HEALTH AND WELLBEING BOARD

Venue: **Town Hall, Moorgate Street, Rotherham S60 2TH**

Date: **Wednesday, 12th November, 2014**

Time: **1.00 p.m.**

A G E N D A

1. To determine if the following matters are to be considered under the categories suggested in accordance with the Local Government Act 1972.

2. To determine any item which the Chairman is of the opinion should be considered as a matter of urgency.

3. Questions from Members of the Press and Public

4. Minutes of Previous Meetings (Pages 1 - 19)
   Minutes of meetings held on 1st and 24th October, 2014

5. Communications:- (Pages 20 - 24)
   - Better Care Fund (NHS England letter attached)
   - Health and wellbeing Website (Presentation)

6. Joint Protocol between HWBB /Health Select Commission/Healthwatch (Pages 25 - 29)

7. Disabled Children's Charter (herewith) (Page 30)

8. Emotional Health and Wellbeing Strategy (herewith) (Pages 31 - 107)

9. Service Co-production in Rotherham (herewith) (Pages 108 - 142)

10. Date of Next Meeting
    Wednesday, 3rd December, 2014, commencing at **9.00 a.m.**

HEALTH AND WELLBEING BOARD
1st October, 2014

Present:-

Councillor Doyle	Cabinet Member for Adult Social Care and Health **(in the Chair)**
Councillor Beaumont	Cabinet Member for Children and Education Services
Tom Cray	Strategic Director, Neighbourhoods and Adult Services
Chris Edwards	Chief Officer, Rotherham CCG
Jason Harwin	South Yorkshire Police
Fiona Jordan	NHS England (representing Carol Stubley)
Martin Kimber	Chief Executive
Dr. Julie Kitlowski	Clinical Chair, Rotherham CCG
Jason Page	Executive Lead, Referrals and Pathways, Rotherham CCG
Dr. John Radford	Director of Public Health
Dorothy Smith	Director of Schools and Lifelong Learning, RMBC

Also in Attendance:-

Richard Butterworth	South Yorkshire Police
David Hicks	Rotherham Foundation Trust (representing Louise Barnett)
Michael Holmes	Policy Officer, RMBC
Ian Jerrams	RDaSH
Shona McFarlane	Director of Health and Wellbeing, RMBC
Donald Rae	Special Education Needs and Disability Strategic Lead
Mark Scarrott	Finance Manager, RMBC
Janet Wheatley	Voluntary Action Rotherham
Chrissy Wright	Strategic Commissioner, RMBC

Apologies for absence were received from Councillor Emma Hoddinott, Chris Bain, Tracy Holmes, Naveen Judah and Carol Stubley.

S21. QUESTIONS FROM MEMBERS OF THE PRESS AND PUBLIC

There were no questions from the member of the public present at the meeting.

S22. MINUTES OF PREVIOUS MEETING

Resolved:- That the minutes of the meeting held on 27th August, 2014, be approved as a correct record.

Arising from Minute No. S15 (Peer Challenge), it was noted that the Peer Challenge had been deferred in light of the corporate governance inspection taking place. It would be arranged at some point in the future.

S23. COMMUNICATIONS

Peer Challenge
See Minute No. 22 above.

Pharmaceutical Needs Assessment (PNA)
Dr. John Radford, Director of Public Health, reported that a draft PNA had been produced in line with the statutory requirement for the Board to produce such a document before April, 2015.

A PNA was a tool required by NHS England to allow new pharmacies or changes in pharmacies across the Borough. It was a legal framework for pharmacies to enter the market place. This would be of particular importance in the town centre when the new emergency and urgent care centre at the Hospital opened and the maintenance of a pharmacy over that period.

The document would be circulated to Board Members as part of the 2 months consultation period with comments submitted to the Board. Once finalised and published there will be a process to update whenever required.

CAMHS Strategy
This item would now be discussed at the November Board meeting together with the Emotional Health and Wellbeing Strategy.

Alex Jay Independent Inquiry
A special Board meeting was to be held on 24th October at 1.00 p.m. to discuss the report.

S24. BETTER CARE FUND

Chris Edwards, CCG, reported that the Task Group had communicated via e-mail due to there being no significant changes to be made to the submission. A joint tele-conference had taken place with NHS England to provide external assurances.

No significant feedback had been received as yet but a report would be received as to whether NHSE's requirements had been met.

Resolved:- That the report be noted.

S25. SOCIAL CARE SUPPORT GRANT 2014-15

Shona McFarlane, Director of Health and Wellbeing, presented a report on the transfer to the Local Authority of the above Grant, details of the local allocations and the recommendations on how it could be spent for the 2014/15 financial year. NHS England would transfer £6.166M to the Council which included an increase of £1.351M from 2013/14.

Payment of the Social Care Support Grant was to be made via an Agreement under Section 256 of the 2006 NHS Act. The Agreement would be administered by the NHS England Area Team and would only pass over to local authorities once the Section 256 Agreement had been signed by both parties.

The Grant must be used to support Adult Social Care Services that delivered a health benefit. However, beyond that broad definition, NHS England wanted to provide flexibility for local areas to determine how the investment in Social Care Services was best used.

Guidance required NHS England to ensure that the local authority agreed with its local health partners on how the funding was best used. Health and Wellbeing Boards would be the forum for discussions between the Area Teams, CCGs and local authorities on how the funding should be spent. NHS England would make it a condition of the transfer that RMBC and RCCG had regard to the Joint Strategic Needs Assessment for their local population. It would also be a condition that RMBC demonstrated how the funding transfer would make a positive difference to Service users.

The Fund would be overseen by a robust joint governance framework which supported achievement of the following:-

- Reduction in emergency admissions
- Reduction in delayed transfers of care from hospital
- Proportion of older people still at home 91 days after hospital discharge into rehabilitation
- Number of re-admissions to hospital within 30 days of discharge

It was proposed that the Grant be used to support existing Services and Transformation Programmes where such services or programmes were of benefit to the wider health and care system:-

- Additional short term residential care places or respite and intermediate care
- Increased capacity for home care support, investment in equipment, adaptations and telecare
- Investment in crisis response teams and preventative services to avoid hospital admission
- Further investment in reablement services to help people regain their independence

The appendix to the report submitted set out the proposed spending programme.

Discussion ensued on the proposed spending programme with the following issues raised:-

- Would consideration be given to the individuals entering the criminal justice system as part of the Mental Health Service?
- Was there sufficient funding for the development of community based Dementia Care
- RDaSH would be evaluating their triage project which had been running in conjunction with the Police

Resolved:- (1) That the programme of expenditure set out in the report be approved.

(2) That the development of a light-touch performance framework for the Grant be approved.

(3) That as part of the Board review, the processes and sub-groups be reviewed together with the appropriateness of the memberships.

S26. PERFORMANCE MANAGEMENT FRAMEWORK

Dr. John Radford, Director of Public Health, presented the current position on the reporting framework for 6 Priorities of the Health and Wellbeing Strategy drawing attention to:-

- Reducing hospital admissions due to alcohol related illness – activity had worsened. Although it reflected an increase in hospital admissions it was not an accurate figure. The CCG were carrying out work to understand the issues and had a pilot in place to reduce alcohol related hospital admissions

- Discussions were taking place with South Yorkshire Police regarding the number of FPN waivers which resulted in attendance at binge drinking courses – it was believed that the number was higher than reported

- The trend in terms of healthy life expectancy in Rotherham was improving. There were issues in relation to childhood obesity and very high levels of inactivity in Rotherham than elsewhere in the country

Discussion ensued with the following issue raised/clarified:-

- There was poor dental health in children of 2-5 years. Public Health England had been asked to submit a report setting out the trends. It again raised the issue of fluoridation and persuading parents to give their children water/milk rather than sugary drinks

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

(2) That a report be submitted to a future Board meeting in relation to the trends associated with Priority 2 particularly relating to reduced hospital admissions due to alcohol related illness, the number of FPN waivers and children's dental health.

(3) That future performance management reports highlight any indicators off target together with the reasons for such performance.

S27. HEALTHWATCH ROTHERHAM

Further to Minute No. 88 of 26th March, 2014, Chrissy Wright, Strategic Commissioning Manager, reported that the contract for Healthwatch Rotherham had terminated with Parkwood Healthcare Ltd. on 31st August, 2014, and the contract commenced with the social enterprise Rotherham Healthwatch Ltd. on 1st September.

Rotherham Healthwatch would continue to deliver the service under the same terms and conditions as the previous provider using the original specification for the service and the existing staffing arrangements. All existing staff had been transferred to Rotherham Healthwatch Ltd. under TUPE regulations.

The report also set out performance for the first half of the year as well as future work for the remainder of the year.

As of yet it was not known whether there would be Government funding post-March, 2015. If funding was forthcoming it was the intention to recommission the social enterprise.

Discussion ensued with the following issues raised/clarified:-

- The contract was currently until April, 2015
- Healthwatch had also work on the Mental Health Review and the SEND Review
- The social enterprise had been fully aware of the risk of the possibility of no further funding when the contract had been signed
- The decrease in the number of volunteer hours and volunteers used during July

Resolved:- (1) That the setting up of the social enterprise Rotherham Healthwatch Ltd. be noted.

(2) That the termination of the contract with Parkwood Healthcare Ltd. and the transfer of the rights and obligations of the Healthwatch Rotherham Service to Rotherham Healthwatch Ltd. be noted.

(3) That the progress achieved be noted.

(4) That further updates be submitted in due course.

(5) That the reduction in the number of volunteer hours and volunteers used be referred to the Chief Executive of Rotherham Healthwatch Ltd. for comment.

(6) That the Board's congratulations be conveyed to those concerned in achieving social enterprise status and wished well for the future.

S28. VACCINATIONS AND IMMUNISATIONS FOR PREGNANT WOMEN

Further to Minute No. S11. Dr. Julie Kitlowski, CCG, reported that agreement had now been reached and that midwives would be trained to give vaccinations but not until next year.

David Hicks, TRFT, stated that there were issues around training, resources and the timing of when vaccinations were due, however, it was the Trust's intention to implement the programme next year.

An action plan would be drawn up. It was imperative that any barriers to implementation were raised so agencies could work together and agree a way forward.

Fiona Jordan, Screening Officer, NHS, reported that a lot of work was carried out with GP practices and the hospital emphasising the need to increase the uptake of the Pertussis. There was a need to ensure that all pregnant women were offered the vaccination by their GP or midwife and that the statistics were captured of those who refused the offer. Weekly e-mails were sent to practices to reiterate the message.

Resolved:- That an update be submitted to the next Board meeting.

S29. DIABETIC RETINOPATHY SCREENING

Jacky Mason, NHS England, reported that the NHS Diabetic Eye Screening Programme had been introduced to reduce the risk of vision loss in people with Diabetes. Everyone with Diabetes who was 12 years of age or over should have their eyes screened once per year to check for signs of Diabetic Retinopathy.

The joint Barnsley and Rotherham Programme was commissioned in 2007 and provided by Barnsley Hospital Foundation Trust. In line with the national trend, the diabetic population in Barnsley and Rotherham was increasing year on year. It currently had 27.707 registered patients 25,906 of which were eligible for screening. Those not eligible were managed in line with the national programme guidance and reviewed and validated every 3 months to ensure they still met the exclusion/suspension criteria.

The programme was currently commissioned on behalf of Public Health England via NHS England South Yorkshire and Bassetlaw Area Team to the national service specification for Diabetic Eye Screening.

Programme performance was reported nationally on a quarterly basis and also into the quarterly Programme Board. Any performance issues were escalated to the SYB Screening and Immunisation Advisory Group NHS England Public Health Commissioning Local Delivery Group and South Yorkshire Commissioners Group.

The programme in Rotherham was currently underperforming in some areas. These were being monitored by an action plan with a monthly update submitted to the SYB Screening and Immunisation Team.

The combined programme update was currently above the Public Health Outcomes Framework standard of 70% but below the stretch achievable target of 80%. Each individual programme showed a similar picture. In attempting to address, patients who had DNA had been surveyed and some of the findings acted upon including offering clinics at evenings and weekends.

All cancer and non-cancer screening programmes were subject to an external quality assurance review. The Barnsley and Rotherham review was planned for October, 2014 and would be the first programme in SYB to be quality assured in this manner.

Resolved:- That the report be noted.

S30. SPECIAL EDUCATIONAL NEEDS AND DISABILITY TRANSFORMATION

Further to Minute No. 107 of 4th June, 2014, Donald Rae, Special Education Needs and Disability Strategic Lead, presented an update on the implementation of the Reforms to support children and young people with special educational needs and a disability.

The 'In It Together' event held on 4th July, 2014, had attracted over 500 parents and young people who were able to gather information from education, health and care providers and attend workshops to discuss how best to introduce a more personalised approach/how the new assessment model was developing. It is expected that it will become an annual event not lease to ascertain the views of children, young people and parents about Rotherham's SEND Local Offer website.

The 2 key tasks required to be in place by 1st September had been met i.e.:-

- Rotherham's SEND Local Offer Website (www.rotherhamsendlocaloffer.org). The site aimed to provide as much information as possible within the site and not a link to other sites

- New assessment system for those with special educational needs and disability bringing together separate systems for early years, schools and colleges. SEN Statements and Learning Difficulty Assessments had been replaced by Education Health and Care Plans and a timetable had been published showing how the Statements would transfer to the new EHC Plan

The report also set out a range of actions that had been agreed by the Special Educational Needs and Disability Transformation Commissioning Group. Whist some of the actions would be delivered quickly others were more long term reflecting that the transformation of services would take up to 3 years.

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

- The new working practice was much more focussed on what was best for the parent and the young person particularly those aged 16-25 years.
- A further major change was how the plans the plans were reviewed, how schools were involved, care professionals working in a different way and how the plan was progressing particularly as a young child became a young person
- The new model had to have the parent and young person at the heart and deliver what they wanted
- There had been implications for the training and supporting of staff
- The new care plans included input from all professionals that represented the needs of the individual
- The CCG was fully engaged with the new way of working
- There was an issue that health data tended to be 4-5 years out of date but work was taking place on how to gather information through the health system much earlier so that babies with complex needs and the implications thereof were known throughout the system
- The Joint Strategic Needs Assessment had a particular section containing all the SEND details and was monitored as part of the regular scheduled updates
- Rotherham's SEND Local Offer website was continually updated with any links to organisations of interest some of which were suggestions from parents. There was a danger of putting too many onto the website but if it came from a recommendation it was included
- The website had been built on the same platform as Connect to Support
- The new system allowed a much more open assessment with regard to how resources would be allocated and how much was available

Resolved:- (1) That the progress made be noted.

(2) That an update be submitted in 12 months.

S31. DATE OF NEXT MEETING

Resolved:- (1) That a special meeting be held on Friday, 24th October at 1.00 p.m.

(2) That a meeting of the Health and Wellbeing Board be held on Wednesday, 12th November, 2014, commencing at 1.00 p.m. in the Rotherham Town Hall.

HEALTH AND WELLBEING BOARD
Friday, 24th October, 2014

Present:-

Councillor Doyle	Cabinet Member, Adult Social Care and Health **In the Chair**
Councillor Beaumont	Cabinet Member, Children and Education Services
Robin Carlisle	Rotherham CCG (representing Chris Edwards)
Tom Cray	Strategic Director, Neighbourhoods and Adult Services
Jason Harwin	South Yorkshire Police
Councillor Hoddinott	Deputy Leader
Shafiq Hussain	Voluntary Action Rotherham (representing Janet Wheatley)
Naveen Judah	Healthwatch Rotherham Ltd.
Martin Kimber	Chief Executive, RMBC
Carol Levell	NHS England Commissioning Body (representing Carol Stubley)
Dr. John Radford	Director of Public Health

Also Present:-

Steve Ashley	Chair, Rotherham Local Safeguarding Children's Board
Chris Bain	RDaSH
Warren Carratt	Service Manager - Strategy, Standards & Early Help
Shona McFarlane	Director of Health and Wellbeing, RMBC
Phil Morris	Safeguarding Children and Families
Paul Theaker	Operational Commissioner

Apologies for absence were received from Louise Barnett and Carol Stubley

S32. QUESTIONS FROM MEMBERS OF THE PRESS AND PUBLIC

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

S33. RESPONSE TO THE ALEXIS JAY REPORT ON CHILD SEXUAL EXPLOITATION IN ROTHERHAM

At the request of the Chair, each partner reported as to the governance taking place within their organisation and what their respective priorities were in response to the findings of the Jay report:-

Rotherham Local Safeguarding Children Board
The Board Chair, Steve Ashley, reported that the Board was at the early stages of preparing an action plan in response to the Jay Report although the CSE Sub Group has incorporated the recommendations into its action plan. The outcome of the recent inspection from Ofsted was awaited and would impact upon the action plan currently being compiled. Urgent areas of work being undertaken were:-

- Auditing - the auditing process that the Board undertook to reassure itself that partners were fully engaged. There were now extra resources to increase the amount of auditing carried out. A thematic audit process had been put in place where audits would be repeated over a period of time until satisfied that the Board and partners were fulfilling its function e.g. auditing had commenced on cases where contact had been made through the "front door" and those that were determined "no further action required" as to whether those decision were correctly made. The findings would be reported on a monthly basis.

- Building contact with all the communities in Rotherham. Work had been commissioned as to how that would take place recognising that all partners were engaged in some form of community liaison so as to avoid duplication. There was a need to get on with this work urgently.

- The Board had considered the reccomendations and has submitted a report requesting the development of a Needs Assessment and Commissioning Plan for a Post-Abuse Support Service. The Jay report had clearly highlighted that there could be anything up to 1,400 victims and it had been the original intention to try and identify as many as possible. However, this was not thought to be a practical course of action so there was a need for support to be available for when victims came forward. It was also important that there were plans and support in place for those victims who were now over the age of 18 and not just for current children and young people who were victims of CSE.

- There had been dialogue between the Chairs of the Safeguarding Adults Board and Local Safeguarding Children Board to ensure that they are working together to support young people through transition to adulthood.. It is imperative that any individual receives appropriate services throughout their lives and continued into adulthood.

Public Health

Dr. John Radford reported on the overall provision that partners had put into place for post-abuse support.

- Needs Assessment – work was underway with the CSE Group and a set of indicators developed with the Framework of Need placed within the JSNA. The work would give an indication of need in the medium term as well as an indication of service performance in relation to people accessing that need. Performance measures in terms of waiting times for services and ensuring people were getting the services were required. Work was underway currently and would feed into the JSNA.

- A summary of the activity being undertaken currently in relation to the response to CSE. The interim Police and Crime Commissioner had invested an additional £80,000 for Independent Domestic Violence

Advisors.

- Allocation of funding:-
  £20,000 to GROW to increase the capacity to support victims over 16 years of age in a family context
  £20,000 to Rotherham Women's Counselling Service/Pit Stop for Men to increase specialist counselling
  £20,000 to increase the CSE Small Grants Fund established in August, 2014, administrated by South Yorkshire Community Foundation
  £49,000 additional capacity currently being commissioned through the voluntary sector through a tender process with a further £11,000 held in contingency
  £53,000 allocated to Youth Start to increase capacity to support 7-25 year olds post-abuse support service
  £200,000 allocated by the CCG to provide additional capacity to RDaSH

- Understanding from the CCG that there was a clear pathway for the referral for men/women with embedded sexual disfunction to be referred through to the specialist centre in Sheffield for counselling. The specialist psychiatric support could be accessed through a GP with no barriers to the service.

- Public Health would co-ordinate all services including the CCG, RDaSH etc.

- Funding had been allocated to the various services and it could be identified what the funding was for and what those services could and could not provide. For children it was clear that the referral was through a single point of access and that pathway needed to be cascaded to the NHS, Local Authority and voluntary sectors so everybody was clear.

- The second task was much more complex and needed to be done with some urgency and that was to establish a correct pathway through the system because people would vary in their need. Some adults would want recourse to justice and would require referral through SARC; some would need a pathway to individual counselling; some would need drug and alcohol services relating to sexual health issues

- "1 size fits all" may not be the best method of tracking to see where victims went and where they received the best access to services.

RDaSH

- Some of the CCG resources provided was to look at existing Service users who felt confident enough to disclose and ascertain how the Service was supporting them in their core services, how it responded to presenting new cases, ability to provide an immediate and fast

track response, monitoring the ongoing needs of individuals and interfacing with the Services already provided.

- There was a responsibility to support staff not only with regard to refresher training but how to respond in circumstances where an existing Service user may start to disclose issues not previously mentioned.

- All were being taken forward in conjunction with the CCG.

- Experience of those currently seeking support of the Service showed that the clients would decide when and where they sought support and resources needed to be flexible enough to provide.

RMBC Commissioning

- The CSE Group has tasked the Head of Integrated Youth Support Service to look at co-ordination in terms of the immediate need from the "front door" to those services in terms of young people and adults.

- Youthstart funding for 1-1 counselling for young people.

- There would be a co-ordinator for both children and young people and adults coming through and speedily referred to the right Services.

- As part of the commissioning exercise, the starting point was an understanding of what post-abuse support could be provided and having a map of service provision.

- The map could be shared with partners to ensure there were no gaps in provision

- The JSNA needed to be strengthened in relation to CSE.

CYPS

- A commissioning group had been established and building on the work referred to above in terms of co-ordination. It would also pick up on the voice and influence of victims, needs analysis, pulling information together from Services and had been given extra funding with a view to commissioning appropriate support as from 1st April, 2015.

- 1 of the biggest delivery vehicles with regard to prevention was Universal Services and Schools had been carrying out direct work with Y8 children to raise awareness of CSE and organised safeguarding sessions in all Rotherham schools. They were fully engaged and understood the referral process. CSE was also part of the tool kit.

NHS England

- Acknowledgement centrally that there had been some confusion around commissioning particularly for ongoing therapy services for adult victims.

- Input had been provided to the DoH for inclusion into a national report with regard to ongoing therapeutic support for adults.

- The DoH wanted some steer for commissioning arrangements on the new commissioning framework coming out next year.

- In the short term Margaret Kitchen had pulled together a Health Steering Group and the information gathered on the action plan would be followed to inform the work the CCG were carrying out

CCG

- Fragmentation of Health Services – it was the responsibility of the CCG refresh plan to put in place a plan which organisations could check the response for other organisations who can steer where resources lay

- If the Board had a criteria by which it assessed the submitted 2015/16 commissioning plans it could check that they addressed the totality of what was required for evident CSE

South Yorkshire Police

- Work needed to progress quickly.

- Although the funding was in place for additional Independent Domestic Violence Advisors there were a limited number of advisors nationally for the demand.

Healthwatch Rotherham Ltd.

- Healthwatch had an escalation process that it adhered to depending upon the severity of the case presented. In the first instance it would be referred to Safeguarding and then look at the other agencies.

- It could be escalated outside of the Borough dependent upon the severity if more than support was needed.

Voluntary Action Rotherham

- The information from the Jay report had been disseminated and considered by members and the Voluntary and Community Sector Consortia.

- A number of meetings had been arranged for organisations to understand the Jay report and provide support provided to post-abuse

victims. As a result of those meetings GROW and SYWS had waiting lists and increased demand.

- As well as the work looking at intermediate needs the organisation, from feedback from voluntary and community organisations, was clear about where the soft intelligence had been reported to, how it was being received, confidence of some of the victims coming forward and how they were being supported by the organisation. Accordingly, clarity was required on those pathways.

- Working with the Safer Rotherham Partnership and the Council in terms of CSE community awareness raising sessions. There was a programme of sessions that would be rolled out across the Borough.

- A conference around CSE awareness raising was to be held on on 4th November specifically targeted at voluntary and community organisations in Rotherham.

- Community cohesion and community engagement work with partners across the piste to support community engagement across all local communities.

Rotherham College

- There had been a full review of all safeguarding procedures and CSE awareness raising training. Dedicated work had been carried out around identification and introduction to the College to ascertain if there was more that the College could do to identify any historical cases and raise awareness of the issues around CSE.

- It was an important transition from childhood and College had a roll to play.

Discussion ensued with the following issues raised/clarified:-

Given the list of funding being provided, how/who would monitor to ensure that the services were available and that victims were accessing them? The worst thing that could happen was partners leaving the meeting thinking funding was going into the services and working on an assumption that they turned themselves into services that victims needed and used. Would the Health and Wellbeing Board be responsible for monitoring and compiling an action plan illustrating what was available, how many victims the Services could deal with and ensure that the right services were being provided/used by victims?

The funding had been allocated to groups as a short term measure. Work was needed to identify those organisations that had seen an increase of referrals since the publication of the Jay report and were responding to that need. It was very clear that there needed to be longer term planning for all partners.

The funding was very short term and there was a need to identify organisations that had seen an increase in the number of referrals since the publication of the Jay report and were responding to that need. It was clear that there needed to be longer term planning for all partners. What would the services look like post-April, 2015?
Currently it was not known who the victims would have the confidence in to make a disclosure and if they did, making the assumption that that Service could help for a particular period of time. As things progressed there would be more experience and the ability to advise as to which service had much better outcomes than others.

Was there somewhere GPs could ring in to take advice about the different referrals routes?
For existing victims of CSE the point of contact should be the Referral Team in CYPS which GPs were aware of. An area that would be reviewed and developed very quickly was the appropriateness and feasibility of a central point of contract for anything to do with a wide range of issues.

How did the work fit in with the work of the Vulnerable Adults Risk Management Group?
In the weeks immediately following the publication of the Jay report, Adults Social Care front door, Assessment Direct, had become very much more alert to the issues. When clients presented with complex needs the assessment now went beyond the presenting issues and through that process had started to identify those they believed could be victims of CSE. Furthermore, 2 very experienced Social Workers had been identified who would work in the Vulnerable Persons Unit so when referrals came through Assessment Direct and referred to the VPU, they would be risk assessed beyond the presented need. They could act as Key Workers and able to refer clients on to support more appropriate to their need and actually support them as they accessed the services such as SARC, GROW, Homeless Teams, RDaSH, DWP etc.

In the past young adults, 18-25 years, would have been assessed through Assessment Direct and the “signs” may not have been spotted. A more thorough assessment was now conducted to try and ensure that was not the case and appropriate case work and support was provided.

Since the additional staff had been placed in the VPU 17 clients potentially requiring further support services had been identified. It was important that this fed into the JSNA not just need for the services already identified but where there were gaps in service provision and lead to improved commissioning.

It was early days and it needed to fit into the emerging strategy. A proposed Vulnerable Adults Risk Management Framework was to be submitted to Cabinet Member.

It was key that the funding followed the victim and the support of

their choice. It was also essential that older teenagers did not fall through the gaps when they crossed over from Children's Services to Adult Social Care. Were the Services flexible enough to deal with that?
The importance of the funding following the victim was acknowledged but also, as the processes were developed, it would be equally as important to establish where the best outcomes were and assist the client in assessing whether or not a different service would be better for them.

Was there sufficient capacity in the voluntary sector?
No organisation was saying they were fully resourced and had all the resources they needed, however, it was important that the resources should follow the victims. Agencies needed to understand who the victims were and their needs to ensure they were being signposted to the most appropriate service. More information was required in terms of the post-abuse victim, the current work and the preventative work. The Voluntary and Community Sector did a lot of preventative work on how CSE occurred and how it could be prevented.

The Safeguarding Board made training available free at the point of access and had trained officers from the voluntary and community sector who delivered CSE training. E-learning was also available.

Were all Rotherham schools actively engaged?
Every school in Rotherham was engaged in the CSE agenda and their safeguarding responsibilities. Should a school not engage it would be escalated quickly and also referred to the Safeguarding Children's Board.

With regard to Schools and the preventative agenda, what was contained in the CSE training and did it include online grooming?
In addition to the direct work from the CSE Team, the Healthy Schools Adviser worked to embed the DHSE curriculum which covered sexual relationships. To also assist, every secondary school had a Police Officer who work across the 16 secondary schools and were on site to provide advice and support to the teaching staff.

The arrangement also included MyPlace etc.

Over the age of 10, Crucial Crew was part of Rotherham School's curriculum of which internet safety formed part of.

