You are hereby summoned to a meeting of the Health Select Commission to be held on:-

Date:- **Thursday, 26 October 2017** **Venue:-** **Town Hall, Moorgate Street, Rotherham S60 2TH**
Time:- **3.00 p.m.**

HEALTH SELECT COMMISSION AGENDA

1. To consider whether the press and public should be excluded from the meeting during consideration of any part of the agenda.

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

3. Apologies for Absence

4. Declarations of Interest

5. Questions from members of the public and the press

6. Communications

7. Minutes of the Previous Meeting held on 21st September, 2017 (Pages 1 - 12)

For Discussion

8. Evaluation of Whole School Project and Next Steps (Pages 13 - 63)
Ruth Fletcher-Brown, Public Health, to introduce

9. Response to Scrutiny Review: Child and Adolescent Mental Health Services - monitoring of progress (Pages 64 - 77)
Beki McAlister, Strategic Commissioning Manager, CYPS to present

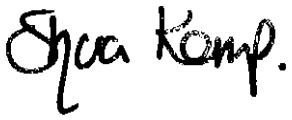
For Information

10. Joint Health Overview and Scrutiny Committee for the Commissioners Working Together Programme

11. Healthwatch Rotherham - Issues

12. Dates of Future Meeting
Thursday, 30th November at 10.00 a.m.

Thursday, 14th December at 10.00 a.m.



SHARON KEMP,
Chief Executive.

Membership:

Chairman:- Councillor Evans
Vice-Chairman:- Councillor Short
The Mayor (Councillor Rose Keenan), Councillors Allcock, Andrews, Bird, R. Elliott, Ellis, Ireland, Jarvis, Marriott, Rushforth, Sansome, Whysall, Williams and Wilson.

Co-opted Members:
Vicky Farnsworth and Robert Parkin (Rotherham Speak Up) and Peter Scholey.

HEALTH SELECT COMMISSION
21st September, 2017

Present:- Councillor Evans (in the Chair); Councillors Andrews, R. Elliott, Jarvis, Marriott, Rushforth, Short, Whysall, Williams and Sansome.

Councillor Roche, Cabinet Member for Adult Social Care, was in attendance at the invitation of the Chairman.

Apologies for absence were received from The Mayor (Councillor Eve Rose Keenan) and Councillor Bird.

24. DECLARATIONS OF INTEREST

There were no Declarations of Interest.

25. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

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

26. COMMUNICATIONS

1. An information pack had been circulated separately, including:-

   RDaSH Child and Adolescent Mental Health Services (CAMHS) Performance Report – the Health Select Commission (HSC) would be having an update on CAMHS in October and this might help to inform Members' key lines of enquiry
   Social Prescribing overview
   Health and Wellbeing Board minutes from July

2. Schools Mental Health pilot evaluation event on Wednesday 25th October – the Chair asked if one of the Members who had been involved in the monitoring visits to the schools would be available to attend the event to represent the Select Commission

   After the meeting it was confirmed that Cllr Marriott would attend.

3. An early date to note for diaries was a two part event facilitated by the LGA on health prevention, with all Select Commission Members encouraged to attend. The sessions would be on 23rd and 30th November. More detail would follow but it was noted that useful Ward profiles would be available

27. MINUTES OF THE PREVIOUS MEETING HELD ON 20TH JULY, 2017

Consideration was given to the minutes of the previous meeting of the Health Select Commission held on 20th July, 2017.

Arising from Minute No.16 Membership of the Health, Safety and Welfare Panel 2017/18, it was noted that there was still a vacancy for a Member from HSC. Expressions of interest were requested.

Arising from Minute No. 17 (Adult Social Care Provisional Year End Performance 2016/17), follow up information for performance measure No.14 (permanent admissions to residential care of people aged 18-64) on sub-cohorts by age and service user group had been included in the agenda pack.

Arising from Minute No. 19 (Health Select Commission Work Programme), it was noted that the item on the refresh of the Health and Wellbeing Strategy had been postponed to November but there was still a good opportunity for the Select Commission to be involved at an early stage.

Arising from Minute No. 21 (Healthwatch Rotherham), Councillor Roche confirmed that the Autism Partnership Board had met on 20th July, work on the Autism Strategy was underway and an officer had recently been appointed who had been involved in developing the national Autism Strategy.

Resolved:- That the minutes of the previous meeting, held on 20th July, 2017, be approved as a correct record.

28. TRANSFORMATION INITIATIVES - CARE CO-ORDINATION CENTRE AND INTEGRATED RAPID RESPONSE

Dominic Blaydon, The Rotherham Foundation Trust (TRFT), presented a briefing paper to update the Health Select Commission on progress in relation to further development of the Care Co-ordination Centre (CCC) and Integrated Rapid Response (IRR) services currently provided by TRFT. The ambition within the Rotherham Place Plan was to extend both services to include mental health and social care, providing a multi-disciplinary approach to address the whole needs of the service user, resulting in an improved experience and more effective use of resource.

The role of the Care Co-ordination Centre, which was developed about five years ago, was to provide a telephone based nurse-led approach providing advice to health professionals on the correct care pathway for patients in urgent need. This could be through a district nurse, community physician or a referral to intermediate care. It was intended to address the high number of GP initiated hospital admissions and to act as a portal to community health to see whether they were able to support a patient rather than them going to hospital. It has been very successful, for example reducing GP referrals to the Medical Assessment Unit by around 20%.

