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.