Were there arrangements in place for those children who were not in school?
The Education Welfare Service was a key partner in terms of being the "eyes" for those children at risk of CSE. 1 of the Team Leaders was a CSE Champion. There were also links with the Elective Home Education Team who would assess situations where children were being taught in the home environment rather than in school. There was no such legal concept as a part-time timetable and the Series Case Review outlined the dangers of children being out of school on a part-time basis. A lot of work

was carried out in Schools to identify where that practice was in place and to challenge that. The advent of Academisation was more problematic when the Authority was not part of the reporting structure, however, the Education Welfare Officer support function still existed and they were challenged.

The new Director of Safeguarding had successfully secured agreement for a dedicated post in the Safeguarding Team to have oversight of Missing Children and Runaways which was an area the Police had been looking at for some time.

When would a report be submitted on pathways?
It was hoped that a document would be available by the end of the following week on the structures of Services and contact numbers.

Other work in terms of the JSNA and the Needs Assessment would take a little longer but hopefully by the end of November.

It was noted that the governance arrangements would need to be considered by the CSE Sub-Group initially.

It had been stated that CSE should be more prominent in the Board's priorities. Did the Board need to add a 7th priority or highlight that Safeguarding was a priority, of which CSE was prominent, that ran through all 6 priorities?

- The Board should give it prominence, not as an activity, but ensure that it was clear through the commissioning strategy that commissioning against the JSNA which identified CSE as a key priority for Service delivery.
- The Board should identify a unique contribution it could make and capable of being held to account for it. It was important that outsiders could see what had been delivered and construct a governance that the dynamic relationship contributed to the outcomes it needed to achieve
- CSE would be a thread running through the Health Commissioning Strategy from what was identified in the JSNA and various parts of the commissioning i.e. Children's, Mental Health and Safeguarding.

The additional functions of the Board also needed to be highlighted.

Was the Protocol between the Rotherham Local Safeguarding Children Board, Health and Wellbeing Board and the Children, Young People and Families Strategic Partnership still relevant?
It was fit for purpose and compliant with Working Together 2013 statutory guidance. However, it needed to be very clear who held who to account. Steve Ashley stated that the Local Safeguarding Children CSE was the statutory responsibility of the Local Safeguarding Children's Board which would be much more agressive in terms of holding the agencies who are members of the LSCB to account. The relationship between the two Boards had to be stronger and, although the Board may not wish to add a

further priority, it was suggested that a formal statement be included when the Health and Wellbeing Strategy was reviewed of the intention for CSE to be one of the major priorities over the coming year.

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

(2) That discussions take place between the Chairs of the Health and Wellbeing and Local Safeguarding Children Board with regard to the way forward.

(3) That the Needs Assessment and Pathways document be distributed to all partners by e-mail once completed.

(3) That the Health and Wellbeing Board's website be updated as a matter of urgency.

S34. DATE OF NEXT MEETING

Resolved:- (1) That a meeting of the Health and Wellbeing Board be held on Wednesday, 12th November, 2014, commencing at 1.00 p.m. in the Rotherham Town Hall.

NHS England

Publications Gateway Ref. No. 02396

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To:
Rotherham Health and Wellbeing Board
NHS Rotherham CCG

Copy to:
Rotherham Metropolitan Borough Council

29th October 2014

Dear colleague,

Thank you for submitting your revised Better Care Fund (BCF) plan. I know this has been a very rigorous and demanding process, so I am extremely grateful for the considerable thought and work that has gone into your plan. It is clear that your team and partners have worked very hard over the summer, and have a clear commitment to improving people's care.

I am writing to confirm the outcome of the plan assurance process. As you will know, plans have been subject to a robust and consistent methodology to assure the quality of local plans (the Nationally Consistent Assurance Review (NCAR)). While I recognise the significant progress that has been made in such a short space of time, the review process identified a number of fundamental delivery risks and areas where the plan needs to be strengthened further. The outcome of the NCAR process has therefore placed your plan in the **'Approved Subject to Conditions'** category.

It is important to stress that we consider the conditions to be critical to the successful delivery of your plan, and at this stage it means that your plan has not yet been fully approved. The full NCAR outcome report for your plan is attached to this letter.

As set out in the NCAR methodology document published in August[1], areas whose plans fall into the 'Approved Subject to Conditions' category will need to fulfil specified conditions before their plan is fully approved. If required, you will receive additional support to assist you in meeting these conditions.

The conditions are set out below:

- Condition 4a: The plan must address the outstanding narrative risks identified in the NCAR report
- Condition 4c: The plan must address the outstanding analytical risks identified in the NCAR report

Appended to this letter is your NCAR outcome report which documents the agreed actions. In order to assist you in revising your plan, we have appointed a Better Care Advisor Nick Clarke who will work with you to develop an action plan to detail how and by when the agreed actions will be addressed to meet the above conditions. Once the conditions have been met your plan will be considered again for approval. More detail on this process is included further in this letter.

We recognise that you may need to start entering into spending commitments now in order to ensure continuity of service. If this is the case, and you feel that with appropriate support you will meet the conditions set out in this letter, then you should proceed with gearing up for implementation on the basis that you will meet the conditions (and thus move to an approved plan). However, we strongly recommend that:

i. Commissioners should not enter into any S.75 agreement to pool budgets and/or under which a local authority is to commission the relevant services until plan approval has been obtained;
ii. If embarking on any procurement process before approval is confirmed, commissioners should make it absolutely clear to potential providers in all procurement documentation that the award of a contract will be strictly conditional on that approval being obtained, that the commissioners have discretion to abandon, amend or vary the procurement at any point prior to contract award, and will have no liability to potential providers for wasted bid costs or otherwise should they exercise that discretion;
iii. If commissioners reach the point at which they are ready to enter into contractual arrangements with any provider for the relevant services when their plan has still not been approved, they should either (and preferably) defer doing so until approval has been obtained, or (and only if entering into the contract at that stage is entirely necessary) only do so having included in the relevant contract appropriate provisions to ensure that the contract (or the contract insofar as it relates to the relevant services) is conditional on final plan approval by NHS England and other appropriate protections as further described in the attached guidance document;
iv. Commissioners should under no circumstances make payments to providers prior to approval being obtained. In the event that payments are made and approval is not granted, commissioners will not receive funding for those payments.

Please ensure you follow the guidance issued by NHS England and include standard wording approved by NHS England in every formal document that could commit any element of your share of the national £3.46bn 15/16 BCF monies which is being routed via CCGs (i.e. contracts, procurement processes, Section 75 Agreements and such like) to ensure that it makes clear that it is subject to final plan approval by NHS England. The guidance is attached to this letter.

NHS England may not approve the expenditure that has been committed to and this is why it is essential to follow the guidance. If the clause is not included and NHS England does not approve the expenditure, it will be for local commissioner(s) – not NHS England – to fund any shortfall.

With regards to following the guidance, I recognise that in practice CCGs will be planning to put their BCF allocation into a pooled fund under section 75 of the NHS Act 2006, and for a significant proportion of that to be spent by partner local authorities rather than the CCG. The recommendation to insert a standard clause in all contracting documents, procurement documents, and section 75 agreements relating to BCF expenditure applies to CCGs. However, given the release of the entire CCG BCF allocation will remain subject to approval of a plan, local authorities will need to work closely with relevant CCGs to consider any proposals to enter into spending commitments that are dependent on the release of CCG funds to the section 75 pool. If local authorities choose to go ahead with entering into spending commitments, they would bear the financial risk of entering into a contract which they may find in April they do not have the funding for if NHS England does not approve the plan.

For clarity the guidance only applies to the BCF funding that is routed directly through the CCG. You will be aware that a small proportion of your total BCF allocation (the Disabled Facilities Grant and Social Care Capital Grant) will be paid directly to the local authority by the Department of Health and Department of Communities and Local Government under section 31 of the Local Government Act 2003. The detailed terms and conditions under which this part of your area's BCF allocation will be paid will be confirmed later this year, but we expect this will include an equivalent requirement for this money to be spent in line with an agreed and approved BCF plan.

I want to reiterate that the policy intent is that all BCF funds will remain within the local area as per the published guidance.

Process for getting to approval

To support you to improve your plan you have been allocated a dedicated Better Care Advisor Nick Clarke who will work with you to develop an action plan setting out how and when you will address the agreed actions and meet the conditions outlined above. This action plan should be submitted to bettercarefund@dh.gsi.gov.uk by 14 November 2014. This process of agreeing an action plan will also include agreeing a programme of further support.

Your Better Care Advisor will also work with you to agree the level of resubmission and further assessment that will be required, and the timetable for submission. Your updated plan will be subject to an assurance process that is proportional to the materiality of the conditions set out in your NCAR outcome report (i.e. if these are wide-ranging the plan may be subject to a full NCAR assessment, but if they are narrower in scope your Better Care Advisor will agree the level of resubmission required to secure approval).

The aim is to get your plan to a fully approved status by end of December 2014.

Once the conditions set out earlier in this letter have been met, your plan may be approved subject to the following standard conditions which apply to all BCF plans. These are as follows:

- The Fund being used in accordance with your final approved plan and through a section 75 agreement;
- The full value of the element of the Fund linked to non-elective admissions reduction target will be paid over to CCGs at the start of the financial year. However, CCGs may only release the full value of this funding into the pool if the admissions reduction target is met as detailed in the BCF Technical Guidance[2]. If the target is not met, the CCG(s) may only release into the pool a part of that funding proportionate to the partial achievement of the target. Any part of this funding that is not released into the pool due to the target not being met must be dealt with in accordance with NHS England requirements. Full details are set out in the BCF Technical Guidance.

These conditions would be imposed through NHS England's powers under sections 223G and 223GA of the NHS Act 2006 (as amended by the Care Act 2014). These allow NHS England to make payment of the BCF allocation subject to conditions. If the conditions are not complied with NHS England is able to withhold or recover funding, or direct the CCG that it be spent in a particular way.

Non-elective (general and acute) admissions reductions ambition

As there is a considerable amount of time between the submission of BCF plans and their implementation from April 2015, we recognise that some areas may want to revisit their ambitions for the level of reduction of non-elective admissions, in light of their experience of actual performance over the winter, and as they become more confident of the 2014/15 outturn, and firm-up their plans to inform the 2015/16 contracting round. Any such review should include appropriate involvement from local authorities and be approved by HWBs. NHS England will assess the extent to which any proposed change has been locally agreed in line with BCF requirements, as well as the risk to delivery of the ambition, as part of its assurance of CCGs' operational plans.

The Better Care Fund remains a significant enabler for delivering better, more integrated care for people locally. I hope that some further time and additional support and information will enable you to take the final steps to having a fully approved plan, and move quickly towards implementation.

Once again, thank you for the work and local leadership that you have shown in developing your plan so far.

Yours sincerely,

Dame Barbara Hakin
National Director: Commissioning Operations
NHS England

[1] http://www.england.nhs.uk/wp-content/uploads/2014/08/bcf-nat-ass-methodology.pdf
[2] http://www.england.nhs.uk/wp-content/uploads/2014/08/bcf-technical-guidance-v2.pdf

Joint Protocol Between Rotherham Health and Wellbeing Board, Health Select Commission and Healthwatch Rotherham

This joint protocol ensures that the local Health and Wellbeing Board (HWB), Health Select Commission (HSC) and Healthwatch Rotherham develop a constructive and productive working relationship with one another. Each body has an independent role and a shared aim to reduce health inequalities and improve health and wellbeing outcomes. The roles are distinctive but complementary and must add value to each other's work, and avoid duplication. This joint protocol details the distinctive roles of each body, and presents examples of working together and reporting arrangements.

Rotherham Health and Wellbeing Board

The HWB is a statutory, sub-committee of the council. Locally, it is the single strategic forum to ensure coordinated commissioning and delivery across the NHS, social care, public health and other services directly related to health and wellbeing, in order to secure better health and wellbeing outcomes for the whole Rotherham population, better quality of care for all patients and care users and better value for the taxpayer.

The board brings together key decision makers to address issues of local significance and to seek solutions through integrated and collaborative working, whilst being an advocate and ambassador for Rotherham collectively on regional, national and international forums.

Main functions of the board:

- To enable, advise and support organisations that arrange for the provision of health or social care services to work in an integrated way**,** for the purpose of advancing the health and wellbeing of people in Rotherham
- To ensure that public health functions are discharged in a way that help partner agencies to fully contribute to reducing health inequalities
- To assess the needs of the local population and lead the coordination, development and delivery of the local Joint Strategic needs Assessment (JSNA) and Health and Wellbeing Strategy
- To oversee the development of local commissioning plans, ensuring they take account of the Health and Wellbeing Strategy and are aligned to other policies and plans that have an affect on health and wellbeing
- To hold relevant partners to account for the quality and effectiveness of their commissioning plans and request relevant information from any of its members or agencies represented on the board (cross over with scrutiny function)
- To ensure arrangements are in place to provide assurance that the standards of service provided and quality of services are safe, meet national standards and local expectations

Health Select Commission (health overview and scrutiny)

Legislation sets out that health scrutiny can scrutinise any matter in relation to commissioning or providing health and wellbeing services in the local area. This includes holding to account all local commissioners and providers of publically funded health and social care services (including the HWB, Clinical Commissioning Group, NHS organisations) for the quality and outcomes of services; ensuring they reflect the local Health and Wellbeing Strategy, are accessible and equitable, and meet the needs and aspirations of local people.

Scrutiny can request information from the above bodies/organisations, request that they attend meetings, and make recommendations for service improvement.

The terms of reference for the HSC specifically mention scrutinising the following:

- health services commissioned for the people of Rotherham
- partnerships and commissioning arrangements in relation to health and well-being and their governance arrangements
- measures for achieving health improvements and the promotion of wellbeing for Rotherham's adults and children
- measures designed to address health inequalities
- public health arrangements

It is a requirement for the relevant body/organisation/officer to consider and respond to the recommendations in a timely way following a scrutiny review. This will generally require a full response to all recommendations to be made within two months of the review report being presented to cabinet, as set out in the Council Constitution. However NHS commissioners and service providers do have a duty to respond in writing to a report or recommendation within 28 days if so requested. If the recommendations involve both the council and one or more health partners, or only health partners, they should be presented at the next HWB meeting following presentation at cabinet.

NHS bodies and commissioners, including the Clinical Commissioning Group, are required to consult with scrutiny on substantial developments or variations to local health services. If scrutiny has significant concerns with any proposal, it has the power to make referral to the Secretary of State for Health.

Any referral made to scrutiny by Healthwatch Rotherham must be acknowledged and advised of what action will be taken.

Local Authority Health Scrutiny guidance published by the Department of Health in June 2014 sets out duties and responsibilities for local authorities and health partners to ensure effective scrutiny.

Healthwatch Rotherham

Healthwatch is the new independent consumer champion for both health and social care. It is a vital part of the government's health reform plans to give people a stronger voice and drive improvements in services.

Healthwatch Rotherham will represent the views and experiences of the diverse communities in the borough, ensuring the voices of vulnerable people and hidden communities are heard.

The national vision for local Healthwatch is that it will:

- Act as local consumer champion representing the collective voice of patients, service users, carers and the public
- Support individuals to access information about services
- Provide or signpost people to independent advocacy if they need help to complain about NHS services
- Have real influence with commissioners, providers, regulators and Healthwatch England using their knowledge of what matters to local people

The vision for Rotherham's local Healthwatch was created by the Healthwatch Rotherham Board.

Vision: Healthwatch Rotherham will be known by all communities and individuals as delivering on its promises backed up by robust action and supported by improvements in local services.

Mission: To be the first point of contact for all of Rotherham's communities and individuals, to help them to have a means of improving their own and others quality of health, wellbeing and social care.

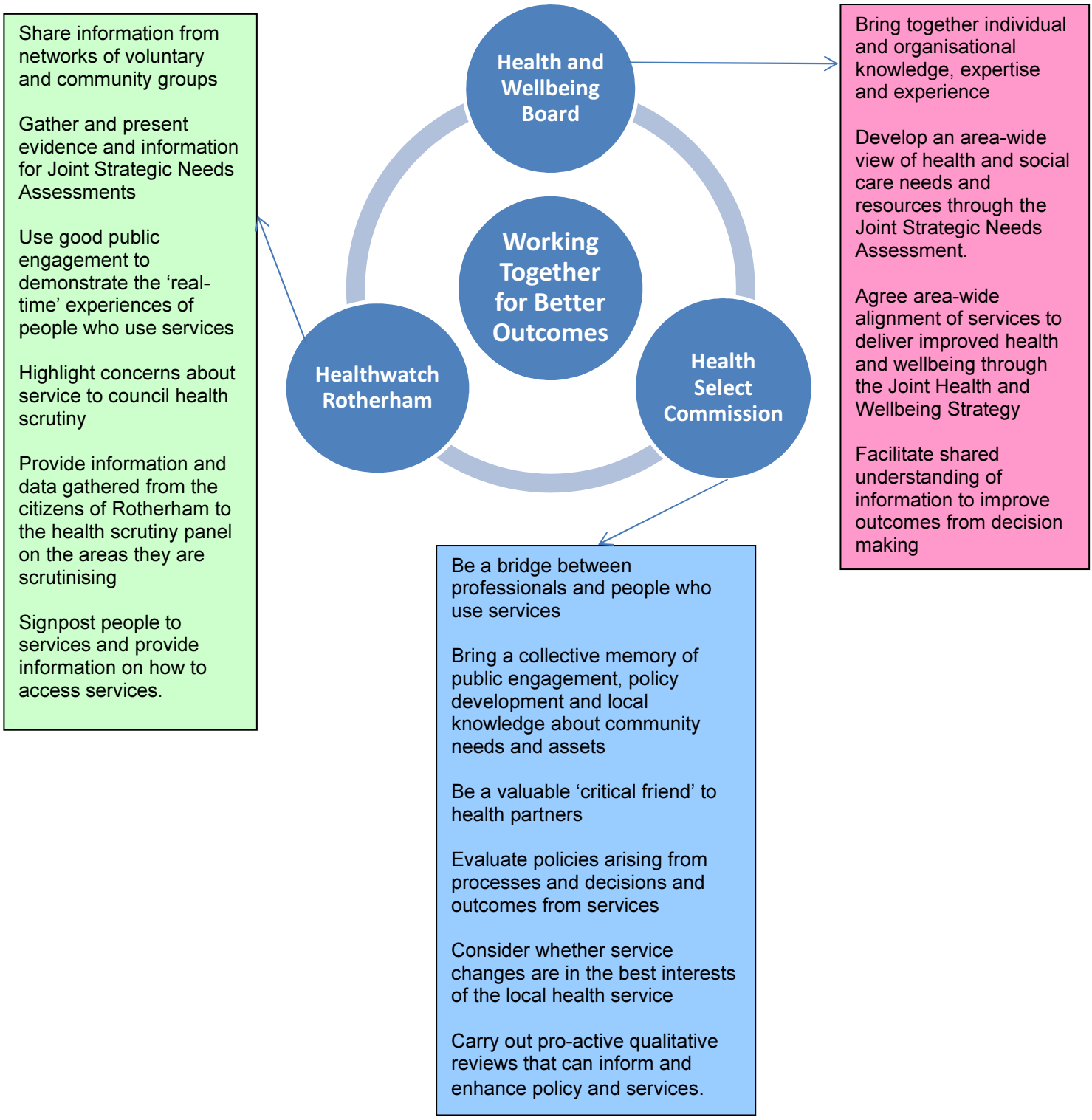
Values: To be an impartial and trusted friend to help communities and individuals to achieve their desired results and be recognised for being a fiercely independent organisation by the citizens of Rotherham.

Healthwatch Rotherham will also influence the development the local JSNA and health and wellbeing priorities, through its seat on the Health and Wellbeing Board.

Working Together

All three bodies recognise they have a role to play in the way that local services are planned and delivered and that how they interact with each other will directly influence and add value to outcomes for local people and communities.

Diagram below adapted from 'Local Healthwatch, health and wellbeing boards and health scrutiny - Roles, relationships and adding value' CfPS http://cfps.org.uk/publications?item=7195



Joint Principles, Actions and Reporting Arrangements

The Rotherham Health and Wellbeing Board, Health Select Commission and Healthwatch Rotherham agree to adhere to the following:

Key Principles:

- To improve health and social care services and reduce health inequalities in Rotherham
- To ensure and enable early and inclusive discussions about key health and wellbeing challenges
- To develop relationships based on openness, honesty and accountability

Actions:

1. To ensure regular and timely sharing of information, including sharing key actions, minutes and work plans as appropriate. As required, update reports to be presented at the respective boards to ensure transparency, provide an early opportunity to comment and to avoid duplication.

2. To coordinate the work plans of each body, ensuring duplication is avoided, cross-cutting issues are managed and clarity is given as to how each body can add value.

3. To ensure the understanding of roles and responsibilities between each body, members of each will have a seat, and/or be invited to attend meetings or joint discussions with regards to work plans and key areas of work:

- Chair of HWB invited to attend HSC and share minutes of meetings
- Open invitation for scrutiny members to attend HWB as observer/s
- Chair of Healthwatch Rotherham to have a formal seat on the HWB and receive minutes of and attend where appropriate the HSC
- Healthwatch items raised at HWB to be noted through the minutes shared at HSC meetings
- HSC has a standard agenda item enabling Healthwatch to bring issues to their attention
- Once per year the three bodies to share their draft work programmes to reduce the possibility of duplication and/or align their plans
- The chair of each body to attend joint briefings or meetings as required

Reporting Arrangements

The agreement between the HWB and HSC states that scrutiny reviews taking place that have implications for health and wellbeing board partners, should be circulated to the board for information at the early scoping stage.

Once a scrutiny review has taken place, the recommendations should be fed back to the HWB following agreement by cabinet (if implications for the council) and/or the appropriate board or committee (if implications for health partners).

Healthwatch Rotherham, as a formal member of the HWB, are able to raise issues with the board and request reports or information to be presented as appropriate.

Reporting from the HWB to HSC on delivery and performance of the health and wellbeing strategy will be undertaken annually.

Formal Agreement

Rotherham Health and Wellbeing Board, Health Select Commission and Healthwatch Rotherham agree to adhere to the principles, actions and reporting arrangements above in order to work effectively together.

Signed on behalf of the three bodies:

Cllr J Doyle	**Cllr B Steele**	**Naveen Judah**
Chair of the Health and Wellbeing Board	Chair of the Health Select Commission	Chair of Healthwatch Rotherham

Date …...../……/2014

Disabled Children's Charter for Health and Wellbeing Boards

The ..... **Health and Wellbeing Board** is committed to improving the quality of life and outcomes experienced by disabled children, young people and their families, including children and young people with special educational needs and health conditions. We will work together in partnership with disabled children and young people, and their families to improve universal and specialised services, and ensure they receive the support they need, when they need it. Disabled children and young people will be supported to fulfil their potential and achieve their aspirations and the needs of the family will be met so that they can lead ordinary lives.

By [date within 1 year of signing the Charter] our Health and Wellbeing Board will provide evidence that:

1. We have **detailed and accurate information** on the disabled children and young people living in our area, and provide public information on how we plan to meet their needs
2. We **engage directly with disabled children and young people** and their participation is embedded in the work of our Health and Wellbeing Board
3. We **engage directly with parent carers** of disabled children and young people and their participation is embedded in the work of our Health and Wellbeing Board
4. We set **clear strategic outcomes** for our partners to meet in relation to disabled children, young people and their families, monitor progress towards achieving them and hold each other to account
5. We **promote early intervention** and support for smooth transitions between children and adult services for disabled children and young people
6. We work with key partners to **strengthen integration** between health, social care and education services, and with services provided by wider partners
7. We provide **cohesive governance** and leadership across the disabled children and young people's agenda by linking effectively with key partners

Signed by ..... **Date** ..... .
Position: Chair of Health and Wellbeing Board.

For guidance on meeting these commitments, please read the accompanying document: Why sign the Charter?

every disabled child matters

Every Disabled Child Matters (EDCM) is the campaign to get rights and justice for every disabled child. It has been set up by four leading organisations working with disabled children and their families – Contact a Family, the Council for Disabled Children, Mencap and the Special Educational Consortium. EDCM is hosted by the National Children's Bureau, Charity registration number: 258825.

The Children's Trust, Tadworth is a national charity providing specialist services to disabled children and young people across the UK. These services include rehabilitation and support for children with acquired brain injury, expert nursing care for children with complex health needs, and residential education for pupils with profound and multiple learning difficulties at The School for Profound Education. Charity registration number: 288018. Find out more about the work of The Children's Trust, Tadworth at www.thechildrenstrust.org.uk

The Children's Trust Tadworth
For children with multiple disabilities

ROTHERHAM BOROUGH COUNCIL – REPORT TO HEALTH & WELLBEING BOARD

1.	**Meeting:**	**Rotherham Health & Wellbeing Board**
2.	**Date:**	**12 November 2014**
3.	**Title:**	**Emotional Wellbeing & Mental Health Strategy**
4.	**Directorate:**	**NAS**

5. Summary:

The draft Emotional Wellbeing and Mental Health Strategy 2014-19 has been developed to support Local Authority, Health Commissioners and service providers to improve the emotional health and wellbeing of children and young people in Rotherham.

The final draft of the Strategy and associated action plan has been widely consulted upon. This has been approved through both the Rotherham MBC and Rotherham Clinical Commissioning Group (RCCG) governance processes and is attached to this report and details the key recommendations and actions to be taken forward.

6. Recommendations:

Health & Wellbeing Board is asked to:

6.1 Approve the final draft of the Emotional Wellbeing & Mental Health Strategy 2014-19

7. Background

The draft Rotherham Emotional Wellbeing and Mental Health Strategy for Children and Young People 2014-19 has been produced by RCCG Commissioners, RMBC Commissioners and RMBC Public Health and draws on national and local guidance, local needs information, surveys of local emotional wellbeing and mental health services and information from key stakeholders.

The strategy includes sections on the scope of the strategy, the needs of children and young people, services in Rotherham, investment, challenges and risks and recommendations. The strategy and needs analysis are attached to this report.

The strategy was widely consulted on with a wide range of stakeholders in June and July 2014, including RMBC Children and Young People Services, schools, colleges, NHS providers and VCS providers. There have also been specific consultation sessions with parents/carers and with the Youth Cabinet.

The responses from consultation have been evaluated and the draft Emotional Wellbeing and Mental Health Strategy was substantially amended to take into account the comments that have been made. In addition, the Rotherham Health Watch report on Child and Adolescent Mental Health Services (CAMHs) was reviewed to ensure that the key findings are addressed within the strategy.

The Rotherham CCG commissioned Attain, an independent sector consultancy organisation, to review CAMHs and their report was considered by the CCG. The Attain recommendations that the CGG agreed to take forward have been included within the strategy.

The key recommendations outlined within the Strategy are as follows:

Recommendation 1 - Ensure that services are developed which benefit from input by young people and parents/carers.

Recommendation 2 - Develop multi-agency care pathways which move service users appropriately through services towards recovery

Recommendation 3 - Develop family focussed services which are easily accessible and delivered in appropriate locations.

Recommendation 4 - Ensure that the services being delivered are effective, appropriate and represent the best value for money for the people of Rotherham.

Recommendation 5 - Ensure that the services being provided are delivered at the appropriate time as required and not restricted to normal operating hours.

Recommendation 6 - Ensure that services across all tiers of provision are delivered by appropriately trained staff and that training and support is provided to Universal/Tier 1 services to ensure that patients do not unnecessarily move to higher tiers of provision.

Recommendation 7 - Ensure well planned and supported transition from child and adolescent mental health services to adult services.

Recommendation 8 - Explore the option of a multi-agency single point of access to mental health services for children and young people to ensure that appropriate referral pathways are followed.

Recommendation 9 - Ensure that services are better able to demonstrate improved outcomes for children and young people accessing mental health services.

Recommendation 10 - Promote the prevention of mental ill-health.

Recommendation 11 - Reduce the stigma of mental illness.

Recommendation 12 - Ensure that patients do not face inappropriate delays in accessing services, across all tiers, for assessment and treatment which adversely affect their recovery.