A phased approach was being taken to implementation to realise benefits within the available resource and to manage risk. The first phase was to include urgent mental health referrals; work on this had commenced and from a local authority perspective was quite straight forward. Then they would be looking at linking up with RMBC and the work that they were doing on social care referrals, for people in crisis or with a high level of need.

The Integrated Rapid Response Service, formerly known as both the Fast Response Service and as the Community Assessment Rehabilitation and Treatment Scheme (CARATS), was commissioned to provide short term care packages at home for people at risk of hospital admission. It could also be used to expedite hospital discharges of vulnerable patients who no longer had a medical need and to prevent hospital re-admissions, and was working well. Instead of a patient being admitted to hospital because they were not safe at home, the IRR service went in and provided wrap around care, followed by a handover to Community Health after 72 hours.

The Service works alongside the CCC and the intention was also to extend IRR to include Mental Health and Social Care needs by working with the local authority, to provide time limited re-ablement for people experiencing a short term crisis. This would lead to a more holistic approach to care to support people with a greater level of need or more complex needs and would address any safety issues arising from providing a more one dimensional service.

Partners were also considering how IRR would link in with the integrated locality. The thinking was that urgent on the day care could be transferred to IRR, thus freeing up integrated locality workers to carry out the planned work with people with long term conditions and to be more proactive. Phase 1 of the Rapid Response Service would be co-location prior to full integration in phase 2.

The following issues were highlighted/discussed:-

- Patients calling the CCC directly and how long they might wait to speak with someone – At present the CCC was only accessed by health professionals not patients, mainly when there were working with someone and wanted information about care pathways. There had been discussion regarding expansion to specific groups of patients being able to make direct contact with the CCC. More broadly, how and where people access the NHS was almost a separate workstream.

  Under RDaSH's old structure, patients would contact each business division, which were set up and resourced differently, including different service hours. Then overnight calls went to clinical staff at one central contact point and if clinical staff were busy then they did have to wait. Under the new CCC arrangements the initial point of contact would be staffed by

administrative staff 24:7 who then passed on the record to the right people; this was a significant improvement.

- Amber risk regarding GPs, what were the issues and were there contingency plans to prevent this becoming red? – There was an issue around how the CCC fitted in with the sepsis care pathway they were trying to resolve. More generally GPs feared that a reconfiguration of the CCC would mean its existing functions were compromised by the changes as it was such a good service for GPs in providing advice about current care. A fuller response would follow.

  It was highlighted that from the RDaSH perspective it was a very phased implementation to help manage risk, so initially the administrators would just be working on mental health and then other RDaSH services would be gradually introduced, to help manage that, both for patients and for the existing service.

Resolved:-

That the Health Select Commission note the update.

29. RDASH ROTHERHAM CARE GROUP TRANSFORMATION PLAN - UPDATE

Steph Watt and Matt Pollard presented an update on the RDaSH Adult Mental Health transformation activity, as outlined to the Commission in Summer 2016.

Members were reminded of the key issues that had emerged from consultation with stakeholders, which had been drivers for the reconfiguration. In particular, care closer to home, “telling it once”, better access to health and not being bounced between services due to issues within the organisational structure had been raised by patients and carers

RDaSH had now moved from age related, cross-Trust business divisions to place based locality Care Groups. The Rotherham Care Group was comprised of Adult and Older People’s Mental Health Services, Learning Disability Services and Drug and Alcohol Services. A recovery and wellbeing ethos underpinned the services with care wrapping around the patient through multi-disciplinary teams and a new pathway framework. The new structure was based around two localities, north and south, although smaller specialist services, such as young onset dementia, continued to be borough-wide. A “deep dive” into access to front door services was also planned.

The Trust had also considered how IT would support the new structure and a new patient record system (PRS) would be introduced from April 2018 to be more streamlined and effective. Information governance was an important issue for mental health and processes were in development.

RDaSH were working with TRFT on Electronic Patient Records (EPR) to help with information sharing across physical health and social care, supported through funding from the Better Care Fund (BCF).

It was hoped to extend the two social prescribing pilots with the voluntary and community sector to "front door" work. Discussions were taking place with The Samaritans regarding work with people needing support but who did not necessarily meet statutory service requirements, again through the BCF.

The new management team was in place and work is underway on estates to move teams into the localities – on an interim basis initially, with a view to future co-location with health and social care, generating economies of scale and efficiencies as well as benefits for patients.

A phased roll out of the new pathways was commencing with brief interventions initially - prevention and stopping deterioration. RDaSH would be working proactively with TRFT and RMBC on the Integrated Rapid Response service mentioned above.

Benefits for patients would be a better experience through care closer to home, improved access and a more unified structure. There were also efficiencies, firstly from the management restructure and the PRS, plus an admin review was taking place. Efficiencies had been looked at from back office functions rather than clinical teams.

More integrated working had many positives but changes did bring about anxieties and the trust was continuing to work closely with stakeholders and patients.

Discussion ensued with the following issues raised/highlighted:-

- Patient records kept and stored in paper files, including off-site, and practical issues and timescales for moving fully to EPRS – Services were trying to be "paper-light" but there would still be a need to archive paper records for a period of time. To follow up with a written response.

  The development of the Rotherham Care Record would enable information sharing across partners when they were directly involved in patient care, including Primary Care and Social Care. This would enable services to see what care a patient was receiving and also patients who were in hospital, which linked back to the CCC and IRR service and who they could support. The strategic intent was there within the appropriate information governance arrangements for each organisation to develop this to improve patient care.

The local Accountable Care System came under the auspices of the Health and Wellbeing Board and there had been discussions about the development of the common record with Adult Social Care fully involved and willing to share information as appropriate to improve care.

