- Multi-agency Development Group comprising representatives from:-
  Carers Groups i.e. Forum
  RMBC Adult and Children
  Rotherham CCG
  RDaSH
  Voluntary Sector
  Rotherham Foundation Trust
  Job Centre Plus
  Carers Corner

Consultation/Community Engagement

- Crossroads AGM
- Magna Event
- Carers Forum
- Adult Services Consortium
- Carers Resilience Service
- Barnardos

Outcomes
- Carers in Rotherham are more resilient and empowers
- The caring role is manageable and sustainable
- Carers in Rotherham have their needs understood and their wellbeing promoted

Where are we today
- A step in the right direction for Carers
- Draft document
- Not complete
- Not perfect
- Open to suggestions

The Future
- Aiming to present to Health and Wellbeing Board September meeting
- Strategy shared widely
- Development group – Delivery Group
- Rollout of actions – monitored by delivery group
- Annual review and update

Discussion ensued with the following issues raised/highlighted:-

- Can you explain the Pledge? How you can influence the Pledge that carers in Rotherham were not financially disadvantaged as a result of their caring role?
  Part of that was to ensure that carers had access to benefits advice and support. The work taking place with the Carers Resilience Service was funding that support and had been successful in carers getting Carers Allowance and obtaining Attendance Allowance for the people they cared for. It was not all about money but a little bit of finance could make a big difference to carers

- There was felt to be a difference in the language used in the Pledge and in the Outcomes
  We can take that back and change it. The Pledge was picked up from the National Carers Strategy as it was at present. There were plans for a new National strategy for which the consultation finished on 31st July and was another reason why Rotherham's publication had been delayed until September to ensure it was not out of line

- There were a lot of carers in Rotherham. How do you think this will help reach more carers and support them?
  There were a lot of groups in Rotherham and the information would be cascaded as widely as possible. Once the Carers Strategy was approved it would be rolled out, promoted and shared out to as many people and in as many ways possible

- Were Directorates playing ball with the new initiative? How were they linking in with you at all?
  The development group was multi-agency and working along with the Directorates. Within the Forum, the Carers Forum was the independent voice for carers. A Carers Issue Log was to be introduced whereby anybody who felt that they were not getting the services or there was some sort of failing would enter it onto the Issue Log. It would then be taken back to the people that should be addressing it i.e. the Directorates and other agencies

- As Directorates were planning out new ways of working were you being involved?
  Over the last 18 months, there had a tremendous improvement. The very fact that there was a will to put a Carers Strategy in place in Rotherham was a great step forward. One of the things identified quite early on was the need for a strong carer's voice in Rotherham which benefitted everyone. Part of the Strategy was the development of the Carers Forum. The Officer who led the Group was very keen on commissioning some support for the Forum because it was run by carers for carers

- The delivery plan stated the intention to develop an online assessment form for carers. How accessible would that be for older people?
  One size never fitted all and was another way of ticking the box on carer's assessments. We need carers to come forward and assessments completed to ascertain their needs and support them

- Outcome 3 target for working to ensure Rotherham became carer friendly. What sort of tools were in place locally to ensure employers, public and private sector, catered to employees' needs?
  Crossroads Care (a voluntary sector organisation) had carer friendly policies in place i.e. flexible working etc. Realistically if it was not law there were some employers who would not do it. The Council did some work with their own employees to find out how many of them were carers. There were ways that carers could be supported such as flexible working but it was for us all to raise the issue and address them

Elizabeth and Jayne were thanked for their presentation.

Resolved:- (1) That the draft Strategy and delivery plan be noted.

(2) That an appropriate timescale be agreed with the Delivery Group to receive a progress update on implementation once the strategy was signed off.

22. HEALTH AND WELLBEING BOARD

The minutes of the Health and Wellbeing Board held on 20th April and 1st June, 2016, were noted.

23. IMPROVING LIVES SELECT COMMISSION UPDATE

Councillor Cusworth reported that it was still work in progress but the Improving Lives Select Commission work programme shortlist included:-

Domestic abuse
Safeguarding
CSE post-abuse support
Early Help
Special Educational Needs and Disability

The Select commission had been careful to ensure there was no duplication with the work of this Select Commission.

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

It was noted that the next meeting would be held on 8th August, 2016.

Papers were published on the website at the link below.

http://modgovapp/ieListDocuments.aspx?CId=1045&MId=13847&Ver=4

25. HEALTHWATCH ROTHERHAM - ISSUES

No issues had been raised.

26. DATE OF FUTURE MEETING

Resolved:- That the next meeting of the Health Select Commission be held on Thursday, 22nd September, 2016, commencing at 9.30 a.m.