It should be noted that as the governance process progresses for final approval of the Strategy, the key recommendations and actions are already being acted upon. The development of multi-agency care pathways is a priority piece of work and will address a number of issues in relation to thresholds/access to services and pathways such as post diagnosis ASD. A workshop with stakeholders has been held and is informing the work of small time-limited working groups that have been established for each multi-agency pathway.

The Strategy has been approved by the RMBC Cabinet Member for Children & Education Services and by the RCCG Operational Executive and is coming to the Health and Wellbeing Board for final joint RMBC/RCCG approval.

8. Finance

There are no financial implications at this stage. There may be financial implications arising from implementing the recommendations contained within the Emotional Wellbeing & Mental Health Strategy. Any such financial implications that arise will be fully outlined within future reports that are submitted through governance structures.

9. Risks and Uncertainties

- That the Emotional Wellbeing & Mental Health Strategy recommendations are not implemented within timescales.

10. Policy and Performance Agenda Implications

- Rotherham Health and Wellbeing Strategy 2012-2015
- Ofsted framework and evaluation schedule for the inspection of services for children in need of help and protection, children looked after and care leavers

Contact Name: Chrissy Wright, Strategic Commissioning Manager, Tel: 822308 Email: chrissy.wright@rotherham.gov.uk

Contact Name: Kate Tufnell, Head of Contracts and Service Improvement, Tel: 302743 Email: Katherine.Tufnell@rotherhamccg.nhs.uk

Rotherham Metropolitan Borough Council

NHS Rotherham Clinical Commissioning Group

DRAFT

Emotional Wellbeing & Mental Health Strategy for Children & Young People 2014-19

Version 3.1

Version Number	Revision date	Summary of Changes	Change By	Changes accepted
1.1	26.02.14	First draft following initial meeting	SM	Yes
1.2	27.02.14	Updated tier information with data from consultation	SM	Yes
1.3	04.03.14	Amendments & additions from PT & RFB	SM	Yes
1.4	04.03.14	Amendments following meeting with PT & RFB	SM	Yes
1.5	05.03.14	Format amendments	SM	Yes
1.6	05.03.14	Amendments & additions from NP	SM	Yes
1.7	06.03.14	Amendments & additions from NP Changes at Strategy Meeting	SM	Yes
1.8	10.03.14	Updated pyramid model & recommendations	SM	Yes
1.9	11.03.14	Updated with amendments from PT, RFB, NP & Miles Crompton	SM	Yes
1.10	12.03.14	Updates at CAMHS Strategy & Partnership Meeting	SM	Yes
1.11	19.03.14	Amendments from RFB, NP, BM and comments from Healthwatch	SM	Yes
1.12	24.03.14	Amendments following meeting	SM	Yes
1.13	07.04.14	Amendments following consultation	SM	Yes
1.14	08.04.14	Amendments from BM	SM	Yes
1.15	08.04.14	Meeting amendments	SM	Yes
1.16	09.04.14	Further additions following meeting	SM	Yes
1.17	06.05.14	Additions & amendments following meetings	SM	Yes
2.0	06.05.14	Ready for consultation	SM	Yes
2.1	19.05.14	Amendments regarding PRUs	SM	
2.2	28.05.14	Addition on page 28 on Family Nurse Partnership	SM	
2.3	10.07.14	Reductions	SM	
2.4	17.07.14	Amendments	SM	
2.5	01.08.14	Amendments following review by PT	SM	
2.6	28.08.14	References added	SM	
3	10.09.14	Final amendments made	SM	
3.1	11.09.14	Final draft following final amendments by RFB & NP	SM	

Approval Process			
Name/Meeting	**Date of Issue**	**Version Number**	**Approved**

Contents

Executive Summary

Traditionally mental health in the UK has had not had parity with physical health (Royal College of Psychiatrists, 2013). As a result there is a perception that children and young people with a mental health problems have not benefited from equitable treatment compared to those with physical conditions.

There has recently been a re-focus on mental health and a key policy initiative is to achieve 'parity of esteem' with physical health.

There is good reason why there must be this change in focus and particularly for children & young people when the following key facts are considered:

- One in ten children aged between 5 and 16 years has a clinically diagnosable mental health problem. About half of these (5.8%) have a conduct disorder, 3.7% an emotional disorder (anxiety, depression) and 1–2% have severe ADHD;
- At any one time, around 1.2–1.3 million children will have a diagnosable mental health disorder;
- Half of those with lifetime mental illness (excluding dementia) first experience symptoms by the age of 14, and three-quarters before their mid-20s;
- The rates of disorder rise steeply in middle to late adolescence. By 11–15 it is 13% for boys and 10% for girls, and approaching adult rates of around 23% by age 18–20 years;
- Self-harming in young people is not uncommon (10–13% of 15–16-year-olds have self-harmed) but only a fraction of cases are seen in hospital settings;
- Although effective treatments are available only around 25% of those who need such treatment receive it;
- 11–16 year olds with an emotional disorder are more likely to smoke, drink and use drugs;
- Around 60% of Looked After Children and 72% of those in residential care have some level of emotional and mental health problem. A high proportion experience poor health, educational and social outcomes after leaving care;
- Looked After Children and care leavers are between four and five times more likely to attempt suicide in adulthood;
- One third of all children and young people in contact with the youth justice system have been looked after. It is also important to note that a substantial majority of children and young people in care who commit offences had already started to offend before becoming looked after;
- Young people in prison are 18 times more likely to take their own lives than others of the same age;
- The costs of mental health problems for the English economy have recently been estimated at £105 billion per annum;
- Children of teenage mothers are generally at increased risk of poverty, low educational attainment, poor housing, poor physical and mental health, and have lower rates of economic activity in adult life; and
- Young people in prison are 18 times more likely to take their own lives than others of the same age.

It is also clear that focusing on the mental health issues of children and younger people can help to reduce the numbers of patients who continue to experience mental health issues into adulthood.

Key stakeholders in Rotherham (RCCG, RMBC and RDaSH) came together in March 2014 with the purpose of developing a strategy for the emotional wellbeing and mental health of children and young people in Rotherham. A thorough evaluation was undertaken of both national and local guidance around the mental health of children and young people in order to identify the key themes which would need to be addressed in a comprehensive strategy.

The next stage was to understand the specific mental health needs of children & young people in Rotherham, and information was collated from both national and local research initiatives. The prevalence of mental health disorders varies significantly according to a range of socio-economic and demographic factors and it is estimated that in Rotherham it is 14% above the UK average.

The development of the strategy has been informed by formal input from all key stakeholders, including parents/carers, young people and stakeholders in both the statutory and voluntary/community sectors.

Child and Adolescent Mental Health Services (CAMHS) in Rotherham are commissioned in 4 Tiers:

- Tier 1/Universal services are delivered by a range of providers including GPs, Health Visitors, School Nurses, Social Workers and voluntary services and offer general advice and identify mental health problems earlier in their development.
- Tier 2 services are delivered, usually on a 1:1 basis, by professionals with training in mental health, including RDaSH CAMHS, Integrated Youth Support Services (IYSS) and Rotherham & Barnsley MIND.
- Tier 3 provides specialist services for more severe, complex or persistent disorders, usually through multi-disciplinary teams. Providers include RDaSH, IYSS, Rotherham & Barnsley MIND and the Child Development Centre.
- Tier 4 provision is similar to Tier 3 in that it is provided by multi-disciplinary teams but in inpatient or highly specialised outpatient units.

Tier 1, 2 and 3 services are currently commissioned predominantly by RCCG and RMBC. Tier 4 services are commissioned by NHS England.

The strategy outlines examples of service provision in each of the 4 Tiers and highlights ‘additional required delivery’ in each area taking into consideration local needs and national guidance.

This additional service delivery has been condensed into 12 key themes or recommendations as follows:

Recommendation 1 - Ensure that services are developed which benefit from input by young people and parents/carers.

Recommendation 2 - Develop multi-agency care pathways which move service users appropriately through services towards recovery

Recommendation 3 - Develop family focussed services which are easily accessible and delivered in appropriate locations.

Recommendation 4 - Ensure that the services being delivered are effective, appropriate and represent the best value for money for the people of Rotherham.

Recommendation 5 - Ensure that the services being provided are delivered at the appropriate time as required and not restricted to normal operating hours.

Recommendation 6 - Ensure that services across all tiers of provision are delivered by appropriately trained staff and that training and support is provided to Universal/Tier 1 services to ensure that patients do not unnecessarily move to higher tiers of provision.

Recommendation 7 - Ensure well planned and supported transition from child and adolescent mental health services to adult services.

Recommendation 8 - Explore the option of a multi-agency single point of access to mental health services for children and young people to ensure that appropriate referral pathways are followed.

Recommendation 9 - Ensure that services are better able to demonstrate improved outcomes for children and young people accessing mental health services.

Recommendation 10 - Promote the prevention of mental ill-health.

Recommendation 11 - Reduce the stigma of mental illness.

Recommendation 12 - Ensure that patients do not face inappropriate delays in accessing services, across all tiers, for assessment and treatment which adversely affect their recovery.

Whilst the above 12 recommendations are not exhaustive, it is felt that they are the basis of a robust emotional wellbeing and mental health strategy and will improve the mental health of the children and young people of Rotherham.

These recommendations have been incorporated into an Action Plan, as detailed in Appendix 6, and the stakeholders identified in that document will work together to implement the recommendations within the agreed timescales. It is important to see this action plan as a dynamic and long term document which will facilitate the implementation of the strategy over the next few years.

1. Introduction

Improved emotional health and wellbeing is associated with a range of better outcomes for people of all ages and backgrounds. These include:

- improved physical health and life expectancy
- better educational achievement
- increased skills
- reduced health risk behaviours such as smoking and alcohol misuse,
- reduced risk of suicide
- improved employment rates and productivity
- reduced anti-social behaviour and criminality
- higher levels of social interaction and participation

Source - various including Annual Report of the Chief Medical Officer 2012

The emotional health and wellbeing of children and young people is nurtured primarily at home, however everyone delivering children and young people's services (particularly early years and schools) has a role in improving outcomes and reducing inequalities. This includes supporting the public to make healthier, informed choices to improve emotional health and wellbeing and to improve access to services where and when they are needed.

This Strategy has been produced to support Local Authority and health commissioners and service providers to improve the emotional health and wellbeing of children and young people (0 to 18 years) in the borough of Rotherham. It is the second strategy for emotional health and wellbeing of children and young people in Rotherham. The Strategy builds on the information provided by the Emotional Health and Wellbeing Analysis of Need 2014.

The Strategy has been developed in partnership with a range of organisations that work to deliver child and adolescent mental health services across the borough and is based on existing research and the results of various consultations undertaken by the Rotherham Metropolitan Borough Council (RMBC), NHS Rotherham CCG (RCCG) and other partners.

Actions and work resulting from the Strategy will be further informed by research and information, including the work of Healthwatch and other partners.

In addition, RCCG commissioned Attain Commissioning Services to undertake a comprehensive review of mental health services provided by Rotherham Doncaster and South Humber NHS FT (RDaSH). This was completed in May, 2014 and the results have contributed to the development of this Strategy.

Action to implement this strategy will only be effective if there is sustained partnership working across all sectors. To facilitate this partnership working a 'CAMHS' Strategy and Partnership Group (terms of reference can be found at Appendix 3) has been established, which will report into the Rotherham Health and Wellbeing Board.

2. Scope

2.1 Vision

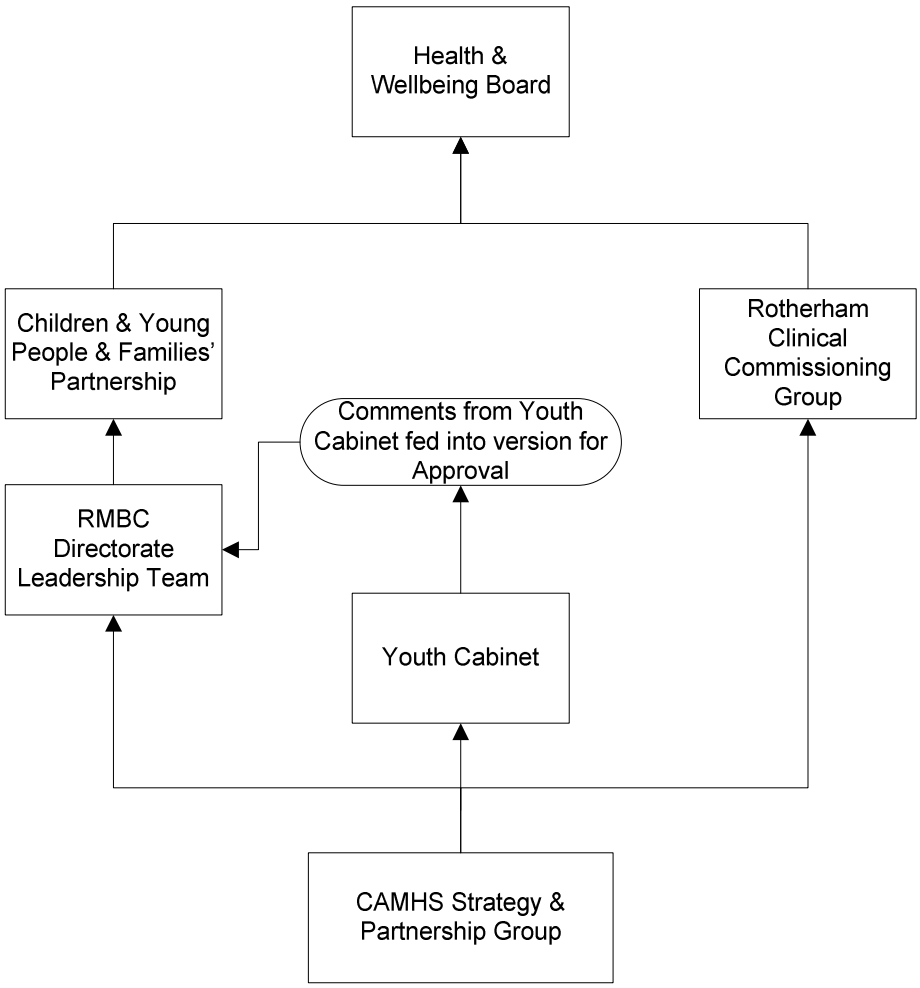
Our vision is for the children and young people of Rotherham to have the best possible emotional health and wellbeing, to build social and emotional resilience, promote good parenting skills and for our services to identify problems early and respond to them quickly.

2.2 Governance

The strategy will require approval from Rotherham Clinical Commissioning Group, RMBC's Directorate Leadership Team and Children and Young People and Families Partnership as well as being presented to young people via Youth Cabinet before final approval is granted by the Health and Wellbeing Board.

Once approved, ongoing monitoring will be undertaken by the CAMHS Strategy & Partnership Group and update reports will be fed into both RCCG and RMBC governance procedures, as well as ensuring that children and young people are kept up to date with progress and have an opportunity to feed in their views and comments. Figure 1 below sets out the approval and reporting processes.

Figure 1 Approval & Reporting Process



2.3 Tiered Approach to Services

A wide range of services play an important role in the promotion and support of children and young people's emotional health and wellbeing. They work together to deliver a four tier model of Child and Adolescent Mental Health Services (CAMHS) as outlined in *Together We Stand* (Health Advisory Service, 1995). This model is illustrated in Figure 2.

The following is a definition of child and adolescent mental health services:

> *Child and Adolescent Mental Health Services is commonly used as a broad concept that embraces all those services that contribute to the mental health care of children and young people, whether provided by health, education, social services or other agencies. As well as specialist services, this definition also includes universal services whose primary function is not mental health care, such as GPs and schools, and explicitly acknowledges that supporting children and young people with mental health problems is not the responsibility of specialist services alone*
>
> Source – http://www.everychildmatters.gov.uk/health/CAMHS/

Appendix 5 contains a diagram which combines the conventional 'Tiered' model with a Social Services 'Windscreen' model. This maps specific local Rotherham services across the different levels of service provision and demonstrates that a majority of services can be found in Tier 1 which supports an early intervention and prevention approach.

Table 1 shows the different levels of the tiered approach, together with information on the types of service to be found at each level.

2.4 Commissioning

Commissioning is the process through which the needs of people are assessed, potential resources available to meet those needs are identified and decisions are taken about how best to use resources to maximise outcomes.

In the area of emotional health and wellbeing, responsibility for commissioning and providing services at each of the tiers shown in Figure 2 lies with a number of agencies.

Tier 1 services are wide ranging, open access provision. Some Tier 1 services are commissioned via the Local Authority and Health, whilst others are non-commissioned services, such as those in the wider voluntary sector.

In terms of Tier 2 and 3 child and adolescent mental health services, commissioning is led by RCCG on a regional basis from Rotherham, Doncaster and South Humber NHS Foundation Mental Health Care Trust (RDaSH). RMBC's Children and Young People's Services (CYPS) are a partner in this commissioning model which is led by RCCG.

Services for children and young people commissioned by RMBC are commissioned in line with the Children and Young People's Commissioning Strategy. Services commissioned by RCCG are commissioned in line with the NHS Rotherham CCG Commissioning Plan. A small amount of child and adolescent mental health services activity is also commissioned by RCCG from other local providers where Rotherham patients access services which are

geographically more convenient. These providers include; Sheffield Health and Social Care, Nottinghamshire Healthcare, and South West Yorkshire NHS FT.

Tier 4 services are commissioned by NHS England from specialist providers.

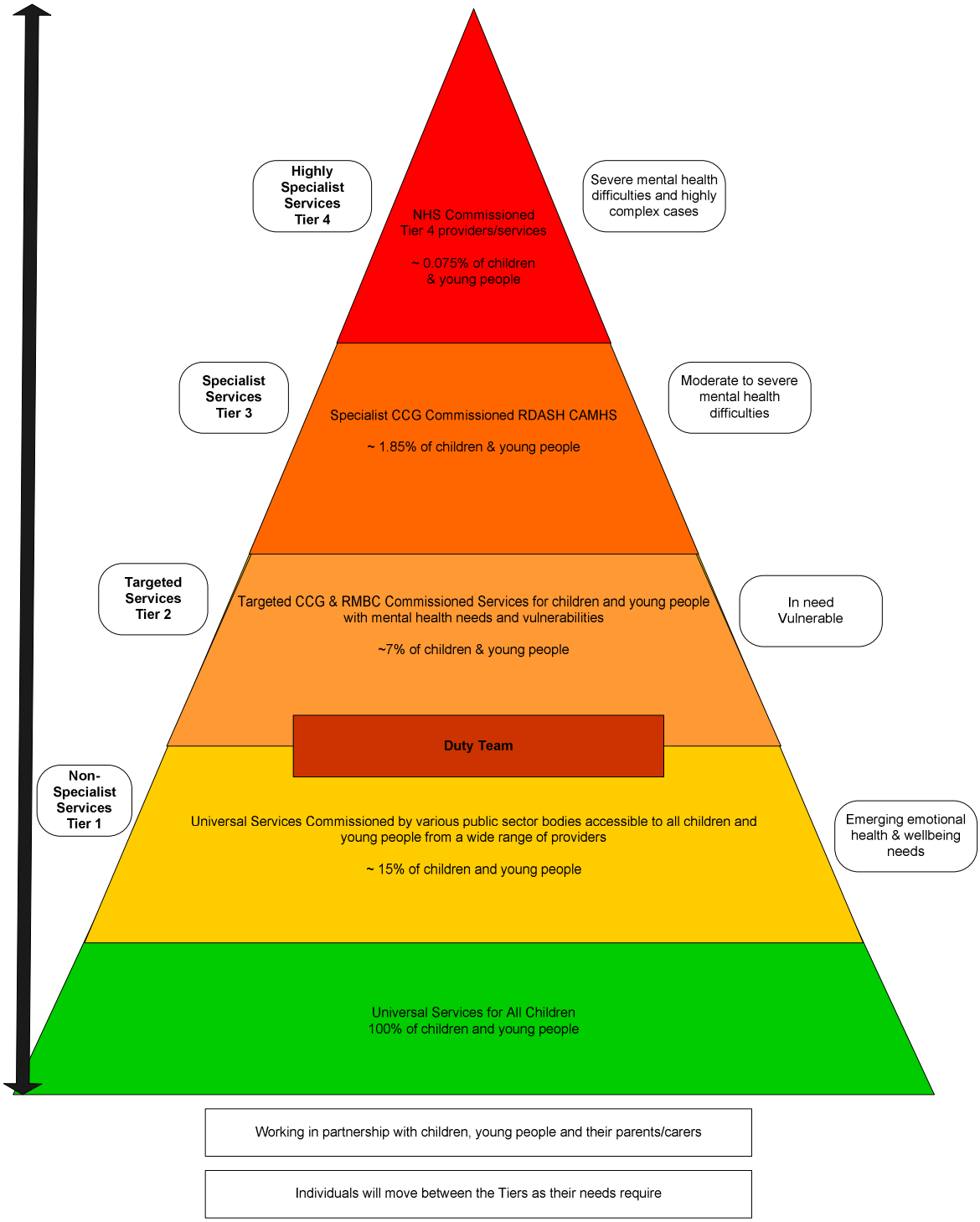
2.5 Analysis Of Need

A separate report - Analysis of Need: Emotional Wellbeing & Mental Health for Children & Young People 2014 sets out the various national guidance, such as 'No health without mental health' and 'Closing the Gap' which has informed this Strategy. In addition, the report also references local guidance and details the results of a needs analysis for Rotherham both of which have also been taken into account when formulating recommendations and subsequent action plans.

This strategy and its recommendations will inform commissioning activity for both the CCG and RMBC for 2014-19 as we endeavour to deliver additional value for money, achieving 'more for less'.

Figure 2

Comprehensive Child & Adolescent Mental Health Services in Rotherham (CAMHS)



Kurtz Z,1996.

NB Figures and percentages in each Tier are estimates based on national prevalence numbers

Table 1

Tier	Description	Professionals providing the service include but are not limited to	Function/Service
4	Essential tertiary level services such as day services, highly specialised out-patient teams and in-patient units	Services provided by professionals, usually on the basis of a multi-disciplinary team approach • Child and adolescent psychiatrists • Clinical child psychologists • Nurses (community or inpatient) • Child psychotherapists • Occupational therapists • Speech and language therapists • Art, music and drama therapists Family Therapists	• Child and adolescent inpatient units • Secure forensic units • Eating disorder units • Specialist teams (e.g. for sexual abuse) • Specialist teams for neuro–psychiatric problems
3	Specialised services for more severe, complex or persistent disorders such as depression & eating disorders		Services offered by multi-disciplinary teams: • Assessment and treatment • Assessment for referral to T4 • Contributions to the services, consultation and training at T1 and T2
2	Services provided by professionals with training in mental health	Services provided by professionals, usually on a 1:1 basis • RDaSH CAMHS workers eg social workers, therapists, nurses, doctors, psychologists • IYSS Youth Start • Rotherham & Barnsley Mind • Education psychologists	Child and adolescent mental health services professionals should be able to offer: • Training and consultation to other professionals (who might be in T1) • Consultation to professionals and families • Outreach • Assessment • Therapeutic interventions
1	Services provided by a wide range of commissioned and non-commissioned providers	Services provided by professionals, usually on a 1:1 basis • GPs • Midwives • Health visitors • School nurses • Social workers • Teachers & pastoral support • Integrated Youth Support workers • Education psychologists • Paediatricians • Voluntary services	Child and adolescent mental health services at this level are provided by professionals working in universal services who are in a position to: • Identify mental health problems earlier in their development • Offer general advice • Pursue opportunities for mental health promotion and prevention

3. Services in Rotherham

3.1 Tier 1

Services in Tier 1 are provided by practitioners working in universal services which can be accessed by any child or young person and are not necessarily mental health specialists. Services within this Tier are predominately open referral and are delivered in a variety of settings which are regularly accessed by children and young people, such as children's centres, schools, youth centres, GP practices etc. See Appendix 5 for examples of Tier 1 services.

In addition to the services included in Appendix 5, there are also a variety of support services which support schools at very early levels of intervention. These include; The Autism Communication Team, Behaviour Support Service and Learning Support Service.

Tier 1 services provide the following:

- General advice
- Promote mental health and wellbeing
- Focus on early support around reducing risk taking
- Offer practical support
- Offer listening services
- Support parents
- Help identify, refer on and support children and young people who may require targeted or specialist services

A Common Assessment Framework (CAF) may be required where referral is needed.

3.1.2 Work to Support Tier 1 Activity

3.1.2.1 Targeted Mental Health in Schools (TaMHS) (Wolpert et al. 2011)

Targeted Mental Health in Schools (TaMHS) was a 3 year national project established in 2008 and supported by Department for Children, Schools and Families and the National Child and Adolescent Mental Health Services Support Service. Following the success of the TaMHS work in Rotherham there has been a conference for schools held in the borough for the last 3 years, focusing on mental health and emotional well-being. The conference last year focused on the wider determinants which can impact on a families' mental and emotional well-being; a seminar is planned for 2014 with a focus on loss and bereavement. it is anticipated that the conferences will be ongoing.

3.1.2.2 Mental Health Training for Tier 1/Universal Workers

Both Rotherham Public Health and Rotherham and Barnsley Mind have been providers of training for universal workers on a variety of mental health issues. These include Youth Mental Health First Aid Training and Self-Harm training.

RDaSH CAMHS are commissioned by RCCG to provide training and support to Tier 1 services.

3.1.2.3 Rotherham Healthy Schools Programme

The Healthy Schools consultant raises awareness of local and national issues, resources and opportunities relating to wellbeing with schools via a variety of methods, in order to support schools to address issues relating to wellbeing. Issues mentioned by the schools are also raised in appropriate forums to raise awareness of upcoming need. Partnership working is key.

Examples of activity relating to wellbeing support for schools are:

- Local Rotherham Healthy Schools Programme devised to reflect local priorities and school needs.
- PSHEe curriculum work supported relating to Relationships and Sexual Health, including Child Sexual Exploitation, Domestic Abuse and positive teenage relationships.
- Update of the Rotherham Healthy Schools Scheme of Work for Personal, Social, Health and Citizenship Education – Primary phase, to include current issues in an age appropriate way. This includes domestic abuse, anti-homophobic bullying and an enhancement of e-safety which therefore supports prevention work on child sexual exploitation.
- Rotherham Healthy Schools Wellbeing Roadshow devised and piloted. External agencies have the opportunity to interact with parents/carers from the school communities to promote their services and support the wider school community at an existing school event.
- Promotion of the Childline input 'This is Abuse' to primary phase schools for Y5&6.
- In conjunction with Public Health, developing and disseminating a drug education resource on MCAT for staff working with Rotherham Young People
- Working with key partners, updated the LA Anti-Bullying Guidance for schools.

3.1.3 Additional Required Delivery Based on Evidence in Analysis of Need

3.1.3.1 All services in Tier 1 to recognise their role in focusing on prevention and strengthening resilience in young people *(Recommendation 10)*

Prevention of mental ill health and promotion of good mental health is the responsibility of all Tiers within CAMHS .The development of the pathways will include a focus on best practice for building resilience amongst young people. Preventative and resilience messages and healthy lifestyle advise, for example; Connect, Be Active, Be Creative and Play, Learning and Take Notice (The Children's Society 2013) will be incorporated into Tier 1 training. In addition the development of a Public Mental Health Strategy, as recommended in the Rotherham Director of Public Health Annual Report (2013/14),will focus on a local commitment to promote mental health and build emotional resilience across the whole of the population in Rotherham.

3.1.3.2 Improved & quicker access to services *(Recommendation 12)*

Work will be undertaken to improve access to Tier 2 services and Tier 2 and 3 RDaSH CAMHS. Work will include:

- Developing a Tier 1 screening tool with clear onward referral criteria
- Enhanced monitoring of the young person's journey and experience
- Improved links across all tiers
- Mechanism to raise service issues ('Issues Log')
- Improved understanding of access and referral processes
- Further development of self-referral into Tiers 2 and 3 child and adolescent mental health services
- Prompt access including out of hours support
- Developing clear care pathways
- Scoping of a 24/7 service

3.1.3.3 Continue to foster good working relationships between workers in Tiers 1, 2 and 3

This work will include, for example, looking at relationships between schools, GPs and IYSS so that these services are assisted and supported in identifying mental health problems as soon as possible.