- Would the economies of scale mentioned have an impact on clinical face-to-face provision over time? - A staff skills review was under way and there may be changes but no intention to reduce front-line staffing but rather to improve the quality of the service. The other areas mentioned had been looked at first in terms of efficiencies.

- Would there be an increase in generic working or was the intention to retain all the specialisms? – The intention was for staff integration into teams to avoid the "patient hand offs" referred to, but there were specialist skills within the teams that need to be retained. So although there might be a generic front point of access and a generic process for people to work through, there would still be specialist workers who could deal with individual service user/patient's needs.

- Dovetailing RDaSH's two localities with other different locality models and the distribution of resources aligned to need – RDaSH had started with two localities as they needed to change but they were working really closely with TRFT and RMBC around how services would be delivered and managed in the community going forward. They were very aware of other plans and would map in the RDaSH services and where possible co-locate as this would bring so many benefits.

  A piece of work had been undertaken mapping demand for RDaSH services which had shown extra demand in the smaller north locality, so they were looking at mapping staff/team volumes for localities and overlaying these with demands from other services or placed on other services from outside RDaSH.

- More information on the RUST project, such as uptake and how to access – It was early days still so more information would be provided in November. This work had already been taking place at Rotherham United through Sport England funding. RDaSH made contact with them at a social prescribing event and the activity they were doing had developed and was now underpinned by professionally trained workers providing some additional support.

Resolved:-

(1) That the Health Select Commission note the update.

(2) That the Health Select Commission receive a more detailed update on the pathway framework at the meeting in November 2017.

30. DELAYED TRANSFERS OF CARE

Ian Atkinson, Rotherham CCG introduced an update on progress with regard to reducing Delayed Transfer of Care (DTOC) at TRFT. As with the other workstreams discussed this was again very much a partnership approach.

NHS England defined patients as ready to transfer out of the hospital setting when:

a) A clinical decision had been made that the patient was ready for transfer

AND

b) A multi-disciplinary team decision had been made that the patient was ready for transfer

AND

c) The patient was safe to discharge/transfer.

Delays in discharge could be linked to a number of different reasons; common areas of delay related to patients waiting for assessment and decision regarding Continuing Care, patients waiting for care packages to be established in the community or awaiting a care home package.

One of the four national conditions set out in the 2017 Better Care Fund planning guidance required health and social care systems to work jointly to reduce DTOC to a level of no more than 3.5% of patients at any one time being classified as DTOC within the hospital setting (equates to an average 15 patients at any one time).

Historically Rotherham health and care community had performed well on DTOC, consistently delivering below the 3.5% target. However throughout 2017 (although comparable to many other areas of the country) TRFT had reported a more challenged position.

In terms of numbers, on average the hospital had 400 beds for patients daily. 83 people per day were discharged from Acute Care, so 3.5% meant around 10 patients being delayed and 5.5%-6% was approximately 24/25 patients classed as being delayed for discharge.

DTOC had had a raised national profile recently and although Rotherham was not a significant outlier; it was a key performance indicator and was at the heart of three main indicators in the Improved Better Care Fund that needed to improve upon. In response partners commissioned an external review undertaken by the Local Government Association and a peer NHS Foundation Trust. This provided an objective view of how flows of

patients, assessment processes were managed and the capacity going forward.

Flow back end of patients out of hospital and bed availability also impacted on A&E performance. Therefore the multi-agency A&E Delivery Board had agreed and was overseeing the Rotherham DTOC action plan based on the recommendations from the review. Key points that partners wanted to challenge themselves on before the onset of winter pressures were highlighted in red in the action plan.

Key issues in the improvement challenge were:-

- integration of the discharge teams (Health and Hospital based Social Work Team) in terms of teams going and providing support around the patient and the family to expedite care out of the hospital
- data and information joined up by using similar data sets e.g. for the stop/start time for the assessment process
- discharging patients home first when it was medically safe to do so then the full assessment

Integrated Better Care Fund (IBCF) funding would help with these issues and the winter pressures, to assist with winter capacity and winter planning, with a good amount of transformation money to work across the system. A report on the IBCF was discussed at Health and Wellbeing Board on 20th September outlining the extra initiatives. The key was bringing those people involved in discharge together in a more coherent way in what was a high pressure environment. The intention was to bring in some jointly funded posts (TRFT and RMBC) to project manage the DTOC pathway and to look at different initiatives to improve practice. Rotherham could also benefit from sharing the learning from colleagues in Sheffield who had really struggled with DTOC so had invested in workforce and organisational development which partners were looking to do in Rotherham.

For patients DTOC was an emotive subject and the CCG had worked with Patient Participation Groups (PPGs) who raised other issues for consideration such as patient flow in the hospital and prescribing on discharge.

Re-ablement capacity was also being looked at as if people quickly accessed rehabilitative services there were benefits in terms of people's independence and moving through the system faster in addition to financial benefits.

The importance of the voluntary and community sector in the plan was emphasised, with £90,000 to be invested in Age UK's really successful Back to Home pilot which was limited to a small number of wards at present.

The following issues and questions were raised by Members:-

- Was there a time limit to get professionals together in order to move patients out more quickly and free up beds? – No target at this juncture but a commitment at multi-disciplinary team meetings to support discharge. As yet more co-ordination was needed.

- Reasons for the spike in March? – Although overall it was still small numbers it did have a ripple effect in the hospital and following winter there had been real reduction in system pressures.

