HEALTH SELECT COMMISSION
27th October, 2016

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

Apologies were received from Councillors Ireland and Marles.

39. DECLARATIONS OF INTEREST

There were no Declarations of Interest made at the meeting.

40. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

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

41. COMMUNICATIONS

(1) Information requested from Foundation Trust at quarterly briefing

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

(2) Information Pack
The pack contained:-

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Schools mental health pilot

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

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

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

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

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

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

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

Waiting times

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

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

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

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

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

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

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

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

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

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

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

As general points for future reports Members requested:

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

Further information requested:

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

Officers and partners were thanked for their attendance and responses.

Resolved:-

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Actions being taken forward included:

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

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

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

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

Resolved:-

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Resolved:-

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

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

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

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

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

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

46. IMPROVING LIVES SELECT COMMISSION UPDATE

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

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

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

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

National transfer of unaccompanied asylum-seeking children:

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

Councillor Cusworth was thanked for her report.

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

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

Janet Spurling, Scrutiny Officer, reported the following:-

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

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

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

Resolved:- That the report be noted.

48. HEALTHWATCH ROTHERHAM - ISSUES

It was reported that no issues had been raised.

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

49. DATE OF FUTURE MEETING

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