3.1.3.4 Development of a self-harm pathway *(Recommendation 2)*

A pathway and guidance for use by universal workers will be produced in conjunction with children's mental health services and universal services. The Youth Cabinet will be consulted and involved in the content.

3.1.3.5 Tier 1 workforce development *(Recommendation 6)*

To have a borough wide training plan for Tier 1 workers to include minimum requirements for staff. This will inform the future commissioned training programmes that will be provided by RDaSH CAMHS, RMBC and the voluntary and community sector.

3.1.3.6 Access to good, safe and accurate information *(Recommendations 1 and 3)*

Involve young people to develop user-friendly information/media messages. Ensuring that children, parent/carers and professionals have access to good information resources in order to promote children's emotional wellbeing through a variety of media ie print, telephone and internet, including new technology and social media.

RDaSH is currently developing the use of technology through the 'Digital First' and '3 Million Lives' initiatives.

3.1.3.7 Continued mapping of Tier 1 provision *(Recommendation 6)*

To continue to map Tier 1 activity through revisiting the directory of services and ensuring that this information is available to other Tier 1, 2 and 3 workers, parents/carers and young people. Mapping of Tier 1 services will ensure that future commissioning considers any changes within the wider child and adolescent mental health services provision. This includes mapping changes in capacity and/or resource.

A directory of services has been developed and is regularly updated and shared with relevant key stakeholders.

3.1.3.8 Develop Self-help and Peer Support *(Recommendation 3)*

Develop consistent self-help messages to be promoted by Tier 1 services for use by children, young people, parents and carers. Develop peer support and 'expert by experience' to support young people to develop coping strategies and promote wellness principles.

3.1.3.9 Take action to reduce the stigma and discrimination associated with mental health problems *(Recommendation 11)*

To work across the Tiers, in partnership with young people, to tackle stigma and discrimination associated with mental health problems. This will be through coordinated action at a borough wide level, as specified in the action plan. Individual services/organisations will be encouraged to consider this in their day to day work.

3.1.3.10 Rotherham Healthy Schools Programme *(Recommendation 10)*

To refine the Programme's Wellbeing Road Show and raise awareness of the programme with key partners together with planning a roll out across Rotherham Schools and Early Years settings.

Distribute updated Rotherham Healthy Schools scheme of work for personal, social, health and citizenship education – delivering primary phase resource to remaining Rotherham Schools.

Continue to promote the Childline input 'This is Abuse' to primary phase schools for years 5 and 6 so that all schools are involved by 2017.

Continue to support curriculum development relating to local and national priorities, including the understanding of 'consent' and work around bereavement.

Promote Samaritans guidance for schools "Help when we needed it most" and the pathway for self harm/suicide in schools.

3.1.3.11 Access for patients from vulnerable groups *(Recommendation 3)*

Carry out equality impact analyses of services to ensure that patients from vulnerable groups have equality of access to emotional wellbeing and mental health

services in Rotherham. From the information gathered an action plan should be developed to address areas where vulnerable groups are not accessing services at predicted rates.

3.1.3.12 Special Educational Needs and Disability (Children & Families Bill 2013) *(Recommendation 3)*

Ensure that future service provision reflects the changes called for in respect of children with special educational needs and disability. Specifically the need to reflect an extended age range to 25 years, to undertake joint 'Health & Care' plans, to be able to offer personal budgets to families and ensure that they are involved in reviewing and developing service provision. Work is ongoing across partner organisations to deliver the requirements of the Bill.

3.2 Tier 2

Tier 2 services offer consultation to families and other practitioners, outreach to identify severe/complex needs, and assessments and training to practitioners at Tier 1 to support service delivery.

Tier 2 services are more targeted services and are frequently accessed by referral from other professionals. Services within this Tier include IYSS Youth Start, Rotherham and Barnsley Mind, Education Psychology and RDaSH CAMHS Tier 2.

Provision at Tier 2 is provided by an individual mental health practitioner and includes assessment and intervention. This could include improving emotional resilience, promoting positive behaviours, developing coping strategies and improving the self esteem of children and young people and the use of specific psychological therapy or medication. See Appendix 5 for examples of Tier 2 services.

3.2.1 Current Delivery

3.2.1.1 IYSS Youth Start

The service provides open access/self-referral for young people aged 11 years and above in order that young people can access when they feel they need the service.

The service now operates from the IYSS Youth Hub which houses a wide range of children and young people's services on an open access basis, where the holistic needs of the young person can be addressed.

3.2.1.2 Joint Youth Start/RDaSH CAMHS Mental Health Clinic

A joint Youth Start/RDaSH CAMHS Mental Health Clinic has been developed and is in operation at the IYSS Youth Hub at the Eric Manns Building in the centre of Rotherham. The Clinic provides for joint assessment and referral into child and adolescent mental health services to the service which best meets the needs of the young person (Youth Start, RDaSH or alternative services ie Mind etc).

The RDaSH CAMHS service has worked alongside the Youth Start service to develop an opportunity for young people aged 14 years and above to self refer into RDaSH CAMHS.

3.2.1.3 Rotherham and Barnsley Mind

Rotherham and Barnsley Mind contribute to the delivery of Tier 2 child and adolescent mental health services within Rotherham by use of a multi-agency team offering mental health support to children and young people up to the age of 18 years. The service is provided in a range of schools and community settings across the borough where children and young people are able to access 1:1 support from a trained professional through delivery of 1:1 mental health support clinics. The service offers a range of consultation opportunities including telephone and face-to-face advice.

The service has also provided of a range of Tier 1 multi-agency mental health training and provided support to Tier 1 staff working directly with children and young people in universal services.

3.2.1.4 RDaSH CAMHS

The service provides a range of Tier 2 targeted services and links with universal services, attending locality meetings with GPs and surgery visits, IYSS, LAAC, Heads of Schools meetings, Primary and Secondary School SENCOs support meetings, Supervision and support to the Family Recovery Programme and the Rowan Centre, engagement with South Yorkshire Fire and Rescue services and engagement with secondary schools/ academies. RDaSH has also delivered presentations to school nurses, health visitors and Child Development Centre staff at the Additional Needs training event. RDaSH also supports and liaises with Public Health, addressing issues around suicide and self-harm and delivering self-harm seminars at local conferences.

The clinical lead has attended the Key working 'train the trainer' to address the Children and Families Act (2014) (the SEND agenda) and takes an active role in the SEND strategy group.

3.2.2 Additional Required Delivery Based on Evidence in Analysis of Need

3.2.2.1 Define Tier 2 interventions *(Recommendation 1)*

Define the level of intervention at Tier 2 and interactions with other Tiers as part of multi-agency pathway developments.

3.2.2.2 Tier 2 workforce skills and competencies *(Recommendation 4)*

To have a borough wide minimum requirement for skills and competencies for Tier 2 staff.

3.2.2.3 RDaSH CAMHS locality workers model of provision *(Recommendation 3)*

To ensure that a locality model of provision is developed, which includes RDaSH CAMHS locality workers working directly with IYSS locality teams and provide specialist support to a range of services in that locality, eg schools, colleges and GPs.

3.2.2.4 Transitions between young people's services and adult services *(Recommendation 7)*

The RDaSH CAMHS service has employed Peer Support Workers (PSWs) who assist in the transition of young people who require on-going mental health support beyond their 18th birthday. Transition work commences at 17½ years. Further work to improve the transition between services is required, particularly within the ADHD pathway and in relation to young people who are first identified around the transition point of age 17 years approaching 18 years.

There are additional challenges where patients also have Learning Disabilities and will need to transfer to specialist Adult LD services.

3.2.2.5 Development of interfaces between services *(Recommendation 2)*

Development of clear interfaces between services across a range of interventions, including within tiers and inter-tier for step-up and step-down support.

3.3 Tier 3

Services in Tier 3 are usually provided by a multi-disciplinary team or service working in a community mental health clinic, child psychiatry outpatient service or community settings. They offer a specialised service for those with more severe, complex and persistent disorders.

The RDaSH CAMHS team provides an integrated tier 2 and tier 3 approach to service delivery in order to support a smooth journey for the young person and their family. Tier 3 aspects of service delivery are focussed on more multi-disciplinary interventions and complex cases. The team employs specialist staff, including child and adolescent psychiatrists and a broad range of other staff who provide a range of therapies including art therapy, cognitive behaviour therapy, family therapy and psychotherapy. See section 3.3.1 for further details.

The RDaSH CAMHS team also provides an integrated service for patients with Learning Disabilities (LD). A specialist team provides support to LD patients with specific interventions as required. There are also a number of LD patients with associated conditions such as ASD and challenging behaviour and these require specific individual treatment. There are cases where such patients require Tier 4 services. This can be challenging when such patients step-down from Tier 4 to Tier 3.

Other providers of Tier 3 services include the Child Development Centre (CDC), The Rotherham Foundation Trust (TRFT) Paediatrics, Youthstart, The Looked After and Adopted Children Children's (LAAC) Support and Therapeutic Team, Educational Psychologists and Rotherham & Barnsley MIND.

3.3.1 Current Delivery

3.3.1.1 RDaSH CAMHS Duty Team

Introduction of the duty team within RDaSH CAMHS which allows anyone to contact the service between 9am and 5pm Monday to Friday for advice and consultation on referrals and support. This service is provided by a range of child and adolescent mental health services practitioners from the team.

3.3.1.2 RDaSH CAMHS Integrated Managerial and Clinical Leadership Team

There has been an improved and strengthened integrated leadership team, which incorporates generic tier 2 and 3 child and adolescent mental health services, Learning Disability services and Know the Score (young people's substance misuse service).

3.3.1.3 RDaSH Clinical Supervision Group

Introduction of group clinical supervision to support clinicians with complex cases. The group includes a range of professional backgrounds, including psychiatry, nursing, family therapy, occupational therapy and social work.

3.3.1.4 RDaSH Clinical Pathway Reviews

Review of pathways, particularly the ASD and ADHD pathways within the RDaSH services in order to streamline assessments and diagnostic procedures and minimise delays in assessment which have been previously identified. There are future plans to align this further with CDC.

3.3.1.5 Improved RDaSH CAMHS Reporting

Improved performance reporting information and progress towards meeting waiting time key performance indicators (KPIs). All referrals are triaged for urgency within 24 hours and urgent referrals assessed within 24 hours of receipt of referral currently. RDaSH CAMHS are working towards a referral to routine assessment target of 15 working days.

3.3.1.6 RDaSH Outcome Measures

Introduction of routine outcome measures across the service, including 'impact' and 'symptom' trackers, with options of session-by-session feedback available to be collected to review progress.

3.3.2 Additional Required Delivery Based on Evidence in Analysis of Need

3.3.2.1 Improved access to advice and support *(Recommendation 3)*

Improved access to advice and support from specialist RDaSH child and adolescent mental health services workers.

3.3.2.2 Routine Outcome Measures*(Recommendation 9)*

Further development by RDaSH and Rotherham & Barnsley MIND of the Children & Young Peoples Improving Access to Psychological Therapies (CYP IAPT) work which developed the use of routine outcome measures

3.3.2.3 Improved links with other tiers (*Recommendations 2 & 3)*

Improved links with other tiers through further development of the RDaSH Locality Worker role.

3.3.2.4 Improved understanding of access and referral processes for Universal/Tier 1 services *(Recommendations 6 & 8)*

Undertake work to improve the access & referral processes for Tier 1/Universal Services when accessing Tier 3 services.

3.3.2.5 Further development and establishment of self-referral *(Recommendation 3)*

RDaSH and the RMBC IYSS services to work together to further develop the self-referral services which have been implemented.

3.3.2.6 Out of hours support when in crisis *(Recommendation 5)*

Further development work to be undertaken to clarify and improve the RDaSH CAMHS Out of Hours service, particularly in respect of the impact on other stakeholders such as TRFT.

3.3.2.7 Develop clear multi-agency care pathways *(Recommendation 2)*

3.3.2.8 Improved access to Tier 4 in-patient beds. *(Recommendation 2)*

The specific Tier 3/Tier 4 interface is important and discussions, which have already started, need to be further developed to ensure that the transition of patients to an inpatient facility is seamless and efficient at what is already a difficult time for the patient and their family.

3.3.2.9 Improved transition to adult mental health services from child and adolescent mental health services *(Recommendation 7)*

RDaSH has already developed the use of Peer Support Workers to aid this process but further work needs to be undertaken.

3.4 Tier 4

Tier 4 child and adolescent mental health services are specialised services, commissioned by NHS England, with a primary purpose of the assessment and treatment of severe and complex mental health disorders in children and young people. Tier 4 services are part of a comprehensive pathway and provide for a level of complexity that cannot be provided for by comprehensive secondary, Tier 3 community services.

The purpose of treatment in these specialist services is to reduce risk using a variety of evidence-based therapies, whilst increasing the young person's psychological wellbeing and enabling discharge from the Tier 4 service at the earliest possible opportunity with the support of community services.

Where possible all children and young people should be treated as close as possible to their home area and in the least restrictive environment.

Further information is available on the NHS England website using the following link:-
http://www.england.nhs.uk/ourwork/commissioning/spec-services/npc-crg/group-c/

NHS England and CAMHs Mental Health Case Managers (MHCM) work collaboratively with local services and Tier 4 providers. A national review of child and adolescent mental health services Tier 4 provision commenced in December 2013 to consider the use and capacity of Tier 4 provision, the final report was published in July 2014. NHS England has recently outlined the intention to undertake a procurement exercise for child and adolescent mental health services Tier 4.

3.4.1 Current Activity

Mental Health Case Managers work closely with the local RDaSH CAMHS service during the admission of patients to Tier 4 in-patient units, whilst young people are in and also to facilitate discharge from hospital in a planned and collaborative way.

3.4.2 Additional Required Delivery Based on Evidence in Analysis of Need

3.4.2.1 Availability of Tier 4 Inpatient places *(Recommendation 2)*

Future actions will depend on the outcome of the national Tier 4 review; the aim will be to ensure that children and young people access Tier 4 beds when absolutely necessary. The appropriate range of Tier 4 provision should be available for all children and young people as locally as us possible and feasible.

3.4.2.2 Improved Tier3/Tier 4 Interface *(Recommendation 2)*

Further work to improve the Tier 3/Tier 4 interface and to ensure that all stakeholders work well together to provide the best outcome for the patient.

3.4.2.3. Scoping Tier 3+ Service *(Recommendation 3)*

Work to explore potential provision for young people requiring more intensive input than currently available at Tier 3 but who would not necessarily be best placed in a Tier 4 bed. This can be referred to as Tier 3+.

3.5 Child and Adolescent Mental Health Services Strategy & Partnership Group

A Child and Adolescent Mental Health Services Strategy and Partnership Group has been established with the following objectives:

- To support the development of local strategic plans to reflect the Child and Adolescent Mental Health Services agenda at a local level by continuously working towards understanding need.
- To co-ordinate and monitor the implementation of the Local and National the Child and Adolescent Mental Health Services Strategies.
- To promote quality standards and best practice and oversee national target implementation at a local level.
- To receive information from relevant sub groups and be notified of any performance issues.

The group meets on a quarterly basis and has representation from all areas of commissioning and service provision across all Tiers of the Child and Adolescent Mental Health Services.

A child and adolescent mental health services 'Top Tips' document has been developed through the group, to provide referral guidance to GPs and partners for young people who need child and adolescent mental health services in order to aid referrals to the appropriate service.

A directory of services has also been developed for GPs and partners which outlines emotional health and wellbeing provision and at which tier they operate.

3.6 Key Messages

Information from the Analysis of Needs demonstrates a requirement for delivering improved access and flexibility to services with a view to providing help and support before a young person reaches crisis point. Work is also needed to support transitions between services, step up and step down and transition to adult services.

Workforce development and improved working relationships between services and tiers will also support a culture of delivering interventions at the lowest levels possible and therefore at the earliest possibility, which will in turn deliver financial efficiencies. Similarly self-help and peer support are key areas to supporting young people to improve their resilience and to support one another.

Developing pathways for grouped conditions would provide information to young people, parents, carers and professionals as well as creating an opportunity to undertake mapping of the range of services and interventions available and defining the thresholds of access to services.

4. Investment

The following table outlines the current investments by RMBC and RCCG within each tier of CAMHS provision.

Tier	Service	Commissioned By	Cost Per Annum
1	Families for Change Intensive Family Support	RMBC	112,946
2	IYSS Youth Start	RMBC	128,000
2	Rotherham & Barnsley Mind	RMBC	60,000
2	LAAC Support & Therapy Team	RMBC	229,000
2	RDaSH CAMHS	RCCG	2,345,058
3		RMBC	139,000

5. Recommendations

The recommendations outlined below have been developed from key findings in the previous sections within this document and the Analysis of Need.

5.1 Recommendation 1 - Ensure that services are developed which benefit from input by young people and parents/carers

The involvement of service users and their families is key to developing services which deliver equality of access and provide the right interventions and support at the right time. Service user involvement will also help to highlight existing barriers to services and inform when, where and how services most need to be accessed by children and young people.

5.2 Recommendation 2 - Develop multi-agency care pathways which move service users appropriately through services towards recovery

Multi agency pathways will clearly define the routes that patients will take for particular pathways, how they are referred in and what interventions are undertaken at various points. Service providers will also benefit from a better understanding of their role in the pathway. Post diagnosis support is also critical to ensure that patients and Parents/Carers don't feel abandoned once the diagnosis element of the pathway has concluded.

5.3 Recommendation 3 - Develop family focussed services which are easily accessible and delivered in appropriate locations

This will include ensuring that services are delivered on a local basis and through a variety of mediums including telephone & web-based support. Services will also facilitate self-referral as appropriate and ensure that the most vulnerable families are not missed. This recommendation will also support the SEND agenda through better joint working between Health, Social Care and Education.

5.4 Recommendation 4 - Ensure that the services being delivered are effective, appropriate and represent the best value for money for the people of Rotherham

From the Analysis of Need there is clearly a high level of need for mental health and emotional wellbeing services in Rotherham. We also know that most mental health issues in adults arise before the age of 18 years. Prevention and early intervention will therefore benefit not just the budgets set aside for children and young people, but also those for adults in the longer term. Services also need to take account of the physical health needs of patients.

5.5 Recommendation 5 - Ensure that the services being provided are delivered at the appropriate time as required and not restricted to normal operating hours

Service provision is moving towards being delivered 7 days a week and 24 hours a day through the needs of patients and improvements in technology. Working with children and young people and their families we need to align, wherever possible, the times of service to the requirements of service users and their parents and carers.

5.6 Recommendation 6 - Ensure that services across all tiers of provision are delivered by appropriately trained staff and that training and support is provided to Universal/Tier 1 services to ensure that patients do not unnecessarily move to higher tiers of provision

Appropriately trained staff and support for them is essential to delivering wider access to services. Aligning with prevention and early intervention, having appropriately trained universal staff will deliver early help as well as identifying and satisfying patient's needs prior to crisis.

5.7 Recommendation 7 - Ensure well planned and supported transition from child and adolescent mental health services to adult services

As noted above, we know that most mental health conditions for adults begin when they are young people; supporting the transition from children and young people's services to adult services will be a key way to reduce distress and crises for those concerned – improving their lives and reducing costs.

5.8 Recommendation 8 - Explore the option of a multi-agency single point of access to mental health services for children and young people to ensure that appropriate referral pathways are followed

A single point of access would improve the speed of access by preventing delays in locating the relevant service and access point, again supporting the Health and Wellbeing Board's early intervention priority. There are multi-agency working benefits to be achieved by a single point of access which require further investigation.

5.9 Recommendation 9 - Ensure that services are better able to demonstrate improved outcomes for children and young people accessing mental health services

The key measure of whether or not a mental health service is achieving is whether or not it is delivering better outcomes for patients and also able to record that.

5.10 Recommendation 10 - Promote the prevention of mental ill-health

A key theme of current national guidance is 'parity of esteem' and the need to see mental health on a par with physical health. Clearly a key factor in achieving that parity is promoting good mental health in the same way that good physical health is promoted. Services at all Tiers need to consider how they promote good mental health and build resilience amongst young people along the themes of Connect, Be Active, Be Creative and Play, Learning and Take Notice.

5.11 Recommendation 11 - Reduce the stigma of mental illness

Mental ill-health remains an area of both actual and perceived discrimination. Providing good quality information, promoting success stories and peer support will all work towards normalising and reducing stigma. Services at all Tiers should develop their own actions to tackle stigma and discrimination and look to work with others across the borough as part a wider initiative.

5.12 Recommendation 12 - Ensure that patients do not face inappropriate delays in accessing services, across all tiers, for assessment and treatment which adversely affect their recovery

Inappropriate delays in service access improve the likelihood of patients reaching crisis point and additional interventions being required. Improved use of resources, through early intervention and prevention, times and locations of access and improved transitions and cross tier/service working will work towards reducing delays and delivering appropriate, accessible services when needed.

6.0 Summary and Next Steps

Whilst the above 12 recommendations are not exhaustive, it is felt that, in considering the key national and local policy drivers and the particular needs of Rotherham patients, they are the basis of a robust emotional wellbeing and mental health strategy and will improve the mental health of the children and young people of Rotherham.

These recommendations have been incorporated into an Action Plan, as detailed in Appendix 6. The various stakeholders identified in that document will work together to implement the recommendations within the agreed timescales.

It is important to see this action plan as a dynamic and long term document which will facilitate the implementation of the recommendations contained in this strategy, but also develop over time as priorities change.

Appendix 1

Glossary of Terms

ACE	Adverse Childhood Experiences
ASD	Autistic Spectrum Disorder
ADHD	Attention Deficit Hyperactivity Disorder
BME	Black & Minority Ethnic
CAF	Common Assessment Framework
CAMHS	Child & Adolescent Mental Health Services
CBT	Cognitive Behavioural Therapy
CCG	Clinical Commissioning Group
CDC	Child Development Centre
CYP-IAPT	Children and Young People's Improving Access to Psychological Therapies
CYPS	Children and Young People's Services
DCSF	Department for Children, Schools & Families
DLA	Disability Living Allowance
EHWB	Emotional Health & Wellbeing
EHWBB	Emotional Health & Wellbeing Board
FT	Foundation Trust
GIFT	Great Involvement, Future Thinking
GPs	General Practitioners
IYSS	Integrated Youth Support Service
JSNA	Joint Strategic Needs Assessment
KPI	Key Performance Indicator
LAAC	Looked After & Adopted Children
LGBT	Lesbian, Gay, Bisexual & Transgender
NFER	National Foundation for Educational Research
NHS	National Health Service
NICE	National Institute for Health & Care Excellence
NSF	National Service Framework
ONS	Office of National Statistics
PICU	Psychiatric Intensive Care Unit
PSW	Personal Support Worker
RCCG	Rotherham Clinical Commissioning Group
RDaSH	Rotherham, Doncaster & South Humber NHS Foundation Trust
RMBC	Rotherham Metropolitan Borough Council
SEN	Special Education Needs
TaMHS	Targeted Mental Health in Schools
TRFT	The Rotherham Foundation Trust

Appendix 2

References

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Department of Health (2004) *Core document, National Service Framework for children, young people and maternity services.* https://www.gov.uk/government/publications/national-service-framework-children-young-people-and-maternity-services

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The Children's Society (2013) The Good Childhood Report http://www.childrenssociety.org.uk/sites/default/files/tcs/good_childhood_report_2013_final.pdf

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Appendix 3

NHS Rotherham Clinical Commissioning Group | Rotherham Metropolitan Borough Council Where Everyone Matters | Rotherham Doncaster and South Humber Mental Health NHS Foundation Trust | mind For better mental health

Revised TERMS OF REFERENCE
CAMHS Strategy and Partnership Group

NAME OF GROUP:	CAMHS Strategy and Partnership Group
ACCOUNTABLE TO:	RMBC Children and Young People Services Directorate Leadership Team (CYPSD), NHS Rotherham CCG Management Executive (OE)
REPORTING THROUGH:	CCG OE, RMBC C&YPD, RDASH CAMHS business division
PRIMARY PURPOSE:	To drive forward and oversee developments through the TRFT implementation of the CAMHS Strategy Action Plan within the area of Child and Adolescent Mental Health Services across Rotherham
COMPOSITION OF GROUP:	Multi-professional, see membership list
SERVICES IN ATTENDANCE:	Rotherham Borough Council Children and Young People Services and Public Health, NHS Rotherham CCG Commissioners, Rotherham Foundation Trust Community Services, Rotherham Doncaster and South Humber Mental Health Trust, Rotherham MIND, Healthwatch
Chair GP Commissioner	NHS Rotherham CCG
Quorate	Representatives from RMBC, RDASH, RCCG, TRFT
Attendance	All members will attend a minimum of 75% of the meetings. If a member is unable to attend they will send a nominated deputy
Objectives	• To support the development of local strategic plans to reflect the CAMHS agenda at a local level by continuously working towards understanding need. • To co-ordinate and monitor the implementation of the Local CAMHS Strategy Action Plan and National CAMHS Strategies. • To promote quality standards and best practice and oversee national target implementation at a local level • To receive financial information on the local CAMHS grant and support the commissioning decision with regard to the allocation. • To receive information from relevant sub groups and be notified of any performance issues • To receive patient, carers and key stakeholders who will feed into service commissioning through the organisations represented above.
SERVICED BY:	NHS Rotherham CCG
FREQUENCY OF MEETINGS:	Quarterly
REPORTING MECHANISM:	NHSR CCG; RMBC Business Division, RMBC C&YP Services, TRFT, RDaSH CAMHS,
MINUTES CIRCULATED TO:	Membership
REVIEW DATE:	12 Months from organisational sign up

MEMBERSHIP

NHSR CCG GP Commissioner
NHSR CCG CAMHS Commissioning Manager
RMBC, Public Health Lead Mental Health
RDASH CAMHS Assistant Director/ Service Manager
RDASH, Consultant Psychiatrist
RMBC Children's and Young People's Commissioner
RMBC, Service Manager
Rotherham MIND Service Manager (On behalf of VSC)
RFT Children's Lead
Clinical Lead Looked After Children's Mental Health Support Team
Youth Start, Emotional Coordinator
Service Manager Education Psychology
YOS Representative

Appendix 4

NICE guidance

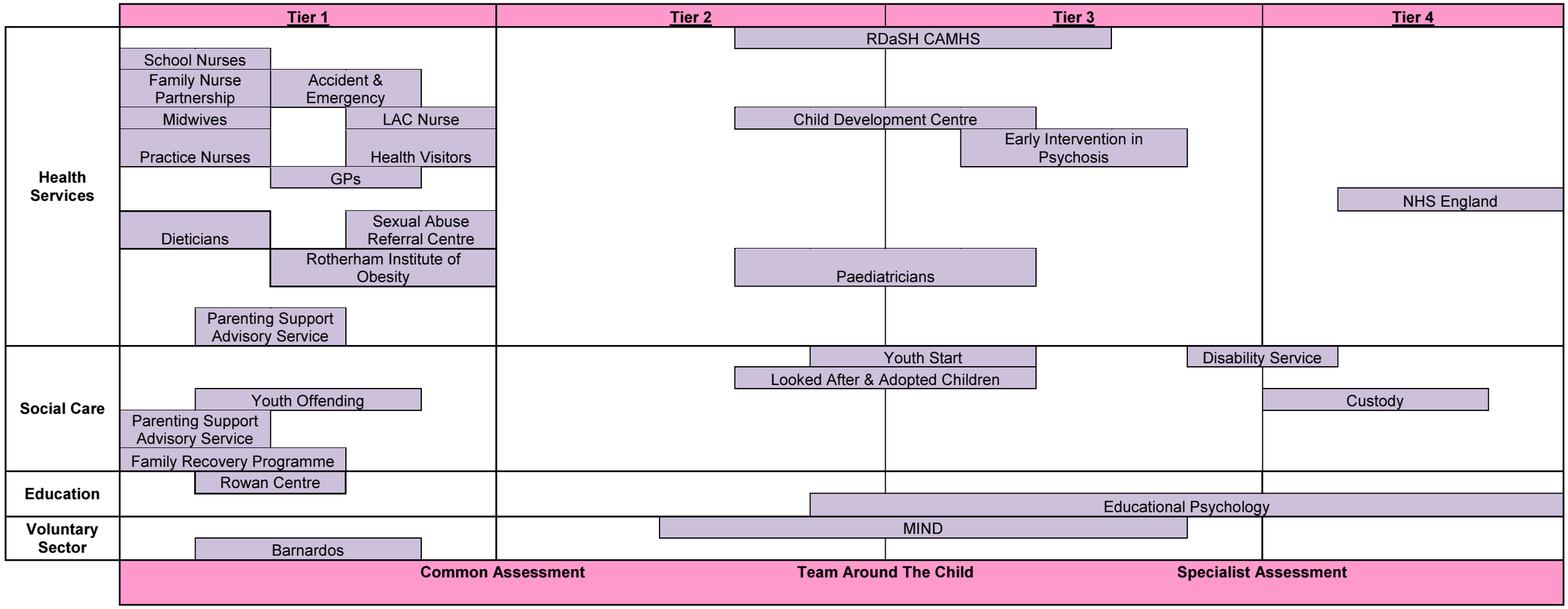
The National Institute for Health and Care Excellence has produced evidence based clinical guidance for England and Wales on a number of topics with relevance to CAMHS practice.