- Information from care homes on their services and bed capacity to help people move out of hospital – The empty beds register was updated weekly. Patient choice of care home could lead to delay if there was no current availability or not until a specific week. In terms of specialisms of care homes a range was in place, including for intermediate care, such as Lord Hardy or Davies Court and health partners also used Ackroyd House.

  Rotherham had an allocation but across the system there was too much reliance on the care home bed base; the wish was to increase care at home where possible and not in residential settings. As highlighted previously a shortage of nursing beds existed in the Borough compared with over supply of residential beds which could be a potential challenge in the future.

- Was a weekly update sufficient given the pressures last winter and with some care homes having vacancies? – The ultimate driver was to keep people at home and it was always a challenge with homes with vacancies, quality and individual preferences. Initiatives were coming through the NHS on bed availability, with some councils having automated systems where care homes could log on and input availability. This would be looked at as at present it was a manual system, hence weekly.

  Within TRFT the award winning SEPIA interactive portal allowed staff to see the live bed base in the community and in hospital. Within the IBCF around £100,000 had been earmarked for IT development to try to get to grips with real time information across the whole system. This would assist with strategic planning and for staff on the ground to access to real time data facilitating discussion with individuals and families on bed/care package availability.

- Delays due to medication not being available did not count towards the DTOC measure but could be an issue and impacted on patient experience, affecting both discharges and transfers of care.

- How quickly was discharge planning initiated when a patient came into hospital and was it linked to an overarching view of capacity? – It was a mixed picture but moving forward on development of the discharge process there was a role for the wards to plan for discharge dates as soon as someone was admitted. There was also a role for the Integrated Discharge Team (IDT) to expedite discharge where the patient needed more complex care, plus set legal guidelines to comply with, which were part of the process.

  It was worth noting that in terms of length of stay TRFT was in the top quartile and doing well on the amount of time people spent in hospital but there were still improvements, as had been mentioned with prescribing. An internal pharmacy resource was needed.

  In terms of care homes, the focus in the TRFT had been on preventing admissions but providing more support to people transferring from hospital to a care home through the Care Home Liaison Service could be looked at. The service had been working more on supporting people who were already there. The IDT would also provide a more streamlined process.

  Coming into winter a significant increase in influenza was anticipated which had not occurred last year but still experienced pressures so the IBCF was very important to help to address this.

- To help reduce delays could patients be discharged with a generic prescription that could be used at any chemist rather than having to go to the hospital pharmacy? Response to follow.

Resolved:-

That the Health Select Commission note the content of the report, including Appendix 1 the Delayed Transfers of Care Action Plan.

31. NEW NATIONAL AMBULANCE STANDARDS

The Scrutiny Officer introduced a short briefing paper on forthcoming changes to national ambulance standards. Following positive evaluation of a national pilot (which Yorkshire Ambulance service had been involved in) new ambulance response categories and standards were being introduced nationally.

Key drivers for change to modernise the service to be suitable for patient demand and current care pathways were outlined.

This issue would be considered by the Yorkshire and Humber Joint Health Overview and Scrutiny Committee as it was a regional service with Wakefield Clinical Commissioning Group (CCG) as the lead commissioner for the region.

Clarification was provided on the targets being applicable to 90% of calls and a request would be made to see if performance data on meeting the response time targets could be disaggregated between urban and rural areas and what performance data could be disaggregated to CCG level, as most data reporting is at regional level.

Rotherham CCG confirmed that YAS would be collecting data based on the new standards from September and would begin to report from October. This data would be available via the CCG website, including any that was reported at a Rotherham level.

Resolved:- That the Select Commission determine any specific questions to submit to the Yorkshire and Humber Joint Health Overview and Scrutiny Committee to ask the Yorkshire Ambulance Service in relation to the new standards.

32. IMPROVING LIVES SELECT COMMISSION UPDATE

There was no update to report.

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

The Chair gave an update from the last meeting of the Joint Health Overview and Scrutiny Committee (JHOSC) held on 31st July, 2017:-

Children's Surgery and Anaesthesia - plans for implementation would be in place by the end of December 2017, with a further update to the JHOSC, probably in October.

Hyper Acute Stroke – the decision from the Joint Committee of CCGs was due in the autumn with an update expected for the next JHOSC.

South Yorkshire and Bassetlaw Hospital Services Review – a new workstream under NHS transformation had commenced recently:-

- to define the criteria to help understand what a sustainable hospital service would be.
- to look at services and define those which were non-sustainable.
- to advise on future models of delivery to ensure long term sustainability.

JHOSC Terms of Reference – a refresh was under way and would be communicated to the Select Commission.

Copies of a powerpoint presentation about the hospital services review and a stakeholder briefing were circulated to Select Commission Members at the meeting.

34. HEALTHWATCH ROTHERHAM - ISSUES

There were no issues to report.

35. DATE OF NEXT MEETING

Resolved:- That the next meeting of the Health Select Commission be held on Thursday, 26th October, 2017, commencing at 3.00 p.m.

Whole School Approach

Ruth Fletcher-Brown, Public Health Specialist, RMBC

Introduction

- What is a Whole School Approach
- Where did it some from?
- How did this work in Rotherham?
- What actions did the schools take?

What do we know?

In an average class of 30 (15 year old) pupils:

- **3** could have a mental health disorder
- **10** are likely to have witnessed their parents separate
- **1** could have experienced the death of a parent
- **7** are likely to have been bullied
- **6** may be self-harming

A whole school and college approach

- *Promoting children and young people's emotional health and wellbeing: A whole school and college approach* was produced by Public Health England & Children and Young People's Mental Health Coalition in 2015.
- It sets out key actions that Head Teachers and College Principals can take to embed a whole school approach to promoting emotional health and wellbeing. These actions are informed by evidence and practitioner feedback about what works.

Eight Principles to promote mental health and wellbeing in schools and colleges

Future in Mind 2015

NHS, public health, local authorities, social care, **schools** and youth justice sectors working together to place the emphasis on building resilience, promoting good mental health, prevention and early intervention. (Chapter 4.

Encouraging schools to continue to develop **whole school approaches** to promoting mental health and wellbeing.

Why whole school approach?

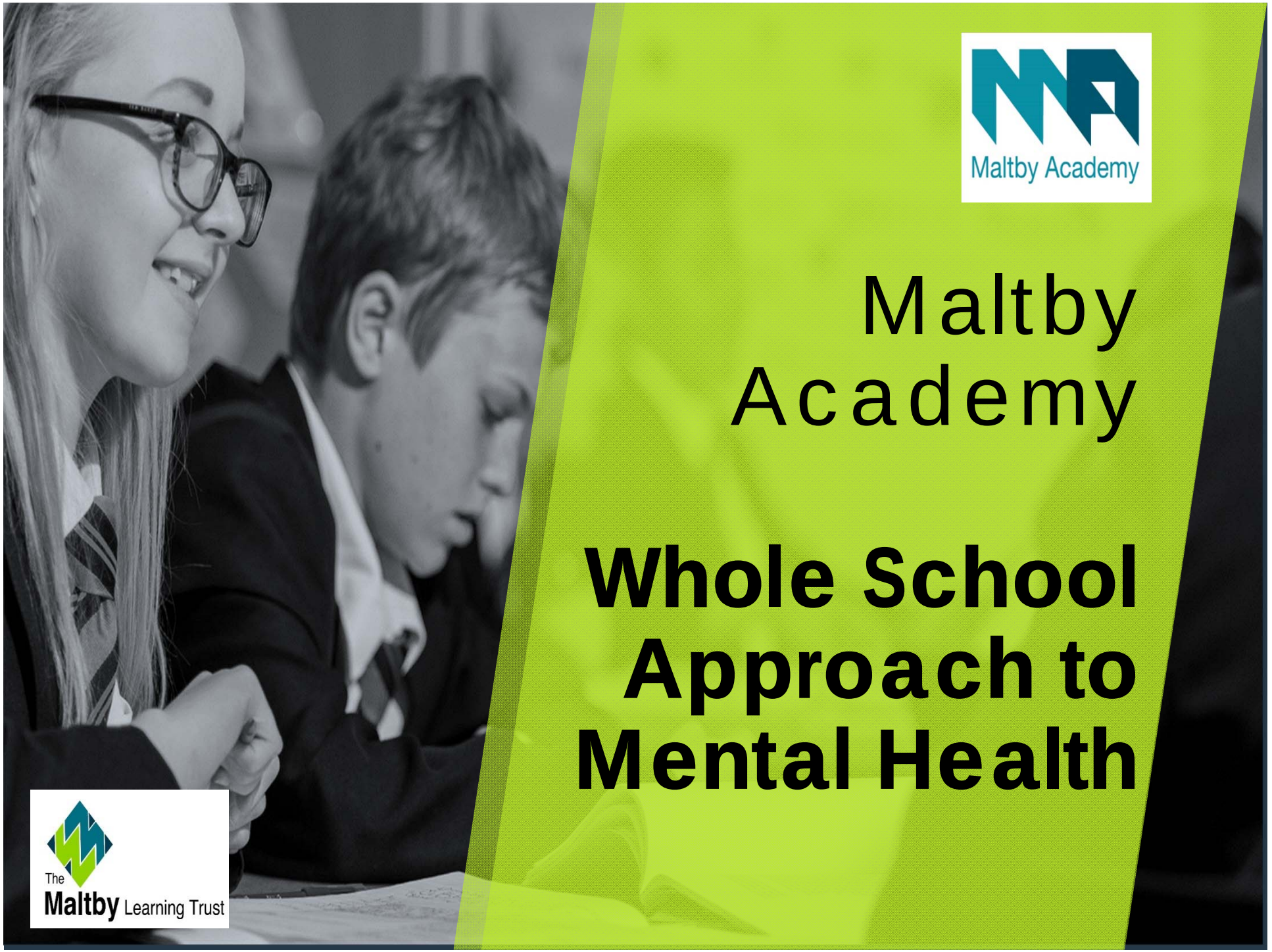
'Evidence shows that interventions taking a whole school approach to wellbeing have a positive impact in relation to both physical health and mental wellbeing outcomes, for example, body mass index (BMI), tobacco use and being bullied.'

(Brooks F (2012). Life stage: School Years. In: Annual Report of the Chief Medical Officer 2012. Our Children Deserve Better: Prevention Pays, London: Department of Health.

What we did

- Funding from CAMHS Local Transformation Fund for 1 school year 2016/2017.
- 6 schools piloted this work; Maltby, Newman, Oakwood, Rawmarsh, Wales and Wingfield.
- Each school looked at the 8 principles and benchmarked themselves against these.
- They took as a minimum 2 areas to develop into an action plan.
- 1 to1 meetings with the schools and once a term as a whole group.
- Elected Members visited all 6 schools.
- Cllr Cusworth was a member of the whole group meetings.

Let’s hear from the schools…..