The following list is correct as of September 2013.

Eating disorders (CG9)
Self-harm (CG16)
Anxiety (CG22)
Violence (CG25)
Post-traumatic stress disorder (PTSD) (CG26)
Depression in children and young people (CG28)
Obsessive–compulsive disorder (OCD) and body dysmorphic disorder (BDD) (CG31)
Bipolar disorder (CG38)
Antenatal and postnatal mental health (CG45)
Drug misuse: psychosocial interventions (CG51)
Chronic fatigue syndrome/myalgic encephalomyelitis (CG53)
Attention-deficit hyperactivity disorder (ADHD) (CG72)
Antisocial personality disorder (CG77)
Borderline personality disorder (BPD) (CG78)
Schizophrenia (update) (CG82)
When to suspect child maltreatment (CG89)
Depression with a chronic physical health problem (CG91)
Nocturnal enuresis – the management of bedwetting in children and young people (CG111)
Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults (CG113)
Alcohol dependence and harmful alcohol use (CG115)
Psychosis with coexisting substance misuse (CG120)
Autism in children and young people (CG128)
Self-harm (longer-term management) (CG133)
Conduct disorders in children and young people (CG158)
Social anxiety disorder (CG159)
Four commonly used methods to increase physical activity (PH2)
Interventions to reduce substance misuse among vulnerable young people (PH4)
School-based interventions on alcohol (PH7)
Physical activity and the environment (PH8)
Maternal and child nutrition (PH11)
Social and emotional well-being in primary education (PH12)
Social and emotional well-being in secondary education (PH20)
School-based interventions to prevent smoking (PH23)
Alcohol-use disorders: preventing harmful drinking (PH24)
Health and well-being of looked after children and young people (QS31)
Insomnia – newer hypnotic drugs (TA77)
Attention-deficit hyperactivity disorder (ADHD) – methylphenidate, atomoxetine and dexamfetamine (review) (TA98)
Structural neuroimaging in first-episode psychosis (TA136)
Domestic violence and abuse – identification and prevention (in progress)

Appendix 5

Mental Health Services for Children in Rotherham - Tiered Model



Appendix 6

Strategy Action Plan

Ref	Sub-Action	Strategy Priority Reference	Detail	Resource Required	Action Owner(s)	Target start date	Target end date	Comment/Update	Date	RAG Status
1	**Ensure that services are developed which benefit from input by young people and parents/carers**									
1.1	Develop voice and influence mechanisms for children and young people		Ensure clauses around voice and influence in all contracts	Lisa Duvall Young People's rep Parent rep Helen Wyatt	Nigel Parkes Paul Theaker	01.04.14	ongoing			
			Work with children and young people to find out how they would like to input into services & feedback							
			Work with children and young people to provide friendly documentation							
			Involve children and young people in service design							
1.2	Implementation		Implement agreed mechanisms							
			Monitor outcomes							
1.3	Develop voice and influence mechanisms for parents/carers		Ensure clauses around voice and influence in all contracts	Lisa Duvall Young People's rep Parent rep Helen Wyatt	Nigel Parkes Paul Theaker	01.04.14	ongoing			
			Work with children and young people to find out how they would like to input into services & feedback							
			Work with children and young people to provide friendly documentation							
			Involve children and young people in service design							
1.4	Implementation		Implement agreed mechanisms							
			Monitor outcomes							
2	**Develop multi-agency care pathways which move service users appropriately through services towards recovery**									
2.1	Pathways (step up/step down/transition) to be further developed for ASD	4.2.2.6 4.3.2.7 4.6.4	Establish working group	Officer Time - CCG, RMBC, RDaSH etc plus input from Healthwatch, Parent/Carer reps, young people's rep and VCS	Nigel Parkes	01.06.14	30.11.14			
			Establish pathway							
			Prioritise pathway							
			Test out pathway							
			Undertake impact assessment for vulnerable groups							
			Develop family friendly presentation							
			Consult with stakeholders							
			Launch pathway							
			Review and update pathway as appropriate			01.04.15	ongoing			
2.2	Pathways (step up/step down/transition) to be further developed for ADHD	4.2.2.6 4.3.2.7 4.6.4	Establish working group	Officer Time - CCG, RMBC, RDaSH etc plus input from Parent/Carer reps, young people's rep and VCS	Russell Brynes Nigel Parkes	01.06.14	30.11.14			
			Establish pathway							
			Prioritise pathway							
			Test out pathway							
			Undertake impact assessment for vulnerable groups							
			Develop family friendly presentation							
			Consult with stakeholders							
			Launch pathway							

			Review and update pathway as appropriate			01.04.15	ongoing			
2.3	Pathways (step up/step down/transition) to be further developed for behavioural issues	4.2.2.6 4.3.2.7 4.6.4	Establish working group	Officer Time - CCG, RMBC, RDaSH etc plus input from Parent/Carer reps, young people's rep and VCS	Paul Theaker	01.06.14	30.11.14			
			Establish pathway							
			Prioritise pathway							
			Test out pathway							
			Undertake impact assessment for vulnerable groups							
			Develop family friendly presentation							
			Consult with stakeholders							
			Launch pathway							
			Review and update pathway as appropriate			01.04.15	ongoing			
2.4	Pathways (step up/step down/transition) to be further developed for emotional health & wellbeing issues (including self-harm)	4.1.3.4 4.2.2.6 4.3.2.4 4.3.2.7 4.6.4	Establish working group	Officer Time - CCG, RMBC, RDaSH etc plus input from Parent/Carer reps, young people's rep and VCS	Ruth Fletcher-Brown	01.06.14	30.11.14			
			Establish pathway							
			Prioritise pathway							
			Test out pathway							
			Undertake impact assessment for vulnerable groups							
			Develop family friendly presentation							
			Consult with stakeholders							
			Launch pathway							
			Review and update pathway as appropriate			01.04.15	ongoing			
2.5	Pathways (step up/step down/transition) to be further developed for substance misuse	4.3.2.4 4.6.4	Establish working group	Officer Time - CCG, RMBC, RDaSH etc plus input from Parent/Carer reps, young people's rep and VCS	Debbie Stovin & Neil Power	01.06.14	30.11.14			
			Establish pathway							
			Prioritise pathway							
			Test out pathway							
			Undertake impact assessment for vulnerable groups							
			Develop family friendly presentation							
			Consult with stakeholders							
			Launch pathway							
			Review and update pathway as appropriate			01.04.15	ongoing			
2.6	Develop and agree a model for post abused trauma incluginds pathway (step up/step down/transition)	4.3.2.4 4.6.4	Establish working group	Officer Time - CCG, RMBC, RDaSH etc plus input from Parent/Carer reps, young people's rep and VCS	Paul Theaker	01.09.14	31.03.15			
			Establish pathway							
			Prioritise pathway							
			Test out pathway							
			Undertake impact assessment for vulnerable groups							
			Develop family friendly presentation							
			Consult with stakeholders							
			Launch pathway							
			Review and update pathway as appropriate			01.04.15	ongoing			
2.7	Protocol (step up/step down/transition)between Tier 2 services (Youth Start, LAAC Team, Rotherham & Barnsley	4.1.3.3 4.2.2.2 4.2.2.6	Draft protocol	Officer Time - CCG, RMBC, RDaSH etc	Paul Theaker & Ruth Fletcher-Brown	01.08.14	01.10.14			
			Agree protocol							
			Prioritise pathway							

	Mind)		Test out pathway	plus input from Parent/Carer reps, young people's rep and VCS						
			Undertake impact assessment for vulnerable groups							
			Develop family friendly presentation							
			Consult with stakeholders							
			Launch pathway							
			Review and update pathway as appropriate			01.04.15	ongoing			
2.8	Protocol (step up/step down/transition) between Tier 3 & Tier 4 provision	4.4.2.2	Draft protocol	Officer Time - CCG, RMBC, RDaSH etc plus input from Parent/Carer reps, young people's rep and VCS	Nigel Parkes	01.08.14	01.10.14			
			Agree protocol							
			Prioritise pathway							
			Test out pathway							
			Undertake impact assessment for vulnerable groups							
			Develop family friendly presentation							
			Consult with stakeholders							
			Launch pathway							
			Review and update pathway as appropriate			01.04.15	ongoing			
2.90	Other clinical pathway development	4.2.2.6 4.3.2.7 4.6.4	Ongoing review to establish gaps in pathways and address as appropriate	Officer Time	Barbara Murray	ongoing	ongoing			
3	**Develop family focussed services which are easily accessible and delivered in appropriate locations**									
3.1	Develop toolkit for families and friends to support children and young people including self help and continued development of the self-referral facility	4.3.2.5	Research best practice & innovation; link to existing resources; where do parents access help & information; develop FAQs; develop toolkit; test with parents; ensure parent representation	Young people's rep Parent rep Potential funding	Nigel Parkes Ruth Fletcher-Brown Barbara Murray	01.06.14	01.01.15 + ongoing review			
			Research where parents access help & information							
			Link to existing resources							
			Develop FAQs							
			Develop toolkit							
			Test with patients, parents and carers							
3.2	User, parent and carer involvement in service development	4.6.5	Map current participation		All partners	01.05.14	31.03.15			
			Hold consultation events				Ongoing			
			Build involvement into future activities							
			Develop innovative range of participation mechanisms							
3.3	Access to pathways for families	4.3.2.5	Publish pathways as part of toolkit	Parent rep	Paul Theaker Barbara Murray	01.09.14	01.12.14			
3.4	Locality based workers delivering services in community, school and home settings	4.2.2.4 4.3.2.3	Research and map where parents & young people access services		Nigel Parkes Barbara Murray Paul Theaker	01.04.14	31.03.15			
			Consult with young people and families on choice and best locations to access services							
			RDaSH CAMHS workers to provide locality based consultations & interventions							
			Workers allocated to specific schools & GP practices and/or locality areas							

			Publish allocations							
			Deliver rolling programme of visits by allocated workers							
			Ensure all service locations are family friendly, including reviewing reception arrangements at Kimberworth Place							
3.5	Develop flexibility of appointment times to meet need		Families, children & young people to be offered a choice of location and times for service access eg school, home, GP		Nigel Parkes Barbara Murray	01.05.14	ongoing			
3.6	Ensure that services reflect the SEND element of the Children & Families Bill 2013	4.1.3.12	Work with SEND Commissioning group to ensure all CAMHS workers contribute to EHC Plans		All partners	01.05.14	ongoing			
3.7	Ensure that services take account of vulnerable groups	4.1.2.11	Ongoing dialogue and attendance at forums. Use of census information, JSNA data etc		All partners	01.05.14	ongoing			
3.8	Explore potential provision of a Tier 3+ service	4.4.2.3	Research best practice & innovation elsewhere		Nigel Parkes	01.09.14	31.03.15			
			Develop draft model for provision							
			Consult with stakeholders on draft model & practicality of implementation							
			Develop financial plan for implementation including efficiency savings							
			Agree if option is viable							
			Seek approval to progress							
			Develop implmentation plan and implement							
4	**Ensure that the services being delivered represent the best value for money for the people of Rotherham.**									
4.1	Use the conclusions of the Attain report to review any areas of service provision which could be more economically delivered, eg recovery college approach	4.2.2.1			Nigel Parkes	01.06.14	01.03.15			
4.2	Reduce inappropriate referrals & incorrect referrals		Delivered through workforce development and training plans, development of pathways and referral mechanisms		Barbara Murray Nigel Parkes Paul Theaker Ruth Fletcher-Brown	01.04.14	ongoing			
4.3	Reduce need by improving resilience of young people and families at lower tiers		Revisit directory to be suitable for universal services		Ruth Fletcher-Brown	01.04.14	01.12.14			
			Review top tips document to be suitable for universal services							
			Develop screening tool							
			Develop minimum training requirements for each Tier							
			Promotion of RDaSH duty time phone number							
			Investigate potential to share care plans across each young person's support network							
4.4	Ensure coping mechanisms are built into all care plans to reduce need for young people to revisit services		Delivered through care plans and the Public Mental Health Strategy	Tier 2 providers	Paul Boyden Barbara Murray Ruth	01.04.14	31.03.15			

					Fletcher-Brown					
4.5	Investigate the options to provide more robust services at an early stage, both in lower tiers and at an early age, to ensure that patients are prevented from moving into higher (and more expensive) tiers				Ruth Fletcher-Brown					
5	**Ensure that the services being provided are deilvered at the appropriate time as required and not restricted to normal working hours**									
5.1	Investigate options for provision of web-based support for parents & young people		Investigate existing information provision Investigate existing information provision Consult with young people and families Explore platforms for delivery Agree options for implementation Obtain funding to implement Develop implementation plan Implement	Youth Cabinet RDaSH All partners Creative Media Service	Ruth Fletcher-Brown	01.06.14	31.12.14			
5.2	Investigate provision for e-platforms (e-clinic), email and text based support		Investigate existing information provision Consult with young people and families Explore platforms for delivery Agree options for implementation Obtain funding to implement Develop implementation plan Implement		RDaSH All Partners	01.06.14	31.12.14			
5.3	Investigate options for provision of a 24/7 service including telephone and crisis support	4.1.3.2 4.3.2.6	Investigate existing information provision Consult with young people and families Explore platforms for delivery Undertake options appraisal Revisit duty/on call service Agree options for implementation Obtain funding to implement Develop implementation plan Implement		RDaSH All partners	01.06.14	31.12.14			
6	**Ensure that services across all tiers of provision are delivered by appropirately trained staff and that training and support is provided to Universal/Tier 1 services to ensure that patients do not unnecessarily move to higher tiers of provision**									
6.1	Collate training & development needs from consultation		Add in information/gap analysis from pathway development		Nigel Parkes Paul Theaker Ruth Fletcher-Brown	01.04.14	01.10.14			

6.2	Develop and implement training plan using electronic training, skills transfer & knowledge sharing	4.1.3.3 4.1.3.5 4.1.3.7 4.2.2.3 4.3.2.1 4.6.3		RMBC & CCG Learning & Development	Nigel Parkes Paul Theaker Ruth Fletcher-Brown Barbara Murray	01.10.14	31.12.14			
6.3	Develop screening tool		Develop model for expected level of training for each tier/service and training resource		Ruth Fletcher-Brown Barbara Murray	01.04.14	01.11.14			
7	**Ensure well planned and supported transition from child and adolescent mental health services to adult services**									
7.1	Links to action 1 – ensure all pathways include paths to exit service with reducing support, transition to adult services or information on how to return to service	4.2.2.5 4.3.2.9	Improve coordination of services between CAMHS and Adult Mental Health, including transitions to adult LD services.		Barbara Murray Nigel Parkes	01.04.14	31.12.14			
8	**Explore the option of a multi-agency single point of access to mental health services for children and young people to ensure that appropriate referral pathways are followed**									
8.1	Explore single access point for triage and referral to relevant provider	4.1.3.2 4.1.3.3	Links to pathways & screening tool; Identify current points of access, how they work and how to improve Establish actions to implement if appropriate		Nigel Parkes Russell Brynes	01.06.14	31.03.15			
9	**Ensure that services are better able to demonstrate improved outcomes for children and young people accessing mental health services**									
9.1	Implement appropriate quality outcome monitoring tool (CIAPT and others)	4.1.3.6 4.3.2.2	Scope current measures Develop actions by service and organisation	All partners	Nigel Parkes	01.09.14	31.03.15			
9.2	Long term tracking of data showing admission to adults services of those who accessed CAMHS as young people		Undertake scoping Develop mechanisms to monitor	All partners	Barbara Murray	01.04.15	ongoing			
10	**Promote the prevention of mental ill-health**									
10.1	Development of a Rotherham Mental Health Strategy	4.1.3.1 4.1.3.3 4.1.3.6 4.1.3.8 4.1.3.10 4.6.2	To be delivered through separate action plan	All partners	Ruth Fletcher-Brown	01.09.14	ongoing			
11	**Reduce stigma of mental illness**									
11.1	How to achieve a cultural change around mental illness	4.1.3.6 4.1.3.9 4.6.1	Link to national strategies & initiatives, Public Mental Health Strategy etc Develop a time table of key points each year to raise mental health awareness	All partners Communica-tion leads Youth Cabinet	Ruth Fletcher-Brown	01.06.14	ongoing			
12	**Ensure that patients do not face inappropriate delays in accessing services, across all tiers, for assessment and treatment which adversley affect their recovery**									
12.1	Delivered through clearer pathways, better referral mechanisms and 24/7 service	4.3.2.8 4.4.2.1 4.4.2.2	Develop charter for Emotional Wellbeing and Mental Health services	All partners	Nigel Parkes Paul Theaker	01.06.14	01.04.15			

Rotherham Metropolitan Borough Council

NHS Rotherham Clinical Commissioning Group

Analysis of Need: Emotional Wellbeing & Mental Health for Children & Young People 2014

Version 2

Version Number	Revision date	Summary of Changes	Change By	Changes accepted
1.0	10.07.14	First draft following discussion with PT	SM	
1.1	01.08.14	Amendments from NP	SM	
1.2	28.08.14	References added	SM	
2	11.09.14	Final version following final amendments by RFB & NP	SM	

Approval Process			
Name/Meeting	**Date of Issue**	**Version Number**	**Approved**

Contents

1. Introduction

Improved emotional health and wellbeing is associated with a range of better outcomes for people of all ages and backgrounds. These include:

- improved physical health and life expectancy
- better educational achievement
- increased skills
- reduced health risk behaviours such as smoking and alcohol misuse,
- reduced risk of suicide
- improved employment rates and productivity
- reduced anti-social behaviour and criminality
- higher levels of social interaction and participation

Source - various including Annual Report of the Chief Medical Officer 2012

The emotional health and wellbeing of children and young people is nurtured primarily at home, however everyone delivering children and young people's services (particularly early years and schools) has a role in improving outcomes and reducing inequalities. This includes supporting the public to make healthier, informed choices to improve emotional health and wellbeing and to improve access to services where and when they are needed.

This Analysis of Need has been produced to inform Rotherham's Emotional Wellbeing and Mental Health Strategy for Children and Young People.

2. National Guidance

This Strategy is informed by a wide range of current guidance the most relevant of which is detailed below.

2.1 National CAMHS Review – 2008

The review made a number of recommendations as follows.

2.2.1. All parents, carers, children and young people throughout the country should have:

- a more positive understanding of mental health and psychological well-being as a result of national media activity
- up-to-date information, in a range of formats, about mental health and psychological well-being and what services are available locally to help them
- good telephone and web-based help and advice
- confidence that staff in the services they use every day:
    - understand child development and mental health
    - actively promote strong mental health and psychological well-being
    - use language that they understand
    - take them seriously

- can identify needs early
- can help their child and can draw on support from others to make sure needs are addressed.

2.1.2 Children and young people who need more specialised support, and their parents and carers, should have:

- a high-quality and purposeful assessment, which informs a clear plan of action and which includes, at the appropriate time, arrangements for support when more specialised input is no longer needed
- a lead person to be their main point of contact, making sure other sources of help play their part, and co-ordinating that support
- clearly signposted routes to specialist help and timely access to this, with help available during any wait
- clear information about what to do if things don't go according to plan.

2.1.3 Children and young people and their families who are vulnerable (such as children in care, children with disabilities and children with behavioural, emotional and social difficulties) should be confident that, in addition to the above:

- their mental health needs will be
- assessed alongside all their other needs,
- no matter where the need is initially identified
- an individualised package of care will be available to them so that their personal
- circumstances, and the particular settings in which they receive their primary support
- appropriately influence the care and support they receive

For those experiencing complex, severe and ongoing needs, these packages of care will be commissioned by the Children's Trust and delivered, where possible, in the local area. Effective regional and national commissioning will occur for provision to meet rare needs.

2.1.4. Young adults who are approaching 18 years of age and who are being supported by CAMHS should, along with their parents and carers:

- know well in advance what the arrangements will be for transfer to adult services of any type, following a planning meeting at least six months before their 18th birthday
- be able to access services that are based on best evidence of what works for young adults, and which have been informed by their views
- have a lead person who makes sure that the transition between services goes smoothly
- know what to do if things are not going according to plan

- have confidence that services will focus on need, rather than age, and will be flexible.

2.2.1. National Service Framework (NSF) for Children, Young People and Maternity Services.

Standard 9 of the NSF specifically deals with '*The Mental Health and Psychological Well-being of Children and Young People*'. This proposed three elements of a 'Vision' as follows:

2.2.1 An improvement in the mental health of all children and young people.
2.2.2 That multi-agency services, working in partnership, promote the mental health of all children and young people, provide early intervention and also meet the needs of children and young people with established or complex problems.
2.2.3 That all children, young people and their families have access to mental health care based upon the best available evidence and provided by staff with an appropriate range of skills and competencies.

It also outlined the following standard:

> '*All children and young people, from birth to their eighteenth birthday, who have mental health problems and disorders have access to timely, integrated, high quality, multi-disciplinary mental health services to ensure effective assessment, treatment and support, for them and their families*.'

2.3 National Institute for Health & Care Excellence (NICE)

Various NICE clinical guidance deals with areas of relevance to child and adolescent mental health services provision. An up to date list of guidance is included in Appendix 3.

2.4 No Health without Mental Health (Centre for Mental Health et al. 2012)

The guidance contains the following priorities:

2.4.1 More children and young people will have good mental health.
2.4.2 More children and young people with mental health problems will recover.
2.4.3 More children and young people with mental health problems will have good physical health and more children and young people with physical ill-health will have better mental health.
2.4.4 More children and young people will have a positive experience of care and support.
2.4.5 Fewer children and young people will suffer avoidable harm.
2.4.6 Fewer children and young people and families will experience stigma and discrimination.

2.5 Children & Young People's Health Outcomes Strategy (Lewis & Lenehan, 2007)

The Public Health Group of the Children and Young People's Health Outcomes Forum focused on developing suggestions and recommendations for how the new health system could improve the life chances of children and young people by promoting good health and acting early where problems are developing.

Highlighted within the document are the views of children and young people in relation to health promotion and illness prevention. They found children and young people generally:

- understand that peer pressure and advertising can work against healthy choices;
- need better information and advice about healthy lifestyles;
- believe that too many public health campaigns are aimed at adults;
- connect being healthy with 'things to do' in their area and access to public transport and sports facilities;
- want involvement in the design, development and evaluation of child friendly campaigns and services;
- recognise and value the role of the school in encouraging healthy behaviour;
- recognise there is a place for social media and want a trusted internet source of accurate health information.

For further information visit:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216854/CYP-Public-Health.pdf

2.6 Everyone Counts – Planning for Patients 2014-15 to 2018-19

This planning guidance specifically outlines the need for Parity of Esteem between physical and mental health. It specifically states:

> '*We are absolutely committed to moving towards parity of esteem, making sure that we are just as focused on improving mental as physical health and that patients with mental health problems don't suffer inequalities, either because of the mental health problem itself or because they then don't get the best care for their physical health problems'.*

The guidance specifically calls for commissioners to be clear about the resources they are allocating to mental health to achieve parity of esteem and that there is specific identification and support for young people with mental health problems. They should also be clear on plans to reduce the 20 year gap in life expectancy for people with severe mental illness.

2.7 Closing the Gap: Priorities for Essential Change in Mental Health (Department of Health, 2014)

Closing the Gap supports the measures in the national mental health strategy '*No Health without Mental Health*', the Mental Health Implementation Framework and the Suicide Prevention Strategy. It is intended to bridge the gap between long term strategic ambitions and short term actions through the following 25 priorities for action.

2.7.1 High quality mental health services with an emphasis on recovery and meeting local need.
2.7.2 An information revolution around mental health.
2.7.3 Waiting time limits for mental health services.
2.7.4 Tackling inequalities in access.
2.7.5 Increasing the uptake of psychological therapies for children and young people.
2.7.6 Extend access to psychological therapies for children and young people.
2.7.7 The most effective services will get the most funding.
2.7.8 More choice.
2.7.9 Reduce all restrictive practices and end the use of high risk restraint.
2.7.10 Friends and family test.
2.7.11 Poor quality services identified sooner and action taken.
2.7.12 Better support and involvement for carers.
2.7.13 Better integration of mental and physical health.
2.7.14 Front-line services respond more effectively to self-harm.
2.7.15 No one in mental health crisis should be refused a service.
2.7.16 Better support for postnatal depression.
2.7.17 Schools supported to identify mental health problems sooner.
2.7.18 End the cliff-edge of lost support at age-18.
2.7.19 People with mental health problems will live healthier and longer lives.
2.7.20 More people will live in homes that support recovery.
2.7.21 A national liaison and diversion service.
2.7.22 Enhanced support to victims of crime.
2.7.23 Support employers to help more people with mental health problems stay in or enter employment.
2.7.24 New approaches to help people with mental health problems move into work and support them when unable to work.
2.7.25 Stamping out discrimination.

2.8 Children and Families Bill 2013

The Government is transforming the system for children and young people with special educational needs and disability (SEND), including those who are disabled, so that services consistently support the best outcomes for them. The Bill will extend the SEND system from birth to 25 years, giving children, young people and their parents greater control and choice in decisions and ensuring needs are properly met. It takes forward the reform programme set out in '*Support and Aspiration: A new approach to special educational needs and disability* progress and next steps' (Department for Education, 2012) by:

- Replacing statements and learning difficulty assessments with new birth to 25 years Education, Health and Care Plans, extending rights and protections to young people in further education and training and offering families personal budgets so that they have more control over the support they need.
- Improving cooperation between all the services that support children and their families and particularly requiring local authorities and health authorities to work together.
- Requiring local authorities to involve children, young people and parents in reviewing and developing provision for those with special educational needs and to publish a 'local offer' of support.

These changes will clearly impact on the future direction of emotional wellbeing and mental health services for children in Rotherham in a number of key areas:

- Extending the age range to 25 years, which may mean that transition to adult services from children's mental health services becomes even more important.
- Requiring a joint 'Health & Care' plan and the associated co-operation between health and social care services necessary to achieve that.
- Requiring the offering of personal budgets to families.
- Requiring the involvement of children, young people and their families in reviewing and developing service provision and the publication of a 'Local Offer'.

3. Local Guidance

3.1 Rotherham Health and Wellbeing Board

There are six identified high level priorities for the Health and Wellbeing Board (HWBB):

3.1.1 Prevention and Early Intervention - Rotherham people will get help early to stay healthy and increase their independence.

3.1.2 Expectations and Aspirations - All Rotherham people will have high aspirations for their health and wellbeing and expect good quality. services in their community, tailored to their personal circumstances

3.1.3 Dependence to Independence - Rotherham people will increasingly identify their own needs and choose solutions that are best suited to their personal circumstances.

3.1.4 Healthy Lifestyles - People in Rotherham will be aware of health risks and be able to take up opportunities to adopt healthy lifestyles.