Maltby Academy
Maltby Academy
Whole School Approach to Mental Health
The Maltby Learning Trust

OBJECTIVES

1. Staff development
2. Leadership and management
3. Working with parents/carers and local communities


PARTNERSHIP WORKING
MALTBY PARTNERS:
CRAGS COMMUNITY SCHOOL
FULL LIFE CHURCH
LOCALITY:
EARLY HELP
CAMHS
MALTBY LEARNING TRUST ACADEMIES
MALTBY ACADEMY

STAFF DEVELOPMENT: PASTORAL NETWORK

- Information sharing between schools on specialist areas of knowledge (eg attachment)
- Input from external providers including Virtual School a… School
- Early transition planning for Year 5's with mental health difficulties
- Input and information sharing with Early Help and CA…
- Access to Restorative Practice training

LEADERSHIP & MANAGEMENT: STAFF TRAINING AND WELLBEING

- 6 staff wellbeing sessions delivered
- New training material developed including therapeutic techniques to work creatively with children and mindfulness activities
- Further 24 training sessions delivered ranging from 1 hour to full day; training offered at no cost to MLT schools (attended by majority of ALL staff across 5 schools)

WORKING WITH PARENTS/CARERS & LOCAL COMMUNITY

- Parent workshops: Anxiety and Exam Stress incorporating mindfulness techniques

- Collaboration with Rotherham Foodbank:
  - Maltby Learning Trust schools collaborated with Full Life Church (Maltby) to implement a 'food drive' within each school
  - Identified families received vouchers for 3 food parcels (9 days of food) over the summer holidays as a separate allocation to standard
  - Taking Maltby Academy as an example, the whole staff group took the initiative on board to contribute food items.
  - Students with SEMH needs were the prime organisers, collecting food from collection points in school, keeping of different food items, assisting in the delivery of food to the

SUSTAINABILITY: MOVING FORWARD

- Pastoral Network:
  - Recognised by Senior Leaders as valuable networ
  - Staff released half-termly to attend.
  - CCG/CAMHS and School Inclusion invited to next
  - Offer of supervision continues

- Staff training and wellbeing:
  - Transgender training delivered October 2017 to 150 primary school staff.
  - Consultation continuing on development of Lifeskills Programme in MA across all year groups.
  - Further consideration for Staff Wellbeing including Charter
  - Commitment reflected in Rotherham MAST role descriptions

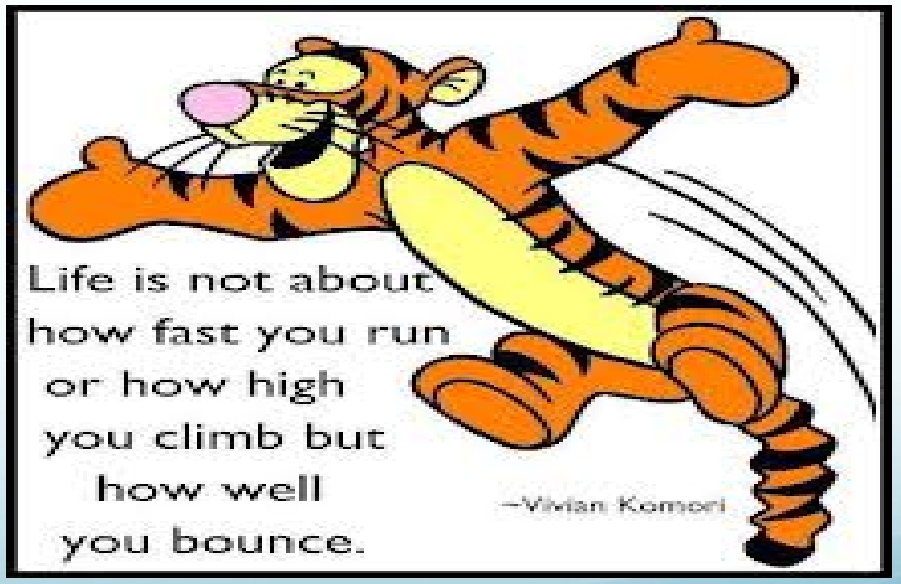
- Intention to link further with Rotherham Foodbank at Full Life

Newman School

A Community Special School

Actions

- To review and improve staff resilience and emotional wellbeing needs in the workplace.
- To review the impact of current emotional resilience interventions and develop the whole school SEMH offer.
- Resilience is :



- Improved support for staff emotional wellbeing and resilience in the workplace

Workplace Wellbeing Charter

Need identified from analysis of whole school staff questionnaire / survey (June 2016)

- Met with Colin Ellis re Workplace Wellbeing Charter. (RMBC Public Health)
- Prioritised as part of the school Developing Excellence Plan (2016-17)
- Attended training (ROSIS) re workplace wellbeing

Impact

- Walking and running group established – all welcome .
- Whole School social events – all welcome.
- Wow board (Corridor display) – celebrating the achievements and contributions of all staff.
- Publications/posters and advice available to staff – dedicated staff room board and dedicated e folder on the Staff Drive.
- Healthy eating week – staff involved in whole school approach and ethos.
- Staff signposted to RMBC counselling and counselling available in school if required.
- Staff choir (with Nordorff Robbins Music Therapist)

Workplace Wellbeing Charter

- Improved support for staff emotional wellbeing and resilience in the workplace

- All standards are now met at **‘ Commitment Level ‘.**
- Staff will readily approach HR Lead and Lead SEMH teacher for support advice re workplace wellbeing.
- Newman School will achieve the Charter at Commitment level (December 2017) and will continue to measure and action approaches to support workplace wellbeing (Annual questionnaire – Governors)

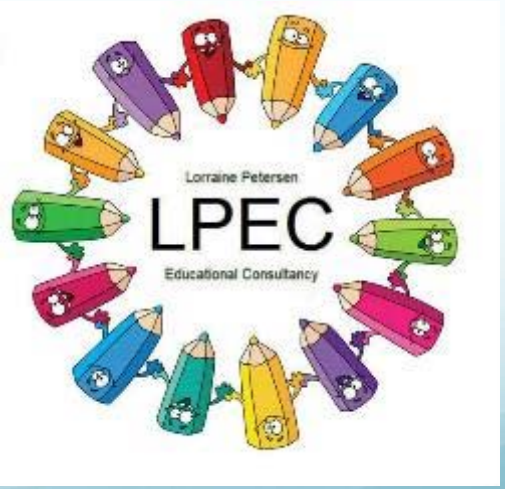
Supporting pupil mental health at

January 2016

- For children and young people, the prevalence rate of mental health problems is 36% in children and adolescents with learning disabilities. (Source : Mental Health Foundation)
- There are 41 (approximately one third) pupils throughout school who have been identified through our SEMH referral system as having mental health concerns : anxiety, depression, eating disorders, conduct disorders and self harm / suicidal thoughts.
- Action 2 : To review the impact of current emotional resilience interventions and develop the whole school SEMH offer.

Impact if not addressed

- Pupils lack motivation and commitment to learning
- Pupils have low self-esteem and self confidence
- Absenteeism
- Disruption
- Challenging/withdrawn behaviours
- Limited or no progress
- Exclusion
- Negative life chances and opportunities
- Leads to more severe and long term mental illness
- Communication break-down
- Staff have increased stress
- Unable to teach effectively
- Sickness and absence increases
- Recruitment and retention issues



Newman School
SEMH referral pathway (November 2016)

Universal services available to all pupils :

- Whole school ethos supports a nurturing approach for all students : small classes and supportive relationships within class groups. Curriculum – PSHE / Circle time. Life skills.
- Staff will identify any students who present with any SEMH concerns to class teacher. Form teacher will complete referral and forward to SEMH lead teacher. (S Kulmer (NMS) / M Cocksedge (NAR))
- Issue identified : shared with parent/carer. SLT informed. Individual pupil action plan (TAMHS) in place or signposted/referred to external support services.
- Action plan and impact shared with class staff teams/whole school/at Annual review.

TAMHS (Targeted Mental Health Support) and CAMHS (Child and Adolescent Mental Health Support)
SEMH Lead to Action plan.

Rainbows	Bespoke timetables /	Family support	ReNew / Myself (self esteem/emotional resilience)	Anger management	Counselling	Sensory Integration	Social group	Music therapy	Inclusion/behavior support	1:1 short term work with EP

Newman School
SEMH referral pathway (November 2016)

Issue resolved/managed
Coping strategies in place : information provided on how to access support in the future

Problem escalating

Any professional/parent or carer :	School :
• Refer to RDaSH CAMHS (GP) • Appointment with CaMHS Dr. • Therapy at home/community. • Hospital admission. • Transition to adult services/peer support worker.	• Referral to SEMH Lead (TAMHS/CAMHS in school) • EHC plan review meeting. • Early Help (Targeted family support) T Smith / L Travis • Liaison meeting with T wileman (LD CAMHS)

Issue resolved/managed
Coping strategies in place : information provided on how to access support in the future

Actions

To review the impact of current emotional resilience interventions and develop the whole school SEMH offer.

- Research with York University (Dr Poppy Nash – School of Psychology)
- Developed an Emotional Resilience Intervention (ReNew)

- The Research project had academic integrity and was successful in developing emotional resilience in participants.
- Counsellor appointed for one year initially (one day per week).
- Attachment Lead training (2 staff).

SEMH case study 2016

Pupil details

Year Group : 11

Gender : Female

Barriers to learning : Anxiety. Emotional wellbeing.

Background

Pupil joined the sixth form in September 2015 from local MLD school.

Starting point

January 2016 - Pupil was becoming very anxious and withdrawn upon arrival at school. Poor engagement in learning and wanting to withdraw from lessons. Isolated from peers.

Actions taken by the school

January 2016 - Pupil started the day being met by Key adult (CH) from her tutor group and she was accompanied to the Our Space (Nurture provision. She was also invited to come at break times. Pupil then developed trusting relationships with the OS team(SD / JM).

May 2016 – Pupil would make her own way to OS and remained until the start of school lessons at 9.40. Pupil would also visit OS during some breaks – she was encouraged to go into the playground with OS staff where she was encouraged to participate in social activities with peers with the support of OS staff.

September 2016 - Counselling – 7 week intervention with Counsellor.

Outcomes

September 2016 - Pupil engaged in relaxation activities within Our Space and accepted the opportunity to discuss concerns with the staff in Our Space. Key staff member form the tutor group was also present. The Key staff member from her tutor group withdrew support slowly and the pupil was encouraged to become increasingly independent - to make her own way to OS at the start of the day and during breaks. She made her own personalized display in Our Space and visited daily before the start of lessons and would join the group of other students during break time.

November 2016 – Pupil is now fully engaged in teaching and learning in main school. She now starts the day in her tutor group with her peers. Happy upon entering school and has a consistent friendship group – pupil links arms and chats with her peers and will chat openly to trusted staff within her tutor group and occasionally seeks out the OS staff.

Pupil engaged very well with the counselling sessions where she was able to engage in practical thrive activities with the counsellor which afforded opportunities for discussion and the development of strategies to reduce anxiety and stress.

There is SDQ baseline and post intervention monitoring (MAST provided a positive impact report July 2017.)