3.1.5 Long-term Conditions - Rotherham people will be able to manage long-term conditions so that they are able to enjoy the best quality of life.

3.1.6 Poverty - Reduce poverty in disadvantaged areas through policies that enable people to fully participate in everyday social activities and the creation of more opportunities to gain skills and employment.

All these are across the Life Course Framework adapted from the Marmot Life Course.

3.2 Rotherham Director of Public Health's Annual Report

The Director of Public Health's Annual Report (2013-14) recommends the development of a Rotherham Mental Health Strategy which will outline local action to promote wellbeing, build resilience and prevent and intervene early in mental health problems in Rotherham. This strategy will have a lifespan focus and therefore will support the vision of this Emotional Wellbeing & Mental Health Strategy for Children & Young People 2014-19 in supporting good mental health in children, young people and families.

3.3 Children's Plan

RCCG has some key areas of work relating to Children's and Maternity services. These are:

- Implementation of the SEND reforms resulting from the new Children's Act 2014.
- A review of the community midwifery service looking at issues such as choice, accessibility and continuity.
- Production of a Rotherham Maternity Services Strategy and service specification.
- A South Yorkshire and Bassetlaw review of children's continuing care service.
- Continuation of the Care Closer to Home workstream looking at pathways of care for children.
- A review of children's therapy services.

4. Tiered Approach to Services

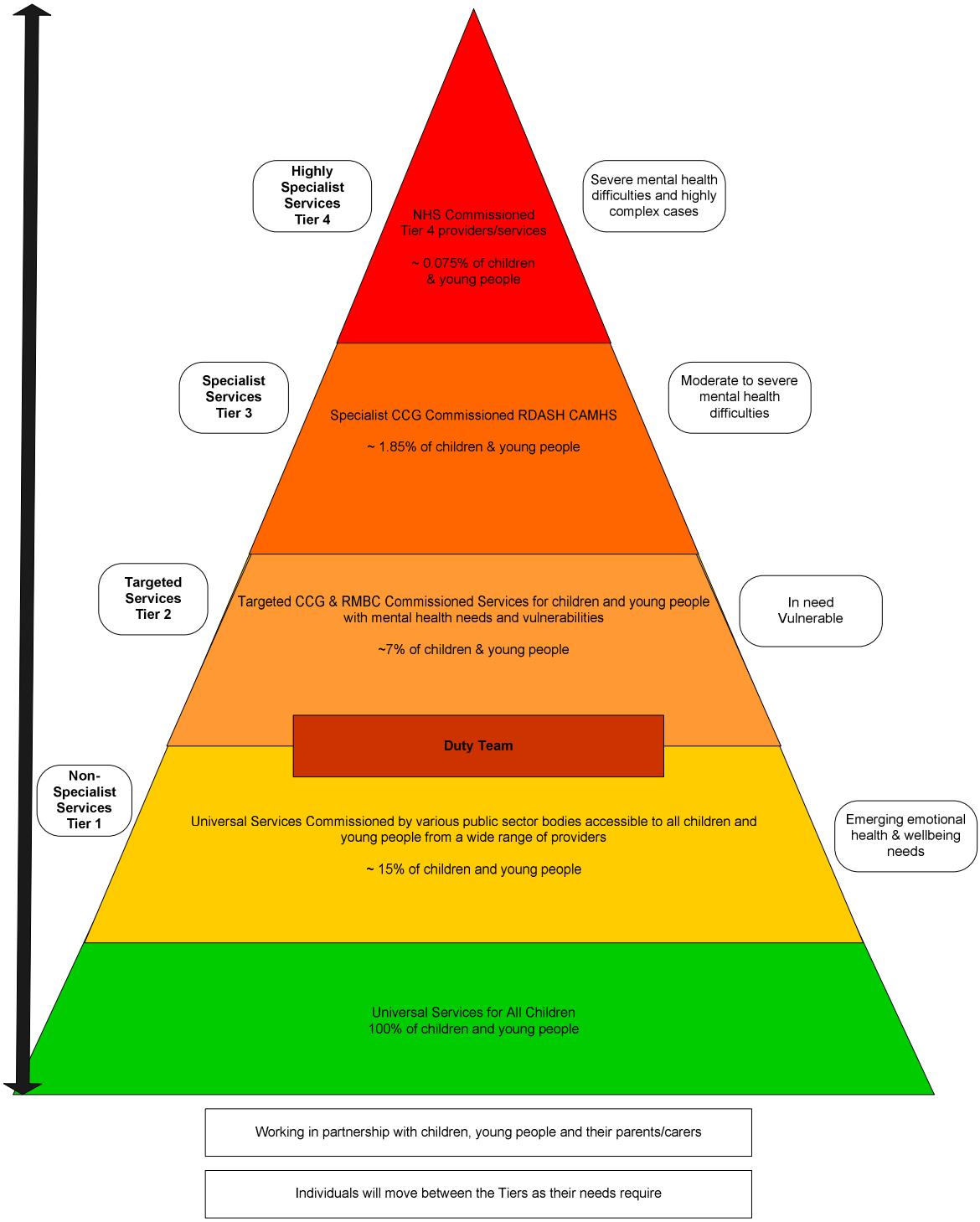
A wide range of services play an important role in the promotion and support of children and young people's emotional health and wellbeing. They work together to deliver a four tier model of Child and Adolescent Mental Health Services (CAMHS) as outlined in *Together We Stand* (Health Advisory Service, 1995). This model is illustrated in Figure 2.

The following is a definition of child and adolescent mental health services:

> *Child and Adolescent Mental Health Services is commonly used as a broad concept that embraces all those services that contribute to the mental health care of children and young people, whether provided by health, education, social services or other agencies. As well as specialist services, this definition also includes universal services whose primary function is not mental health care, such as GPs and schools, and explicitly acknowledges that supporting children and young people with mental health problems is not the responsibility of specialist services alone*
>
> Source – http://www.everychildmatters.gov.uk/health/CAMHS/

Figure 2

Comprehensive Child & Adolescent Mental Health Services in Rotherham (CAMHS)



Kurtz Z, 1996.

NB Figures and percentages in each Tier are estimates based on national prevalence numbers

Table 1 shows the different levels of the tiered approach, together with information on the types of service to be found at each level.

Table 1

Tier	Description	Professionals providing the service include but are not limited to	Function/Service
4	Essential tertiary level services such as day services, highly specialised out-patient teams and in-patient units	Services provided by professionals, usually on the basis of a multi-disciplinary team approach • Child and adolescent psychiatrists • Clinical child psychologists • Nurses (community or inpatient) • Child psychotherapists • Occupational therapists • Speech and language therapists • Art, music and drama therapists Family Therapists	• Child and adolescent inpatient units • Secure forensic units • Eating disorder units • Specialist teams (e.g. for sexual abuse) • Specialist teams for neuro–psychiatric problems
3	Specialised services for more severe, complex or persistent disorders such as depression & eating disorders		Services offered by multi-disciplinary teams: • Assessment and treatment • Assessment for referral to T4 • Contributions to the services, consultation and training at T1 and T2
2	Services provided by professionals with training in mental health	Services provided by professionals, usually on a 1:1 basis • RDaSH CAMHS workers eg social workers, therapists, nurses, doctors, psychologists • IYSS Youth Start • Rotherham & Barnsley Mind • Education psychologists	Child and adolescent mental health services professionals should be able to offer: • Training and consultation to other professionals (who might be in T1) • Consultation to professionals and families • Outreach • Assessment • Therapeutic interventions
1	Services provided by a wide range of commissioned and non-commissioned providers	Services provided by professionals, usually on a 1:1 basis • GPs • Midwives • Health visitors • School nurses • Social workers • Teachers & pastoral support • Integrated Youth Support workers • Education psychologists • Paediatricians • Voluntary services	Child and adolescent mental health services at this level are provided by professionals working in universal services who are in a position to: • Identify mental health problems earlier in their development • Offer general advice • Pursue opportunities for mental health promotion and prevention

5. The Needs of Young People in Rotherham

5.1 Self Reported Emotional Health & Wellbeing

In October 2008 the Department for Children, Schools and Families (DCSF) commissioned the National Foundation for Educational Research (NFER) to develop and deliver the Tellus4 survey. The purpose of this national survey was to gather children and young people's views on their life, their school and their local area. Findings from the survey were used to inform policy development and to measure progress and performance at both a local and national level. The survey represents the views of 253,755 children and young people in school years 6, 8 and 10 in 3,699 schools. Table 2 shows the results from Rotherham compared to England as a whole.

The Rotherham Secondary School Lifestyle Survey is conducted with years 7 and 10. The results from the 2013 survey on how young people think and feel showed the results in Table 3. Responses from both year 7 and year 10 pupils to the questions shown in Table 3 were almost identical.

Table 2 Self Reported Emotional Wellbeing & Mental Health Needs

	Rotherham %	England %	Comparison
Enjoyed good relationships with family and friends	56.4	56.0	√
Children and young people using alcohol	20.0	15.0	X
Children and young people using drugs	2.0	4.0	√
Children and young people smoking	4.0	4.0	=
Reported being bullied	10.5	9.6	X
Consider school deals 'not very well or badly' with bullying	29.0	26.0	X

Source: Respondents from the Tellus4 Survey (2009) sample of school children from years 6, 8 & 10

Key √ means that Rotherham is better than the national position
X means that Rotherham is worse than the national position
= means that Rotherham is equivalent to the national position

Table 3 Rotherham Secondary School Lifestyle Survey

	2012 %	2013 %	Comparison
Feel good about family and home life	64	62	X
Feel good about friendships	77	74	X
Feel good about the way they look	44	37	X
Feel good about school work	57	44	X

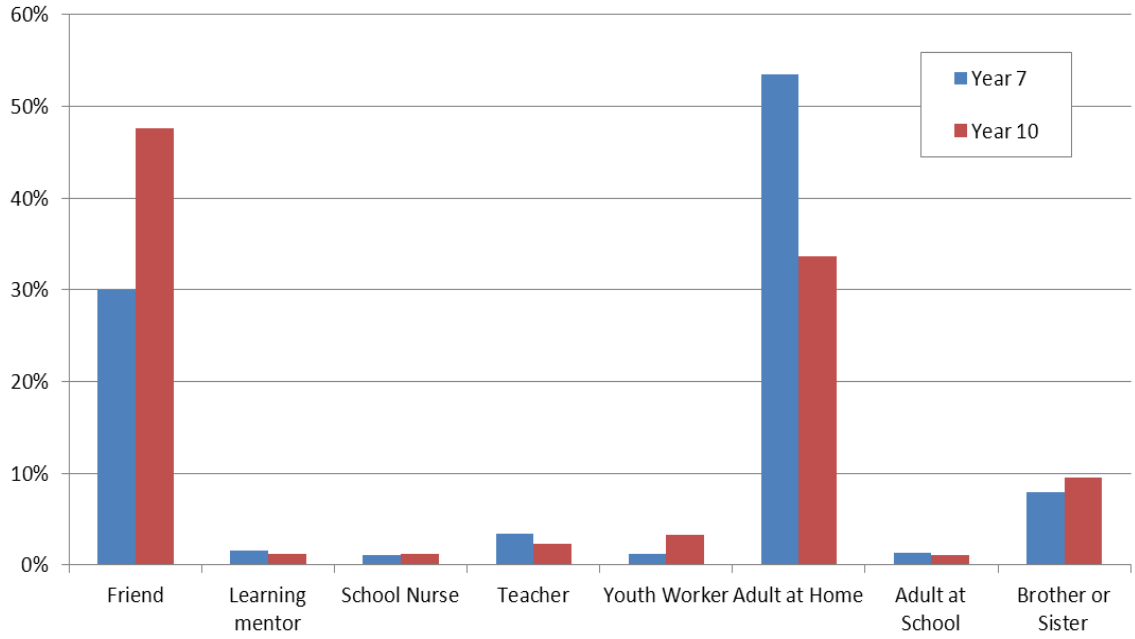
Source: Rotherham Secondary School Lifestyle Surveys 2012 & 2013

Key X means that the position has worsened from 2012 to 2103

Pupils were then asked about who they felt they would mainly discuss their problems with. The results are shown at Figure 3.

The majority of year 7 and year 10 pupils would speak to either an adult at home (54% of year 7 and 34% of year 10) or a friend (30% and 48% respectively). Around 9% of both year 7 and 10 pupils would talk to their brother or sister about their problems. Only 3% of both year groups would mainly talk to a teacher and only 1% of pupils would approach a youth worker, learning mentor, school nurse or other adult at school about their problems.

Figure 3 CHILDREN AND YOUNG PEOPLE'S HEALTH OUTCOMES FORUM – REPORT OF THE PUBLIC HEALTH AND PREVENTION SUB-GROUP



Females in both year groups were more likely to mainly speak to a friend about their problems and males in both year groups were more likely to speak to an adult at home.

Poor mental health for adults, children and young people is associated with poverty, social position, poor housing, other disabilities and trauma such as living in households where there is domestic abuse. Table 4.1, 4.2 and 4.3 highlight some of the measures which would indicate that children and young people who are more at risk of having poorer mental health, showing how Rotherham compares to England as a whole.

Key to Tables

Key √ means that Rotherham is better than the national position
X means that Rotherham is worse than the national position
= means that Rotherham is equivalent to the national position

Table 4.1 Wider Determinants of Health / Risk Factors

	Period	Rotherham	England	Comparison
Children living in poverty (all dependent children under 20 years)	2011	22.3%	20.1%	X
Children living in poverty (under 16 years)	2011	2.3%	20.6%	X
16-18 year olds not in employment, education or training	2012	7.4%	5.8%	X
First time entrants to the Youth Justice System (10-17 years) (per 100,000)	2012	435	537	√
Family homelessness (per 1,000 households)	2011/12	0.5	1.7	√
Children in care (per 10,000 under 18years)	2012	68	59	X
Emotional wellbeing of looked after children (4-16 years) (score)	2011/12	15.3	13.8	Not tested

Source: Public Health England

Table 4.2 Health Improvement

	Period	Rotherham	England	Comparison
Excess weight in children (overweight/obese) (4-5 years)	2012/13	22.2	22.2	=
Excess weight in children (overweight/obese) (10-11 years)	2012/13	35.2	33.3	X
Participation in at least 3 hours of sport/PE (5-18 years)	2009/10	48.1	55.1	X
Hospital admissions due to alcohol specific conditions (0-17 years) (per 100,000)	2008-11	42.9	55.8	√
Hospital admissions due to substance misuse (15-24 years) (DSR per 100,000)	2009-12	70.1	69.4	=
Hospital admissions caused by unintentional and deliberate injuries in children (0-14 years) (per 100,000)	2012/13	102.3	103.8	=
Hospital admissions caused by unintentional and deliberate injuries in young people (15-24 years) (per 100,000)	2012/13	117.9	130.7	√

Source: Public Health England

Table 4.3 Levels of Mental Health & Illness

	Period	Rotherham	England	Comparison
Hospital admissions for mental health conditions (0-17 years) (per 100,000)	2011/12	53.5	91.3	√
Hospital admissions as a result of self-harm (0-17 years) (per 100,000)	2011/12	83.8	115.5	√

Source: Public Health England

5.2 Estimated Emotional Health & Wellbeing Prevalence in Rotherham

The cost of poor mental health to the individual child and young person cannot be under-estimated. We know that there are also significant financial costs. For mental health disorders the annual short term costs of emotional, conduct and hyperkinetic disorders among children aged 5-15 years in the UK are estimated to be £1.58billion and the long term costs £2.35billion (Annual Report of the Chief Medical Officer, 2012: *Our Children Deserve Better: Prevention Pays).*

In addition with 75% of adult mental health problems occurring before the age of 18 it is imperative that the burden of disease is monitored regularly (Dunedin Multi-Disciplinary Health & Development Research Unit http://dunedinstudy.otago.ac.nz cited in the Annual Report of the Chief Medical Officer, 2012: *Our Children Deserve Better: Prevention Pays).*

If children and young people do not receive early intervention and adequate treatment for their mental health problems there is a higher likelihood that they will have poorer academic achievements, face higher unemployment, premature morbidity and long term physical and mental health problems (Goodman et al cited in the Annual Report of the Chief Medical Officer, 2012*).*

At any one time, between 10% and 20% of children will have a diagnosable mental health problem severe enough to require child and adolescent mental health services intervention at Tier 1 to 4. Around 10% of children and young people have similar, but more severe, complex or persistent difficulties, these are referred to as “mental health disorders□. The prevalence of mental health disorders has been established by detailed studies, notably the *Mental Health of Children and Young People in Great Britain* (Green et al, 2004) published by the Office for National Statistics (ONS) which built on the work of a previous study in 1999.

5.2.1 Estimates for Rotherham

The prevalence of mental health disorders varies significantly according to a range of socio-economic and demographic factors. Based on the socio-demographic profile of Rotherham summarised in 5 ACORN Categories (CACI 2012), the prevalence of mental health disorders in Rotherham is estimated to be 14% above the UK average. This results from the higher levels of deprivation in Rotherham which is reflected in the higher proportion of children in the ACORN Category “hard pressed” families.

According to the Interim 2011-based population projection for 2013, there are currently 62,300 children and young people living in Rotherham aged 0 -19. Table 5 shows the profile of Rotherham’s 0-19 population by age.

Table 5 Rotherham’s 0-19 Population

0-4	5-9	10-14	15-19	Total
16,300	15,400	14,900	15,700	62,300

Data from the 2013 annual school census (PLASC) shows that 84.3% of Rotherham’s school age population are from a white British background and 15.7% from a black and minority ethnic (BME) background. National prevalence rates show that white and black

groups have the highest rates of mental health disorder whilst Indians have the lowest rate. However, higher levels of deprivation affecting most BME communities in Rotherham mean that their incidence of mental health disorders is likely to be higher that suggested by their ethnicity alone.

Table 6 illustrates the findings of the ONS study 2004 and gives the percentage estimates of disorders within the population. From this, using our population data, the prevalence of mental health disorders across Rotherham's Children and Young People have been estimated.

It is possible to estimate the prevalence of mental health disorders for Rotherham based on national prevalence rates (ONS 2004) for children aged 5-16, adjusted based on prevalence by ACORN Category to take account of socio-economic factors. This assumes that there will be a similar prevalence for 0-19 as for 5-16, which is reasonable given that rates increase with age. It can safely be assumed that children aged 0-4 will have rates below average and young people aged 17-19 will have rates above average, which will largely cancel each other out.

Table 6 Estimates of Mental Health Disorders in Rotherham Based on National Prevalence Rates

	5-10		11-16		All
	Boys	**Girls**	**Boys**	**Girls**	**5-16**
Total Number of Children	9,426	8,935	9,270	9,074	36,705
Emotional Disorders	2.2% 240	2.5% 250	4.0% 420	6.1% 630	3.7% 1,540
Conduct Disorders	6.9% 740	2.8% 290	8.1% 860	5.1% 530	5.8% 2,420
Hyperkinetic Disorders	2.7% 290	0.4% 40	2.4% 250	0.4% 40	1.5% 620
Autistic Spectrum Disorder	1.9% 200	0.1% 10	1.0% 110	0.5% 50	0.9% 370
Rare Disorders	0.3% 30	0.3% 30	0.6% 60	0.6% 60	0.4% 180
All Disorders	**10.2% 960**	**5.1% 460**	**12.6% 1,170**	**10.3% 930**	**9.6% 3,520**

In Rotherham, there are an estimated 6,800 children and young people aged 0-19 with a diagnosable mental health disorder, 2,600 with an emotional disorder (anxiety and depression), 4,100 with a conduct disorder (eg oppositional defiant disorder), 1,100 with a hyperkinetic disorder, 640 with Autistic Spectrum Disorder and 280 with a rare disorder.

A notable feature of the estimates is the higher incidence of mental health disorders amongst boys, particularly conduct, hyperkinetic and autistic spectrum disorders. The highest rate affecting any sub-group is for conduct disorders which affect 13.7% of boys aged 11-16 from "hard pressed" backgrounds.

5.2.2 Estimates by Child and Adolescent Mental Health Services Tier

A research study by Z Kurtz in 1996 for the Mental Health Foundation entitled *"Treating Children Well"* reported the prevalence of mental health problems appropriate to a response from each child and adolescent mental health services Tier. Estimates of the level of need in Rotherham are shown at Table 7.

Table 7 Estimated numbers of children & young people aged 0-18 in Rotherham with mental health problems appropriate to a response from child and adolescent mental health services (2013 estimate)

CAMHS	Summary of Services	Prevalence	Number
Tier 1	Primary Care	15%	8,916
Tier 2	Specialist & community based	7%	4,161
Tier 3	Specialist	1.85%	1,100
Tier 4	Highly specialist	0.075%	45

The 15% of children and young people estimated to have mental health problems appropriate for Tier 1 is higher than the 9.6% estimated to have mental health disorders in the ONS 2004 study. This probably reflects the difficulty in estimating lower levels of need where services are not just responding to known disorders, but also providing wider advice and preventative activity. The implication is that around 5% of children and young people are at risk of developing a mental health condition and would benefit from Tier 1 services, but do not have a diagnosable disorder.

5.2.3 Disability Living Allowance

In Rotherham, 2,490 children and young people aged 0-17 are entitled to Disability Living Allowance (DLA). Of these 488 children are entitled to DLA because of a mental health condition (20%), of which 389 are boys and are 99 girls. This reflects the significant gender differences observed in the prevalence data.

Only about 8% of children and young people with a mental health condition claim DLA as a result, which suggests that only the more severe and complex cases are likely to be eligible. The main mental health conditions for which DLA is claimed by people under 18 are hyperkinetic and behavioural disorders. There are very few cases where emotional disorders result in entitlement to DLA. It should be noted that some children claiming DLA because of a physical disability will also have a secondary mental health condition.

5.2.4 Special Educational Needs

A total of 4,332 children in Rotherham schools have a Special Educational Need (SEN) classified as either statemented or School Action Plus. Of these 829 children have behavioural, emotional or social difficulty and 784 have Autistic Spectrum Disorder (ASD). The numbers of children and young people aged 5-16 predicted to have these conditions is 3,960 and 370 respectively. This indicates that far more Rotherham children have ASD than national prevalence rates would suggest, possibly because ASD diagnosis rates have increased since the 2004 ONS study. About 46% of children (5-16) expected to have mental health disorders are not statemented or subject to School Action Plus.

5.2.5 Bullying & Feelings of Safety

The 2013 Secondary School Lifestyle Survey showed that 38% of Rotherham year 7 and year 10 pupils had been bullied, the same as in 2012. Table 8 shows the prevalence of bullying by type.

Table 8 Types of Bullying in Rotherham

Verbal	90%
Being Ignored	22%
Physical Bullying	21%
Cyber Bullying	22%

29% of year 10 pupils said that they were victims of cyber bullying compared with 19% of year 7 pupils. The results show that the main reasons why pupils are bullied are their weight and the way they look (the same as the 2012 survey). A high percentage of year 7 pupils also said that they were bullied for another reason.

Table 9 shows the number of young people who reported bullying and how many received help and support as a result.

Table 9 Bullied Young People

	2012 %	2013 %	Change %
Bullying Reported	44	28	-16
Received Help & Support	43	26	-17

43% of pupils that took part in the survey had witnessed bullying of others (similar to last year). 5% said that they had been involved in bullying someone else in the last four weeks.

Children and young people were also asked where the felt safe with the results shown at Table 10. Home was felt to be the safest place with 90% of pupils always feeling safe there. Year 7 pupils tend to feel less safe than year 10 pupils which suggests that confidence increases with age.

Table 10 Safe Places

Place	2012 %	2013 %	Change %
School	56	51	-5
Travelling to and from school	34	28	-6
On local buses & trains	21	18	-3
Waiting for local transport	17	14	-3
In local communities	29	27	-2
Rotherham Town Centre	14	12	-2

5.2.6 Suicide & Suicide Prevention

In a 2007 survey of young adults, 6.2% of 16–24 year olds had attempted suicide and 8.9% had self-harmed in their lifetime. ((McManus S, et al. 2009).Suicide is the leading cause of death in young people. The Office of National Statistics shows that that numbers of suicides (including undetermined deaths) amongst 16-24 have been on the increase since 2007. We know from research that suicide is rarely the result of a one off factor or factor and that for young people the following increases the risk:

- having an existing mental health problems or behavioural disorders
- misuse substances
- family breakdown
- loss of a family member of friend
- social isolation
- abuse, neglect
- mental health problems or suicide in the family

The risk may also increase when young people identify with people who have taken their own life, such as a high-profile celebrity or another young person. In addition young people are not a homogenous group and some of the vulnerable groups listed in 3.3 are at higher risk of suicide, for example looked after children, young offenders and LGBT young people.

There is a growing concern regarding the use of the internet promote suicide and suicide methods and the use of social media in the aftermath of a young person taking their own life. This has been identified as a priority for further research at a national level (Department of Health. Mental Health, Disability and Equality Division 2014).

For young people the protective factors are:

- being loved and feeling secure
- living in a stable home environment
- parental employment
- good parenting
- good parental mental health
- activities and interests
- positive peer relationships
- emotional resilience and positive thinking
- sense of humour.

In Rotherham we are working to improve the support we provide to children who are bereaved as a result of suicide. Research shows that the bereavement due to suicide provokes stronger and longer lasting feelings amongst children and young people (Trickey, 2012). In Rotherham we have introduced a pathway into services/support for children and young person bereaved by suicide this will also act as an alert schools and health professionals.

To date work on suicide prevention includes:

- The development of the Rotherham Community Response plan- Rotherham Multi-agency Guidance for Preventing and Responding to Behaviours which may Indicate Potential Suicide or Self-Harm Clusters, July 2013.
- Rotherham's first suicide prevention conference on 3rd April 2014 to share best practice in relation to suicide prevention and support mangers and frontline staff to understand their role in preventing suicide.
- Launch of the CARE about suicide guidelines for frontline works and the general public
- Provision of information to schools and colleges on suicide prevention including the resource from Samaritans, 'Help when we needed it most'
- Youth Mental Health First Aid Training and roll out of Applied Suicide Intervention Skills Training.

Suicide prevention is not the responsibility of just one sector and requires a multiagency response. Action on suicide prevention for young people needs to include schools, colleges, providers and commissioners of services, police, local media, voluntary sector services, parents, carers and young people themselves.

5.2.7 Self Harm

Self-harm, as defined in the National Institute of Clinical Excellence guidelines (2004), is an:

> *".. an expression of personal distress, usually made in private, by an individual who hurts him or herself. The nature and meaning of self-harm, however, vary greatly from person to person. In addition, the reason a person harms him or herself may be different on each occasion, and should not be presumed to be the same." (NICE, 2004)*

Essentially self-harm is any behaviour where the intent is to cause harm to oneself, this includes self-poisoning or self-injury There is sometimes an assumption that self-harm is an attempt at suicide. While an individual episode of self-harm might be an attempt to end life, acts of self-harm are not always connected to attempted suicide. People may harm themselves as a way of coping with overwhelming situations or feelings. For some people, self-harm may actually be a way of preventing suicide. However we do know that people who self-harm are more at risk of suicide than those who do not self-harm.

The estimates for self-harm amongst young people vary and indeed some may be an underestimate because many young people do not disclose that they are self-harming, treating themselves at home and never coming to the attention of services. However, one survey estimates that 1 in 10 young people self-harms at some point in their teenage years (Hawton et al. 2013).

Young people may self-harm for a variety of reasons and these include:

- being bullied at school
- not getting on with parents
- stress and worry around academic performance and examinations
- parental divorce

- bereavement
- unwanted pregnancy
- experience of abuse in earlier childhood (whether sexual, physical, and/or emotional)
- difficulties associated with sexuality
- problems to do with race, culture or religion
- low self-esteem
- feelings of being rejected in their lives

(Brophy, 2006)

In Rotherham the Youth Cabinet are currently looking at this issue and working with providers and commissioners to look at how awareness can be raised and services improved for young people in Rotherham (please refer to 3.5.3).

Rotherham Suicide Prevention and Self Harm Group are looking at developing guidelines for all staff working with children and young people who self-harm.

5.3 Vulnerable Groups

National evidence has identified that there are a number of groups who are considered to be more at risk of developing emotional health problems than others. Children living with Adverse Childhood Experiences (ACE) generally have poorer health outcomes when compared to children with no ACE. The following are examples of ACE:

- low-income households
- families where parents are unemployed
- families where parents have low educational attainment
- looked after by the local authority
- disabilities (including learning disabilities
- black and other ethnic minority groups
- lesbian, gay, bisexual or transgender (LGBT)
- in the criminal justice system
- a parent with a mental health problem
- misusing substances
- refugees or asylum seekers
- gypsy and traveller communities
- being abused
- young carers
- young people accessing pupil referral units
- teenage parents
- non-standard intake to schools, i.e. children and young people who move schools during the academic year

Further information on prevalence rates for these groups is available in Joint Strategic Needs Assessment available at http://www.rotherham.gov.uk/jsna/

Compared to children and young people with no ACE, those with four or more are at greater risk as Table11 shows.

Table 11 Increased Risks for Young People with 4+ ACE

Type of Risk	Increase in Risk
Smoking	3.96 times more likely
Drinking	3.72 times more likely
Incarceration	8.83 times more likely
Obesity	3.02 times more likely

Bellis MA, Lowey H, Leckenby N, Hughes K, Harrison D. J Public Health (Oxf). 2013 'Adverse childhood experiences: retrospective study to determine their impact on adult health behaviours and health outcomes in a UK population.' Cited in 2012, Annual Report of the Chief Medical Officer 2012: 2012 Our Children Deserve Better: Prevention Pays .

In addition, children and young people with four or more ACE are more likely to have:

- poor educational outcomes/poor unemployment opportunities
- low mental wellbeing and life satisfaction
- had more recent inpatient hospital care and chronic conditions
- been pregnant unintentionally before age 18

There are targeted resources in Rotherham for some of the ACE groups, for example there are dedicated services for young people misusing substances, young carers, youth offenders and a dedicated LGBT group. In terms of emotional health and wellbeing these services operate at mental health Tier 1 whilst providing a level of counselling and emotional support through assessment and 1:1 working, but do not undertake specific programmes relating to mental health. These services tend to have received training through Rotherham and Barnsley Mind regarding bullying and self-harm and also Mental Health First Aid Training and refer on to IYSS Youth Start and RDaSH CAMHS for mental health interventions.

The Looked After and Adopted Children Children's (LAAC) Support and Therapeutic Team provide a dedicated emotional health and wellbeing service for LAAC, giving emotional, mental health and wellbeing advice and support, as well as providing training, advice and support to foster carers and adoptive parents. The service operates at mental health Tier 2 and provides direct therapeutic work with young people including theraplay, art therapy and family and psychological interventions.

Further equality impact analysis is needed to ensure that children and young people from other vulnerable groups have access to emotional health provision.

5.3.1 <u>The Rowan Centre</u>

As noted above, children and young people accessing pupil referral units (PRU)are at increased risk of developing emotional health problems.

The Rown Centre is a PRU providing KS3 and KS4 education to students unable to attend mainstream school on health grounds (both mental and physical) and school age mothers/pregnant schoolgirls. Education and support is offered to students who have additional needs. The centre provides a small, calm and nurturing setting and works in partnership with parents, carers, schools and a range of agencies including CAMHS.

The Centre offers a range of guidance and support under Tier 1 as well as Thrive assessment and emotional support action plans.

5.4 Parental Wellbeing

> '*What happens during these early years (starting in the womb) has lifelong effects on many aspects of health and well-being – from obesity, heart disease and mental health, to educational achievement and economic status.'*
> (The Marmot Review, 2010)

We know that there are certain risk and protective factors observed within families which determine both the physical, mental, emotional and social development of an infant. Such protective factors include:

- authoritative parenting combined with warmth
- an affectionate bond of attachment being built between the child and the primary caregiver from infancy
- having parents who are educated and in employment
- living in warm, dry homes
- family harmony
- the primary caregiver having psychological resources including self-esteem

Risk factors would include:

- poor attachment
- inconsistent and critical parenting
- poor parental/carer mental health
- family instability, conflict or violence
- marital disharmony/divorce
- large family size/rapid successive births
- absence of father
- very low level of parental education
- drug and alcohol misuse
- primary care givers having learning difficulties

Pregnancy and the first five years of life are one of the most important stages within the life cycle (Shribman, S. and Billigham, K. 2009). Maternal mental health is so important to the development of the mother/child bond that within 10–14 days of birth women should be asked appropriate and sensitive questions to identify depression or other significant mental health problems, such as those recommended by the NICE guidelines on antenatal and postnatal mental health. The Chief Medical Officer's report 2012 recommends that services should ensure that where parents have a mental illness both services and interventions are available which take account of their needs and role as a parent.

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Medical Officer's report 2012 recommends that services should ensure that where parents have a mental illness both services and interventions are available which take account of their needs and role as a parent.

5.4.2 Improving Maternal Mental Health

Maternal Mental Health problems affect 1 in 8 women and are a leading cause of maternal mortality. Psychiatric disorders contribute to 12% of all maternal deaths.

In April 2011 NHS Rotherham implemented a Maternal Mental Health Referral Pathway. This was introduced for three key reasons:

I. NICE guidance (Antenatal and Postnatal Mental Health, Clinical Guidance 45) suggests 1 in 8 women will suffer a maternal mental health problems antenatally or postnatally – this equates to more than 500 women per year in Rotherham with young babies and between 500 and 700 pregnant women who currently have no or only a poorly co-ordinated service to support their Mental health.
II. Suicide is the leading indirect cause of death for women up to a year after childbirth (Lewis, 2007) Rotherham has had 2 maternal suicides in the last ten years.
III. Maternal mental ill health can produce adverse outcomes for babies and other children, with consequent long-term impacts, particularly for the child's development. There is robust evidence that babies of parents with mental disorder are more likely to suffer from attachment disorders, also cognitive development deficits and increased likelihood of child psychiatric illness. (NSF For Children, Young People and Maternity Services – Standard 11, 2004)

The pathway is multi-agency and was developed to cover mild, moderate and severe maternal mental health issues. It was agreed by all partners including The Rotherham Foundation Trust FT and RDaSH. Training in the pathway was provided to Midwives during March of 2011 as detailed in section 4.1.2.1 below.

5.4.3 Targeted Early Help Services, including Family Nurse Partnership

RMBC offers a range of Early Help services to families according to how their needs are assessed. If a family's needs are deemed to require statutory intervention, a Child's Assessment will be completed by Social Care teams and an appropriate response will be led by Social Care, with regular statutory reviews.

If a family's needs do not require a statutory intervention an alternative assessment will be completed; wherever a multi-agency response is required, this will be the Family Common Assessment Framework (FCAF). The Family CAF captures a families strengths and difficulties under the categories of alcohol, substance misuse, mental health and emotional wellbeing, work and money, adult skills and learning, exploitation, housing, social isolation and engagement with local services, parenting and basic care skills, family relationships, domestic incidents, anti-social behaviour and crime.

A coordinated response will be formulated which may draw from a number of different services. Children's Centres specialise in responding to the needs of families where there is a child who is 0-5 years old, each school will have an individual offer for children who are

5-18 years old, and the Integrated Youth Support Service will provide a specialist response to children who are 10-18 years old.

In addition to these there are some specialist services in place, including the Targeted Family Support (TFS) Team, who will provide high quality whole family support in line with Rotherham's Early Help Strategy. The team use multi-agency methodology to support families with vulnerable and complex needs across the borough, working to the principles of the Family CAF model.

The work undertaken by the TFS Team is evidenced based, with solution focused interventions and plans used. The intervention is time limited to a maximum of 12 months. All referrals completed to the TFS Team must evidence there are prevalent issues with family relationships; mental health and special educational needs within either the parent/carer or child/children. To be eligible for service provision from TFS, parents/carers or the child must live within the Rotherham Learning Community reach area and the referred child or young person must be between 5 and 13 years of age.

The Family Nurse Partnership programme is licensed by the Department of Health and is an evidence based programme that can positively change the life-course of the clients and their children. Family nurses receive specialist training to work with first time pregnant teenagers up to the age of nineteen years with an intensive home visiting programme offered from early ante-natal until the child is two years of age when the child and mother graduate from the programme to Universal Health Visiting Services.

The family nurses work with the young people to encourage good maternal mental and physical health, raise aspirations, improve economic self-sufficiency and promote strong attachment and positive parenting.

A targeted response is also available through the Families for Change work, which identifies a specific cohort of families according to criteria set out in the Troubled Families Financial Framework, published by the Department of Communities and Local Government (2012). The criteria that trigger inclusion in this cohort are poor school attendance, anti-social behaviour or youth crime and adult worklessness. At least two criteria must be met, alongside a local filter of poor parental mental health, adult misuse of drugs or alcohol and domestic abuse. The response to families in this cohort will also be coordinated using the Family CAF. If a specific need is identified, families will be able to access targeted family intervention services, delivered by a range of providers at various levels of intensity. A family intervention approach will ensure that each family has a dedicated worker who leads a coordinated response for the whole family and provides hands-on interventions (including practical tasks) within the family home. The most intensive family intervention service in Rotherham is delivered by the Family Recovery Programme, an in-house service with eight outreach workers.

Families for Change is also piloting family mediation, which focuses on a restorative approach to repairing family communications, and Multi-Systemic Therapy. During the pilot period there will be places for ten families to access Multi-Systemic Therapy. Multi-Systemic Therapy is for families with a young person between the ages of 11 and 17 who is at risk of going into care due to serious anti-social behaviour and / or juvenile offending. MST is an intensive way of working with families and works to support parents/carers and other family members to develop and sustain strategies to improve their child's behaviour at

home, in school and out in the community. MST is delivered over a period of three to six months using a variety of techniques based upon holistic assessment of the child's ecology. Interventions ay focus upon cognitive and or behavioural change, communication skills, parenting skills, family relations, peer relations, school performance and social networks.

5.5 Voice of Children and Young People

The information below details some of the work undertaken by child and adolescent mental health services and partners to ensure that young people have a voice within the service.

5.5.1 RDaSH Consultation with Children and Young People

RDaSH CAMHS has taken an innovative approach to facilitate participation and to maximise the engagement and experience of children and young people within services with the role of Peer Support Workers (PSW). These are people with a lived experience of mental health difficulties who are employed primarily to help navigate the transition process from children and young people's mental health to adult mental health or wider services such as college.

A key element of the PSW role is to support and maximise participation and they work closely with the Children and Young People's Improving Access to Psychological Therapies (CYP-IAPT) project manager on this agenda. The PSWs have agreed a slogan to underpin our participation agenda '*Your Service, Your Say, Your Way';* designed an associated poster campaign to recruit children, young people and families to engage in service planning and consultation; supported a young person to design a poster to advertise self-referral in our services; and led various consultation events in local colleges and schools which have informed service development.

The RDaSH CAMHS teams commenced self-referral in September 2013 and a feedback audit tool has been developed which will be used to invite feedback from those young people who have accessed the service via self-referral since September 2013 and on an on-going basis to inform service planning and delivery.

The PSWs have devised a project plan for participation underpinned by the '*Ladder of Participation*' (Hart 1992) which will be presented for approval. RDaSH recognises the need to further develop direct consultation and service evaluation with young people and aspire to have a participation strategy that is written by young people.

Two young people have recently been on the interview panel for RDaSH CAMHS clinicians appointed to attend the CYP-IAPT Systemic Family Practice Pathway. An Interview panel training session in April is being advertised for people aged 13 – 19 years.

The CYP-IAPT project manager has supported the PSWs to begin using a sessional feedback measure to capture the young person's on-going experience of working with a PSW. RDaSH CAMHS plan to collate this information to understand how young people's involvement in differing interventions impact on both their experiences and their outcomes.

5.5.2 Youth Start

Youth Start interventions with young people take a client informed approach and each young person is instrumental in designing their own package of individual support.

Young people were recently involved in interviewing for a new counsellor within the service via a young person's interview panel.

5.5.3 Youth Cabinet Manifesto for Self-Harm 2014-15

For 2014-15 Rotherham Youth Cabinet has as a manifesto aim around the issue of self-harm. The Youth Cabinet is examining how services provide support and advice to young people around issues of self-harm. This work is being supported by a small number of Rotherham Councillors who sit on the Council's Scrutiny Committees and Officers from the IYSS, Scrutiny and Public Health.

As part of its evidence gathering, the Youth Cabinet have spoken with their peers in schools and colleges across Rotherham to collect views from a wide range of young people. This evidence has formed the basis of their work and has been used in meetings with representatives of provider agencies, schools/colleges and Council services to discuss current provision and to identify ways in which services to young people can be improved. From this the Youth Cabinet have identified a number of priority areas which they discussed with decision makers, school leaders and commissioners of services with a view to incorporation into service design and delivery.

On completion of this work, the Youth Cabinet will take their report to Cabinet, following which the recommendations will be circulated to partner organisations for action. The initial themes emerging from this work include:

- Consistent, concise and simple messages for ALL organisations
- Clear, consistent referral routes for ALL organisations
- Involve young people to develop user-friendly information/media messages (including new technology/social media)
- Ensure that young people are involved in service design e.g. commissioning of school nurses
- Ensure that advice to young people is available through drop-ins, one-to-one sessions as well as web-based materials
- Improve and standardise the provision of information on self-harm to all schools
- Establish better links between schools and colleges and share best practice (for example work around peer support and strategies to address stress and exam pressure)
- Examine ways in which access to school nurses can be improved
- Availability of resources/training/support for schools, colleges, amongst parents, young people etc.

5.5.4 Chief Medical Officer's Report 2012

The report by the Chief Medical Officer captured the voice of children and young people. The following were recommendations specific to mental health services:

- Managing the transition from children's to adult services has been consistently identified as a problem for young people, in particular for some vulnerable groups such as those with long-term disabilities and mental health problems
- Mental health to be taken as seriously as physical health
- Stigma was highlighted as a key issue for young people with mental health problems, mainly as a barrier to their accessing services and support
- More health promotion campaigns and teaching in schools to counter the stigma associated with mental illness
- Children and young people who use mental health services want a confidential, accessible mental health service, when and where needed and for services to be age appropriate, with flexible opening hours at times that suited them. Preferred referral methods include self-referral and drop-in services available through the internet, mobile phones, text or email.
- Many young people want access to counselling services within their school
- Young people want more support at first presentation, quicker access to help during an emergency, and better out-of-hours and crisis services, with inpatient units that are easier to access.
- Staff who are approachable, available and skilled in engaging and listening to young people. Children and young people valued continuity, confidentiality and support, particularly at transition.
- For young people using mental health services, lack of adequate information is a repeatedly highlighted problem

There were other recommendations from children and young people within this report which relate to the role of schools, school nursing and GPs.

5.6 Voice of Parents and Carers

As part of regular capture of service evaluation, the RDaSH CAMHS service invites parents and carers to complete 'Experience of Service' (ESQ) questionnaires which are collated on a quarterly basis. In the 3 month period of October to December 2013 the feedback shown at Table 12 was received from 25 parents/ carers.

Parents and young people can complete ESQ's at any time throughout the journey in RDaSH CAMHS; forms are available for completion anonymously and posted into a box within the reception area at Kimberworth Place. Parents and young people seen within community settings are also offered questionnaires which can be returned to service anonymously too.

The Parent Carers Forum has been invited to and attended some of the CYP-IAPT steering group for the partnership, which includes Rotherham.

RDaSH CAMHS are equally aware of the need to engage with parents and carers and have agreed that a series of open days across the localities will be hosted with one of the aims being to ask children, young people and parents how they would like to work with the service. Activities on offer during these days include a design a letter competition and the PSWs will host 'stress bucket sessions' where both young people and parents can gain skills.

GIFT is a participation service commissioned by the National CYP-IAPT team and have contacted the Rotherham Parent Carers Forum directly to ask how they would like to be involved in local service delivery. GIFT have asked for our permission to publish our 'Guide to Routine Outcome Measures for Young People and Families' as an example of good practice with the MyAPT's audience of child and adolescent mental health services professionals.

Healthwatch Rotherham are working with parents to gather their experiences of using RDaSH CAMHS to gain insight into the perceived culture of the service. The report will be provided to RDaSH in the summer of 2014 for their comments and feedback prior to the report being provided to parents.

Table 12

Parent/ Carer	Certainly	Partly True	Not True	Don't Know
I feel that the people who have seen my child listened to me	19	5	1	0
It was easy to talk to the people who have seen my child	20	3	2	0
I was treated well by people who have seen my child	21	2	2	0
My views and worries were taken seriously	17	6	1	1
I feel the people here know how to help me	16	6	3	0
I have been given enough explanation about the help available here	15	6	3	1
I feel that the people who have seen my child are working together to help me	14	9	1	1
The facilities here are comfortable (e.g. waiting area)	24	0	0	1
My appointments are usually at a convenient time (e.g. don't interfere with school, clubs, college, work)	10	11	4	0
It is quite easy to get to the place where I have my appointments	19	3	3	0
If a friend needed this sort of help, I would suggest to them to come here	19	5	0	1
Overall, the help I received here is good	19	5	1	0

6. Forthcoming Challenges & Risks

A number of challenges and risks will impact on the CAMHS strategy in the coming years. These include:

- Potentially further reducing budgets, both in Health and Social Care.
- Implementation of the new SEND agenda.
- Future integration of Health and Social care provision.
- The introduction of a different payment system for Mental Health Services.

Appendix 1

Glossary of Terms

ACE	Adverse Childhood Experiences
ASD	Autistic Spectrum Disorder
ADHD	Attention Deficit Hyperactivity Disorder
BME	Black & Minority Ethnic
CAF	Common Assessment Framework
CAMHS	Child & Adolescent Mental Health Services
CBT	Cognitive Behavioural Therapy
CCG	Clinical Commissioning Group
CDC	Child Development Centre
CYP-IAPT	Children and Young People's Improving Access to Psychological Therapies
CYPS	Children and Young People's Services
DCSF	Department for Children, Schools & Families
DLA	Disability Living Allowance
EHWB	Emotional Health & Wellbeing
EHWBB	Emotional Health & Wellbeing Board
FT	Foundation Trust
GIFT	Great Involvement, Future Thinking
GPs	General Practitioners
IYSS	Integrated Youth Support Service
JSNA	Joint Strategic Needs Assessment
KPI	Key Performance Indicator
LAAC	Looked After & Adopted Children
LGBT	Lesbian, Gay, Bisexual & Transgender
NFER	National Foundation for Educational Research
NHS	National Health Service
NICE	National Institute for Health & Care Excellence
NSF	National Service Framework
ONS	Office of National Statistics
PICU	Psychiatric Intensive Care Unit
PSW	Personal Support Worker
RCCG	Rotherham Clinical Commissioning Group
RDaSH	Rotherham, Doncaster & South Humber NHS Foundation Trust
RMBC	Rotherham Metropolitan Borough Council
SEN	Special Education Needs
TaMHS	Targeted Mental Health in Schools
TRFT	The Rotherham Foundation Trust

Appendix 2

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Appendix 3

NICE guidance

The National Institute for Health and Care Excellence has produced evidence based clinical guidance for England and Wales on a number of topics with relevance to CAMHS practice.

The following list is correct as of September 2013.

Eating disorders (CG9)
Self-harm (CG16)
Anxiety (CG22)
Violence (CG25)
Post-traumatic stress disorder (PTSD) (CG26)
Depression in children and young people (CG28)
Obsessive–compulsive disorder (OCD) and body dysmorphic disorder (BDD) (CG31)
Bipolar disorder (CG38)
Antenatal and postnatal mental health (CG45)
Drug misuse: psychosocial interventions (CG51)
Chronic fatigue syndrome/myalgic encephalomyelitis (CG53)
Attention-deficit hyperactivity disorder (ADHD) (CG72)
Antisocial personality disorder (CG77)
Borderline personality disorder (BPD) (CG78)
Schizophrenia (update) (CG82)
When to suspect child maltreatment (CG89)
Depression with a chronic physical health problem (CG91)
Nocturnal enuresis – the management of bedwetting in children and young people (CG111)
Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults (CG113)
Alcohol dependence and harmful alcohol use (CG115)
Psychosis with coexisting substance misuse (CG120)
Autism in children and young people (CG128)
Self-harm (longer-term management) (CG133)
Conduct disorders in children and young people (CG158)
Social anxiety disorder (CG159)
Four commonly used methods to increase physical activity (PH2)
Interventions to reduce substance misuse among vulnerable young people (PH4)
School-based interventions on alcohol (PH7)
Physical activity and the environment (PH8)
Maternal and child nutrition (PH11)
Social and emotional well-being in primary education (PH12)
Social and emotional well-being in secondary education (PH20)
School-based interventions to prevent smoking (PH23)
Alcohol-use disorders: preventing harmful drinking (PH24)
Health and well-being of looked after children and young people (QS31)
Insomnia – newer hypnotic drugs (TA77)
Attention-deficit hyperactivity disorder (ADHD) – methylphenidate, atomoxetine and dexamfetamine (review) (TA98)
Structural neuroimaging in first-episode psychosis (TA136)
Domestic violence and abuse – identification and prevention (in progress)

ROTHERHAM BOROUGH COUNCIL – REPORT TO MEMBERS

1.	**Meeting:**	**Health and Well Being Board**
2.	**Date:**	**12th November 2014**
3.	**Title:**	**Expectations and Aspirations : Co-production in Rotherham – consultation document**
4.	**Directorate:**	**Neighbourhoods and Adult Services**

5. **Summary**

The Expectations and Aspirations work stream of the Health and Wellbeing strategy has a priority in its action plan around co-production of services, this was fully endorsed by the board's member organisations.

The attached consultation report provides information around definitions of co-production, examples of where this is already in place in Rotherham and the suggested approach to move this forward across all organisations.

6. **Recommendations**

(i) That members of the Health and Wellbeing board receive the attached consultation report and associated case studies

(ii) That members of the Health and Wellbeing Board actively consider the adoption of these principles and cascade the report and information within their organisations

(iii) That members of the board consider the suggested two stage approach to move to co-production of services within their organisation

(iv) That members agree to a workshop session being facilitated for members of the board to establish what co-production in Rotherham would look like

7. **Proposals and Details**

Expectations and Aspirations is one of the six strategic outcomes we aim to deliver through the Health and Wellbeing Strategy:

All Rotherham people will have high aspirations for their health and wellbeing and expect good quality services in their community, tailored to their personal circumstances.

A key action which underpins this work is :

- We will co-produce with Rotherham people the way services are delivered to communities facing challenging conditions.

Co-production is about delivering public services in different ways and developing relationships with service users that are equal between professionals delivering these services and those customers and carers in receipt of them.
Co-production is not just about consulting with citizens and "user voice" initiatives, it is much more than this.
There are already some good examples of where co-production is working in Rotherham such as Lifeline, Speak Up and the Rotherham Charter for Parent and Child Voice.

The proposal is that organisations decide which services would be suitable for co-production and begin to move to this as a concept of working, it is clear however that that there are some services which would never be suitable to be co-produced examples of this would be around some health or protection and safeguarding services ie resuscitation services or child protection investigations / services.

We still need to ensure that families and carers can make comments about the services that they / their relatives have received to help improve or shape the services in the future as opposed to them being involved in the delivery of the service itself

The suggested model is across a Staged approach:

Stage 1 – agree that all organisations will begin move around the circle (of co-production) from where they are now towards full co-production (see Figure 1) where appropriate

Stage 2 – organisations then agree on a yearly basis which of their services are suitable for co-production or to move towards co-production and aim to make the required changes during the year

As previously mentioned not every service would lend itself to co-production hence the annual review of services in Stage 2.

We need to ensure that this is right for Rotherham and this consultation will form part of this approach, it is suggested that a workshop is held with Health and WellBeing Board members and organisations to work together to define what it would look like in Rotherham.

8. Finance

Issues around the costs of co-production are particularly complicated. While there is some evidence that it can reduce costs, the available evidence is inconclusive. This may be something that varies between different organisations and different projects.

Co-production may lead to some costs being reduced and others increased. It may only be possible to know whether co-production is cost-effective by looking at things over a period of time. If it is cost-effective it will have reduced the number of inefficient, ineffective and unwanted services.

9. Risks and Uncertainties

Co-production is a very different approach to how our organisations normally deliver their services and although the customer and broader public is involved at different levels there are few services that are currently co-produced in the true sense of the word.
Cultural changes would need to take place from both the service provider and customer angles to grasp the fundamentals of co-production and move this forward in a way that is not detrimental to either party.
It is recognised that there will be also challenges in relation to managing the expectation of the citizens of Rotherham in relation to how co-production will deliver services differently for them

10. Policy and Performance Agenda Implications

The Performance Management Framework underpins the work around the priorities of the strategy and the workstreams.

11. Background Papers and Consultation

Health and WellBeing Strategy
Co-production report – Appendix 1
Co-production audit template
Co- production Case Studies

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Rotherham's Health and Well Being Strategy

Co-production in Rotherham

Sue Wilson
September 2014

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1. Introduction

Expectations and Aspirations is one of the six strategic outcomes we aim to deliver through the Health and Wellbeing Strategy:

All Rotherham people will have high aspirations for their health and wellbeing and expect good quality services in their community, tailored to their personal circumstances.

Underpinning this is the action "We will co-produce with Rotherham people the way services are delivered to communities facing challenging conditions"

This report will examine what co-production is and what it would look like in Rotherham. It includes some examples of where this is already happening across the Borough (albeit to a smaller degree) and those areas nationally where co-production has seen success in delivering services differently

This report covers a suggested two stage approach that would be required to move organisations into a position where co-production of services is a real option and that it is seen as an opportunity as part of any service delivery model and reviewed and explored as part of routine service planning.

Co-production is now a key concept for delivering public services; it can make an important contribution to current challenges and can support:

- Cost effective services
- Improved user and carer experience of services
- Increased community capacity
- Integration
-

Enquiries into abuse and neglect (including the Francis report) highlight the need for services to develop more equal relationships with people who use the services and their carers. Interest in co-production can often be linked with the need to save money; however, there is acknowledgement that the citizen has a vital role in achieving positive outcomes from the services they receive.

It will be important to recognise the role that commissioning plays in delivering services as part of any co-production activity; customers can also play a key role in commissioning services even though they may not be involved in the delivery of those services subsequently.

2. Definitions of co-production

The term co-production dates from the 1970's but more recently has come to describe ways of working in partnership by sharing power with people using services, their carers and the wider citizens.

Co-production means delivering public services in different ways around relationships with service users, these relationships need to be equal and reciprocal between professionals, the people using the services and their families. Where services are co-produced in this way they are far more effective. – (Nesta 2013)

There are many definitions, and many facets, of co-design and co-delivery. What all of them have in common is an ethos and recognition that those who provide and experience services should have an equal say and role in how such services are designed and delivered" (Nesta 2013)

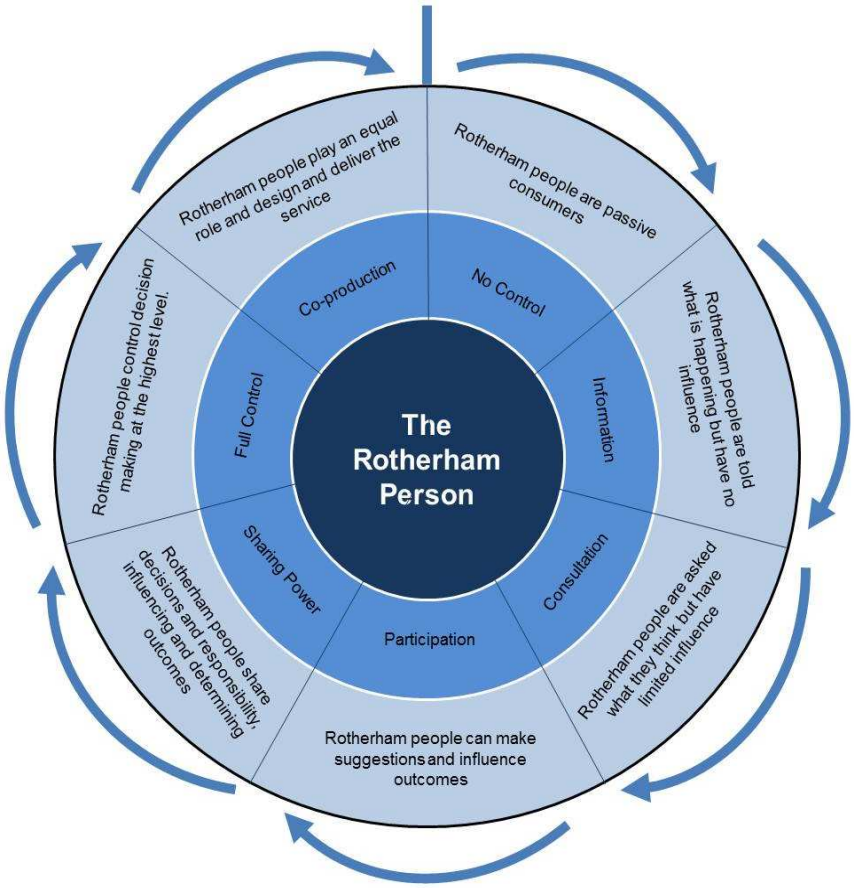
What co-production would mean in Rotherham

- **Recognising Rotherham people as assets:** seeing people as equal partners in the design and delivery of services, not just passive recipients of our services or even worse as a burden on those public services.
- **Building on Rotherham people's existing capabilities:** rather than starting with people's needs which are often seen as the traditional deficit model, co-produced services start with peoples capabilities and look for opportunities to help develop these further.
- **Mutuality and reciprocity:** co-production is about a mutual and reciprocal partnership, where professionals and people who use services come together in an interdependent relationship which recognises that each are just as invaluable to producing effective services and improving outcomes for the people of the Borough
- **Peer support networks:** engaging peer and personal networks alongside professionals as the best way of transferring knowledge and supporting change.
- **Blurring distinctions:** blurring the distinction between professionals and recipients, and between service delivery and service use, by reconfiguring the way services are designed, developed and delivered.
- **Facilitating rather than delivering:** enabling professionals to become facilitators and catalysts of change rather than providers of services.

- **Leading to services becoming more preventative**: in the long-term and in ways which leads to service users being empowered.

Research has found that involving patients and service users in their care and wellbeing planning and for them to identify their own goals and aspirations and navigating the services themselves will help them achieve their goals.

3. <u>The circle of co-production in Rotherham – Figure 1</u>



The challenge for partners in Rotherham is to move services for our customers and citizens from them having “no control” in service design and delivery to where services are “designed, produced and delivered” with and by our customers.

The diagram above shows the direction of travel to be able to achieve the aspiration that the health and wellbeing board has for the co-production of services

4. Examples of Co-production in Rotherham

There are already examples of where co-production is in place, below is a list of examples with more detailed case studies attached at Appendix 1 for a selection of the ones named below **

Lifeline **
Lord Hardy and Davies Court – friends of group
Speak Up **
Charter for the Parent and Child voice **
Social prescribing **
Expert Patient
Education Health and Care Plans
Caring
End of life
Self Care / Self medication
Healthy lifestyles

Personalisation and Person Centred Practice are also examples of a level of co-production of services as our customers are in control of the care that they require and the individual solutions which meet their personal needs.

The Special Education Needs and Disability (SEND) reforms around children and young people with additional needs offer a real opportunity to change how we work with children, young people and their families. The rationale behind the whole SEND reform from a national perspective is around the ethos of co-production. Linking this to the work of the Charter for the Parent and Child Voice is a real opportunity to ensure that co-production is embedded into everything that we do across the partnership of services working with these young people and their parents and carers.

It's important that Commissioning activity in Rotherham includes customer involvement and there are examples nationally where this has been very successful.

Commissioners need to proactively work with providers to develop capacity for co-production over a period of time, as part of market development and market shaping activities.

5. Challenges for co-production

Moving to a co-produced model of delivery will not be easy and it is recognised that the approach and rational needs to be clear

- **It makes additional demands of people who rely on services** and who are by definition already 'in need'. However, a response to this is that the active engagement of people who are users of services is often largely positive; this enables them to make services work for them, growing their own confidence and capacity. Nevertheless, it will be important to ensure that it does not put additional burdens on people's time.

- **It is a cover for the withdrawal of services**; we need to be clear that the reason for co-production is to ensure high quality services with improved outcomes as opposed to there being less money available in the system as a result of public sector efficiencies and government spending reviews.

- **Co-produced services will lead to a postcode lottery**; it is true that services will look different in different areas across the borough but that is to be expected as the assets, resources and needs identified by communities across Rotherham will also look different. There may well still be the need for a central role to ensure consistency in approach and to be clear that everyone is enabled to play a role in co-production but the assumption that identical and generic services produce the best outcomes for people is questioned by co-production.

- **It is just 'participation' by a new name**: Co-production is different from 'voice' based interventions as it recognises that it is critical for people to play a role in the activity of delivering services, not simply to contribute ideas to shaping new services that rely on professionals to deliver them.

- **There is a need to harness the collaborative working** and embed this approach into all settings; professionals would need to start from the position of not necessarily knowing the right answer which will also be a challenge.

Creating a health and wellbeing system which is driven by the people within it, not by the institutions that provide care requires engagement in all stages - in designing, delivering or using, and in evaluating the service.

This recognises that those who provide and experience services should have an equal say and role in how services are designed and delivered. This requires going beyond 'engagement', 'involvement' and 'person-centered' towards real co-design and co-delivery at every level.

There is often confusion between co-production and service user-design, user 'voice' initiatives and consultation exercises.
Many of the 'voice' based initiatives involve people expressing opinions and ideas but ultimately still **only** recognise professionals as being capable of providing the work needed to deliver a service.

6. The proposed approach in Rotherham

The proposal is that all of our organisations decide which services would be suitable for co-production and begin to move to this as a concept of working, (around the circle of co-production) it is clear however that that there are some services which would never be suitable to be co-produced, examples of this would be around some health or protection and safeguarding services i.e. Resuscitation services or child protection investigations / services, however we still need to ensure that families could make comments about the services that they / their relatives have received to help improve or shape the services in the future as opposed to them being involved in the delivery of the services.

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The suggested implementation model is across a staged approach:

Stage 1 – All organisations agree in principle to undertake elements of coproduction and to move around the circle from where they are now towards fully co-produced services (see Rotherham circle of coproduction -Figure 1), this could be a step change or something more radical

Stage 2 – Organisations review on a yearly basis which services are suitable for co-production or to move towards co-production and aim to make the required changes during the year either as part of commissioned arrangements with Service Level Agreements and Service Specifications or changes to in-house delivered services (audit document attached at Appendix 1)

As previously mentioned not every service would lend itself to co-production hence the annual review of services in Stage 2 to ensure that all services and considered and to what levels it would be feasible to apply a co-produced methodology.

Social Care Institute of Excellence (SCIE) recommends four key steps to delivering co-produced services

1. Culture

- Ensure that co-production runs through the culture of an organisation.
- Ensure that this culture is built on a shared understanding of what coproduction is, a set of principles for putting the approach into action and the benefits and outcomes that will be achieved with the approach.
- Ensure that organisations develop a culture of being risk aware rather than risk averse * links to the work of the Dependence to Independence workstream and the development of a “risk taking policy”

2. Structure

- Involve everyone who will be taking part in the co-production from the start.
- Value and recognise people who take part in the co-production process.
- Ensure that there are resources to cover the cost of co-production activities.
- Ensure that co-production is supported by a strategy that describes how things are going to be communicated.
- Build on existing structures and resources.

3. Practice

- Ensure that everything in the co-production process is accessible to everyone taking part and nobody is excluded.
- Ensure that everyone involved has enough information to take part in coproduction and decision making.
- Ensure that everyone involved is trained in the principles and philosophy of coproduction and any skills they will need for the work they do.
- Think about whether an independent facilitator would be useful to support the process of co-production.
- Ensure that frontline staff are given the opportunity to work using co-production approaches, with time, resources and flexibility.
- Provide any support that is necessary to make sure that the community involved has the capacity to be part of the co-production process.
- Ensure that policies and procedures promote the commissioning of services that use co-production approaches.
- Ensure that there are policies for co-production in the actual process of commissioning.

4. Review

- Carry out regular reviews to ensure that co-production is making a real difference and that the process is following the agreed principles.
- Co-produce reviews and evaluations.
- Use the review findings to improve ways of applying the principles of coproduction, so that continuous learning is taking place.
- During reviews and evaluations, work with people who use services and carers, to think about ways of showing the impact that co-production has, as well as the processes that are involved. (SCIE, 2013)

7. The costs of co-production

Issues around the costs of co-production are particularly complicated. While there is some evidence that it can reduce costs, the available evidence is inconclusive. This may be something that varies between different organisations and different projects.

Obtaining reliable information on costs is often difficult. However, even in some of these cases there were costs that were significant, such as for training, there are also costs for professionals in taking time to work more effectively with customers and citizens. However, such activities may reduce costs in the long term if services are more fit for purpose and become more effective over time.
Co-production will probably lead to short-term increases in the use of services and other costs as it increases people's knowledge of and access to services. It may also lead to services that are 'more appropriate'.

Potential savings
One of the key arguments about the economic benefits of co-production is the potential returns from a perspective that focuses on prevention and early intervention when people's needs arise rather than letting them get worse. So if there is investment in community services, this means that people are less likely to need more expensive services (such as crisis and emergency services) later on. This will reduce the cost of acute services in the longer term.

Some of the clearest evidence of the potential savings that can be achieved in prevention using co-production particularly around health services has come from Nesta's People Powered Health programme. This programme focuses on ways to improve practice in health services, including peer support and co-design/co-delivery with people who use services. Nesta's analysis of the programme shows that where these approaches are used with people with long-term conditions, they deliver savings of approximately seven per cent through things like reduced and shorter hospital admissions and fewer visits to casualty departments. They also argue that these savings would grow to 20 per cent as the different parts of the programme support each other. (Nesta, 2013)

A few other points to note about co-production and costs are:

Co-production may lead to some costs being reduced and others increased.
It may only be possible to know whether co-production is cost-effective by looking at things over a period of time. If it is cost-effective it will have reduced the number of inefficient, ineffective and unwanted services.

One of the key studies of the economics of co-production looked at three coproduction/ community capacity projects. It analysed them using a method called 'decision modelling'. This compared what happened with the projects in place with what might have happened if they had not existed. The projects were a time bank, a befriending scheme and a community navigator scheme (volunteers who support people to obtain support services). The authors looked at all of the costs and gave a monetary value to all of the benefits. They recognised that there were limitations in their analysis. However, they made conservative estimates that the projects produced net benefits for their communities in a short time.
Economic evaluations of direct payments, individual budgets and—more recently—

personal health budgets have shown that they are cost-effective. Giving people who use services and carers more control over those services can increase their health and wellbeing. But it is important to give them more support in the form of information, advice and advocacy. This will mean that more people will take up budgets. However, not everyone will benefit from personalised approaches.

Key improvements and savings are around:

•**Spending it on the right things** in the first place (e.g. personal budgets, participatory budgeting)

•**Understanding better what is valued** and how outcomes are achieved (e.g. experts by experience)

•**Accessing and utilising the assets of service users** which may be freely given (e.g. recycling, litter picking, peer advocacy)

•**Adding to the assets of service users** and reducing welfare dependence (e.g. time banks)

•**Reducing formal staff contributions** (e.g. informal carers, breastfeeding support groups,)

•**Improving service quality (**e.g. employment advice service for refugees)

•**Improving long-term health** and well-being (e.g. Expert Patient Programme)

However, it is worthy of noting that it can also cost money by:

•Training for staff, users and other participants

•Generating new demands for the service

As part of the roll out of co-production we need to explore with customers the shared decision making around budgets and any savings that are made as a result, it is important that they are involved with future decisions on how money is spent moving forward.

8. Examples of National Projects

East Dunbartonshire – advisory clinic for people with dementia

http://www.govint.org/good-practice/case-studies/the-east-dunbartonshire-advisory-clinic-model/

All together Now: Putting people, relationships and outcomes first (Swansea)

http://www.ssiacymru.org.uk/home.php?page_id=3917

London Borough of Lambeth – teenage pregnancy project

http://www.govint.org/english/main-menu/good-practice/case-studies/london-borough-of-lambeth.html

Commissioning:

http://www.cihm.leeds.ac.uk/new/wp-content/uploads/2012/01/Co-producing_Commissioning_NEF-3.pdf

Mental Health Advocacy Service, Kirklees PCT and Council

9. References

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Cabinet Office Strategy Unit (2009)

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All together Now: Putting people, relationships and outcomes first (Swansea) http://www.ssiacymru.org.uk/home.php?page_id=3917

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Rotherham's Health and Well Being Strategy

Case Study

Rotherham Charter

Rotherham Charter

Genuine Partnership with Parents, Carers, Children and Young People, Adults and Families

The Rotherham Charter: A Case Study of Living, Promoting and Quality Assuring Co-Production

It was May 23rd 2011. The room was warm with goodwill, excitement and expectation. There was a colourful mixture of people chatting and smiling. Parents and carers, school and LA service staff, front-line to directorate, people from voluntary groups. The Deputy Mayor, two university academics. No dissention or complaint. Bathed in mellow sunlight, an air of friendly and equal partnership was welcomed, enjoyed and savoured by all.

This was the launch day of our Rotherham Charter, a model for co-productive working that was born, nurtured and has since thrived as a result of energetic and determined collaboration between Rotherham parents, LA and voluntary services, schools and young people.

The Charter emerged from powerful stories about their experiences entrusted to a small group of LA researchers by children with additional needs and their parents. It became quickly evident that the wellbeing of a child makes a huge impact upon the wellbeing of a parent or carer, and vice versa, but it is very small changes in practice that can make a big difference. The research coincided with the publication of Brian Lamb's Inquiry into parental confidence and at a SENCO conference in 2010, facilitated by the then recently formed Rotherham Parent Carers Forum on this theme, there was a meeting of minds. The researchers began to work in partnership with Forum parents to explore how to bring about these changes in key organisations that affect their experience and that of their child, beginning with schools. A successful bid to the DfE to develop an innovative project to improve parental confidence in SEN systems was made and the Rotherham Charter was born.

What followed was co-production in its purest sense, although none of us knew the term at that point. Parents and carers were pivotal partners in

Rotherham Charter

Genuine Partnership with Parents, Carers, Children and Young People, Adults and Families

the work that ensued, driving the direction of the project as head teachers, LA, Health, and other services listened to their stories and worked alongside them, thirsty to know how they could improve things.

The four Charter principles arose through this early work, to which as part of Rotherham's Local offer schools and services are now being asked to commit. Parents/carers and children/young people in whatever educational, care or health context they find themselves want to feel confident they will receive **welcome and care**, be viewed as **equal partners** in decision-making, feel **valued and included** and experience **good communication**. Underpinning each of the principles is '**trust**', identified as the defining element.

However, a strong message made clear by these initial discussions was that a set of principles alone do not bring system change. Mechanisms need to be put in place to support organisations to work in this way and to enable some form of quality assurance in which parents/carers and children/young people can place their trust.

Support packages for schools, self-evaluation and accreditation processes were developed. Currently, in the light of the Local offer, further joint work is being completed to ensure the processes are appropriate for services. It was also perceived to be essential that Charter mechanisms and processes themselves must be appreciative; living and breathing the Charter principles. Charter Management and Implementation Teams have grown up ensuring that parent, school and service representatives have equal leadership, voice and responsibility. All packages have been co-constructed and are co-delivered. Feedback from schools and services so far involved has informed us that this is what makes the Charter process so powerful, and so unique.

When the term co-production became a buzz word we realised that this is how we had been working and what we have been promoting and supporting for the last four years.

Rotherham Charter

Genuine Partnership with Parents, Carers, Children and Young People, Adults and Families

Comments about the reality and benefits of co-production

Co-production has not been a straightforward or easy journey. It can be messy. No decision is taken by a service or parent representative without mutual discussion. There is an acceptance that we each have different strengths and needs and ways of communicating with each other to which we have to be sensitive and accommodate. Texts, a chat, e-mail, whatever works for that person. We work hard to make meetings friendly, open and light and ensure everybody has choices and feels comfortable with and confident about their roles. We have different pressures; it is vital to acknowledge and support each other in numerous ways. We remind each other to listen and respond pro-actively.

The power imbalance created by some members of the team being paid workers and others volunteers has to be offset by honest and open acknowledgement and good communication, welcoming different perspectives. It is a way of working that involves both formal systems and informal relationships, safeguarding the confidence of all involved they are functioning as an equal partner without it impacting adversely on their well-being. Empowerment, improved wellbeing and positive change is always the aim.

The thing about co-production is that when it genuinely works it touches everybody involved and makes their lives better. Equal partnership is hard work but enriching. It is inspiring. We all learn continually from the process, the relationships we have made and the improved outcomes we have witnessed:

"For parents in Rotherham the Charter is the only real model of co-production. Co-production is a nice idea and people like to think they do it but the Charter makes it real. Co-production working is time consuming and arduous at times, for both practitioners and families, but is the only way of working that creates a spirit of 'done with' and not 'done to'.

Rotherham Parents Forum Limited

Rotherham Charter

Genuine Partnership with Parents, Carers, Children and Young People, Adults and Families

It gives joint ownership of the services delivered and true understanding of service limitations reduces conflict. Parents in equal partnership can work together with practitioners to enhance their practise and the quality of family life. This may be your living, but it is our life. It is imperative that the voice of families is included with authenticity."
Jayne

"The thing about the Charter is that it's got to happen. It is important that there is no red tape and we have parents leading it and not being hijacked by professionals. That stops being what it was originally meant to be. The professionals do the structure and paperwork and let me put in the bits that I'm good at, I'm a parent and that's what I'm good at…I wish someone would say come in, relax, let's get to know you and not start looking at their watch after fifteen minutes and making you feel like a trouble causer. The Charter has made a difference, it can make a difference. People can re direct their focus."
Jill

"Being involved in the Charter has shown me that I can make a difference, parents views do count, and what can be achieved when services work together alongside parents and children. The Charter has given me hope. I can see a bright future for my little girl, and the other children in Rotherham. It's hard to describe how it feels to speak to a school head teacher and actually see and feel they are listening, and want to help change the system. Some words spring to mind: valued, respected, understood, trusted, proud, but one that stands out is EQUAL. "
Amanda

"It has been collaborative throughout, and continues to be. This is GENUINE partnership. The process of the development exemplifies what can be achieved when parents, a range of key services and schools work together. We soon realised that this process 'works ' for ALL children , getting it right for our most vulnerable children brings everyone along on

the journey and creates an arena of TRUST and communication that has a direct impact on outcomes and achievement for our children."
Jayne

"Working for a service, it can often be difficult to know the best way to develop a relationship with a child, young person or parent who you may only meet once or twice, or who may only know you as a face around a table in a very daunting meeting. I always like to see myself as an advocate for the child or young person with who I am working however I am aware that others may see me as an alliance of a school, a local authority and or a set of bureaucratic systems. As an EP some people may see me as a stepping stone or even a barrier.

My involvement with the Charter has helped me to consider the 'little things' that I do that can make a big difference. My phone calls, my 'promises', a smile, the impact of a trip the toilet in between meetings. Working in such a collaborative way with parents has also helped me to feel my comfortable with being a human! I am not perfect, far from it, and working in such a collaborative way with parents has helped me to see that this is not what parents want, I am not expected to be perfect. I have learnt that as long as I show honesty and integrity, admit my slip ups and stay passionate about the work I am doing then I am doing ok.

The little things above are what really lay the foundation. …I must admit I do not always get it right but I try my best. One of the best things about being involved in the Charter is the reminder of the 'good bits'. Charter work offers us an opportunity to think about the good practice that we see in Rotherham, it also offers a deeper relationship with parents that helps to remind us of why we are doing what we are doing - I was recently shown a fabulous video of an inspiring little lady singing away to 1D at a disco, overcoming so many things to get there, with a dazzling smile on her face!

Rotherham Charter

Genuine Partnership with Parents, Carers, Children and Young People, Adults and Families

Working collaboratively is not an easy process, it takes time, it takes self-reflection and it takes the ability to say 'I could still be doing it better'. It has led me to make some small changes in my practice which I hope have a big impact on those that I work with. However it has led to a huge change in my mindset. I am proud of being involved in the Charter and proud of the journey that it is on...."

Jemma

Rotherham's Health and Well Being Strategy

Case Study

Lifeline Rotherham

Lifeline Rotherham Milton House Project

Co-Production Case Study

Lifeline Milton House Project is a specialist community alcohol service in Rotherham. The service provides drop in, brief interventions, outreach provision, community and service user engagement programmes and criminal justice interventions. Mutual aid providing psycho-social intervention groups such as SMART recovery and Narcotics Anonymous are supported by the service. Assessment's and one to one support sessions are also available.

Our organisation provides 3 areas of volunteering opportunities. Programme support volunteers work alongside staff in delivery of daily service activities; Outreach support volunteers provide support in the community and Peer support mentors.

Volunteer Exchange is a community based project which delivers alcohol support service through volunteering, volunteers audit members of the public and provide follow up interventions and signposting to other services, it provides opportunities to access support and guide people into other services using initial brief intervention tools, raising alcohol awareness and giving brief advice to people affected by alcohol. In addition volunteers provide one to one sessions with clients on Alcohol Treatment Requirements Orders given by South Yorkshire Probation under supervision by Lifeline staff.

Peer mentors are people who have recovered from being affected by substance misuse or alcohol misuse, using their life experience to support others through guidance, group work and by raising awareness of addiction recovery techniques, with an aim of reducing stigma associated with accessing services.

After rigorous training and time to develop through shadowing and co facilitating, volunteers and peer mentors support Lifeline Milton House Project with providing holistic approach to recovery by peer led groups which include a 12 week wellbeing group programme following the five stages of wellbeing, a 12 week relapse prevention group providing learning and tools to stay in recovery, self-awareness sessions building self-esteem, confidence and relaxation sessions and routes to recovery for people who are contemplating starting their recovery from substances, furthermore peer mentors provide befriending services to clients, helping to break down barriers to recovery through supporting to appointments and groups and having somebody personal experience to listen.

Lifeline provides significant support for Rotherham service user involvement groups, which in turn provide a voice for people accessing substance misuse services and alcohol misuse services, influencing the way services are developed. Service user expert group provide feedback to key stakeholders, management of treatment services and at commissioner level.

Rotherham's Health and Well Being Strategy

Case Study

Social prescribing

NEWS FROM

NHS Rotherham Clinical Commissioning Group

Tuesday 4 March 2014

INNOVATIVE SCHEME FOR PATIENTS IN NEED WINS NATIONAL AWARD
Excellence in participation recognised

A SCHEME that provides support to patients most in need in local communities across Rotherham won a prestigious national health award in Manchester last night (Monday 3rd March).

NHS Rotherham Clinical Commissioning Group (CCG), working closely with Voluntary Action Rotherham, was recognised for its exceptional work in helping Rotherham people by picking up Excellence in Individual Participation Commissioner at NHS England's 'Excellence in Participation Awards 2014'.

The ground-breaking social prescribing project links patients with a long-term condition and at risk of hospital admission with activities of support in the community. These activities include; self-management programmes, benefits advice, arts and crafts, befriending, dementia support and advocacy.

The project harnesses the unique expertise and resources within the voluntary and community sector, with Voluntary Action Rotherham providing support in joining vulnerable, disadvantaged and isolated people up with the services that community organisations provide.

Advisors from the voluntary and community sector have joined forces with teams in Rotherham GP practices to work with patients to identify their support needs. They are then offered different types of activities that might be of interest. Patients agree a plan of action with an Advisor, which forms part of an integrated plan to help support them.

One-to-one mentoring is available for those patients who have issues preventing them from accessing services and activities such as transport, loss of confidence or mobility.

Sarah Whittle, Assistant Chief Officer and Project Lead at NHS Rotherham CCG, said: "This is fantastic news for Rotherham and our patients. We are delighted that our hard work has been recognised against tough competition.

"Social prescribing provides a win-win for all involved - we like it as it addresses inappropriate admissions into hospital; GPs like it as it gives them an option apart from referral to hospital or to prescribe medication; it provides the voluntary and community with support for their sustainability and more importantly patients and

carers tell us they **love it** as it improves their quality of life, reduces social isolation and moves the patient from dependence to independence."

Janet Wheatley, Chief Executive at Voluntary Action Rotherham, added: "We are absolutely thrilled to win this award and get national recognition for the fantastic partnership working that NHS Rotherham CCG have led on between GP Case Management Teams, Voluntary Action Rotherham, the Voluntary and Community Sector and most importantly in putting patients themselves at the heart of managing their own care and treatment.

"This project is really creative and innovative work which links into the excellent work that voluntary and community sector groups are providing in Rotherham. The work has been running for over a year now and it is proving very effective in helping patients to become more independent, less isolated, reducing unplanned admissions and improving patients' experiences of the quality of their care. The Award is recognition of a fantastic team effort and approach by everyone involved."

- Ends –

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Rotherham's Health and Well Being Strategy

Case Study

Speak Up

Co-production story

Robert

My name is Robert and I work with the Health Select Committee, on Wednesday the 26th February, 2014, I went to the doctors surgery to ask them how they include the ethnic minority and people with autism and all different types of disabilities.

The Health Select Committee are councillors from Rotherham Town Hall (Janet). The Health Select Committee were set up to help improve health related problems within the Rotherham area.

We work together to build or skills by working as a team. We all make the decisions together. I asked the doctors and nurses questions about how the ethnic minority are included in their surgery, whilst other people on the committee wrote down what they said. I think that by asking the doctors these questions alone it improved my communication skills and others within the committee encouraged me on building this skill as well as the staff as the surgery who cooperated well with us. Also, as part of the health select committee, we travel around homes, inspecting the state of the homes and observing how well people are being taken care of. I knew it was not tokenistic because where we travelled; they had newsletters/leaflets to back up their answers to the questions. We also asked open questions such as how and why instead of closed questions, this allowed us to gain a more in depth answer instead of just yes/no answers.

Alison

My name is Alison, I am a member of the co-production group for the Think Local act Personal board. There are around 10 of us who talk about the different services that are available in our local areas that are used by members of the public such as; health and transport. The people who I work alongside have learning disabilities and/or physical disabilities. We work together to improve the services that are available, at the next meeting we then feed back to the board and tell everyone what we have been doing.

I am also a regional rep for Yorkshire and Humber, at the National forum we talk about four particular subjects including; advocacy, transport, health and supported living. The National forum is run by people with learning disabilities from the nine regions however Voiceability support the meeting alongside two co-chairs. At the National forum we each take back three important points that we have spoken about back to the Regional forum, where we discuss these points and try to make some improvements.

Jodie

My name is Jodie, I am a trainer for I'm a person too and Autism awareness. I'm a person too and autism awareness are training projects that looks at different ways to communicate better with people with learning disabilities and/or autism. We say in the training that we do not want to be treated equally, we just to be equal. The trainers are people with learning disabilities and/or autism and they train practitioners who request the training due to often working alongside people with learning disabilities. Whilst developing the training, we came up with different ideas and information that we can use. We also thought to make it more interactive that we could add videos to it that are real life stories. The trainees are told the ways on how to treat people with learning disabilities and/or autism when they are accessing their services.

David

My name is David and I am a member of Speakup for Autism. This is a group that meet once a week on a Wednesday to discuss issues that may affect us as adults

with Autism. Molla from Sheffield Hallam University attends some of our meetings and we have done some joint work with them. One of these jobs has been investigating how stress affects people with Autism. To do this we have been trying out some stress sensors which straps to our wrist and monitors our stress and by recording our times of stress either by recordings or written on paper. Our stress was later shown in graph form on the computer which shows us how we was during these times.

Kerry

My name is Kerry and I went to Riverside house to take part in a mystery shopper activity. I went on the council internet and was given four things to look for including; the complaints procedure, how to pay your rent and noisy neighbours. I had to see how easy it was to find the information that I needed, I found that it was.