Impact

- Teaching and Associate staff have received training on Attachment, developing resilience (York University), training from MAST (supporting mental health).
- All pupils have equable access to SEMH support (using a graduated approach) – as defined in Newman's SEMH referral pathway.
- Fully trained counsellor appointed and fully utilised, positive impact on pupil mental health.
- Whole school SEMH policy.

Sustainability

- Middle Leader and Senior Leader to become Specialist Leaders in Education (SEMH focus) – aim is for the SLE to support leaders in other RMBC schools to develop a whole school approach to SEMH. The actions undertaken through the project has facilitated lead staff to gain confidence and professional knowledge of the impact of current emotional resilience interventions and the development of the whole school SEMH offer as an approach to promoting positive mental health.

- Continuation of Attachment Lead work – further training to whole staff and embedding practice to promote attachment friendly practice through school.Action research project.

- Counsellor appointed for one more year (considering training own staff in counselling skills).

- Further development and use of a whole school graduated response to SEMH – improvement of analysis of attendance and behaviour data.

Emotional Health and Wellbeing: Developing a whole school approach.

What Oakwood High School did

Focus

- Audit of need:
  - **Staff development** to support their own wellbeing and that of students
  - **Identifying need and monitoring** impact of interventions
  - **Targeted support** and appropriate referral

Initial steps

- Use of outside partners – EPS
- EPS training delivered to whole staff – raising awareness of mental health, wellbeing and resilience
- Developing a system to RAG pupils
  - Extensive research
  - Tools to support

Why we developed a screening tool

- To gain a “snapshot” of pupil wellbeing
- To find a way of gathering pupil voice regarding their wellbeing
- To highlight pupils who may be “under the radar” and need support
- To be able to plan and deliver effective interventions that address pupils’ needs
- To be able to look at trends and patterns across year groups

Why we used SDQ

- Extensive research into wellbeing tools; many used qualitative methods and would take a long time to analyse
- Strengths and Difficulties Questionnaire (SDQ) is a recognised tool, used by CAMHS, Health etc.
- Using Survey Monkey, SDQ could be completed on pupils' ipads
- Numerical responses could be analysed using Microsoft Excel

- Tested the SDQ on staff
- Rolled out to Y9 via email – prepped PLTs
- Analysis of SDQ and identification
- Allocated staff to pupils and interventions based on the 4 areas of need
- Devised entry and exit questionnaires (impact)
- Resources sourced and distributed
- Interventions began at tutor time

Impact

- Interventions ran
- Learning curve – skill set? Confidence?
- Sustainability?
- Drop in tutor session
- Identified a group of pupils – pro social – pupil voice

Staff Wellbeing

- Input from EPS on staff wellbeing
- Identified a core group
- Established a working party
- Small changes that have a big impact
- To look at the workplace charter
- Created an action plan

Promoting Staff Wellbeing: Ideas and comments 13.12.2017

Communicating a sense of value

- Appraisals- this is positive/effective for some and not others
- Morning meetings
- Genuinely ask how something is
- Compliment appearance
- Say thank you for something that is not publicly acknowledged
- Make time for someone

Creating a positive working environment

- Celebrate difference- colour, individuality, creativity in displays- not corporate approach
- To be able to leave something and not get shouted at
- More emphasis on "fun" AND/OR: Positivity Day- not enforced fun
- We already: step up & support each other
- Accessible toilets
- Consider language used around "problems": change mindset, reframing

Promoting healthy work habits and self-beliefs

- Involvement in the union
- Celebrating individuality- how?
- Regular breaks
- Set working hours- no work at home

Making workloads manageable

- Review policies- SLT, Governors, union
- Introducing new policies
- Making time for changes- if you get something wrong it's fine.
- What is actually "reasonable"?

Promoting a work-life balance

"Leave work at work"

Supporting the mental health of staff

- Have supportive line managers
- Clear supervisory channels
- Allow staff to be more open about how they are feeling- positive or negative
- Quality counselling available
- Solution focused meetings

Promoting Staff Wellbeing: Action Plan January 2017

Communicating a sense of value

Appraisals: Do these need to be reviewed- in terms of how they are delivered, who by, when, they content- so they can be a genuine opportunity for staff to talk about positives/ negatives/ goals/concerns etc.?

Promoting positivity: How can etiquette/ emotional literacy be modelled and promoted? – Wellbeing posters/ weekly challenge/ celebrating colleagues' achievements / recognition of effort (how could staff complement each other- small awards/ peer coaching/ emails/ postcards?)

Creating a positive working environment

- **Individuality vs corporate identity:** Can the concerns re. Corporate displays be raised with SLT? Can non-negotiables be discussed whilst allowing creativity in depts.?
- **Positivity Day:** Develop as an event to promote good MH and wellbeing? Posters, literature in staff rooms, embedded across school (staff and students)
- **Language used**: Could this be developed into the wellbeing policy and modelled by Inclusion Team/SLT/HoH ?
- **Toilets/ staff room**: Continue to review/ include in staff wellbeing audit (to share with SLT) to look at environmental factors

Promoting healthy work habits and self-beliefs

- **Unions Reps:** Actively promote membership and involvement
- **Working hours/ expectations:** Does this need to be addressed in a staff wellbeing policy? Look at literature from unions/ good practice from other schools/ discuss with SLT
- **Regular breaks**: How can this be promoted/ embedded in practice? How can we ensure colleagues have dinner?
- **Celebrating individuality**: Relates to points raised on Value and Positive environment sections

Making workloads manageable

- **Review policies**: Consider usefulness of staff wellbeing policy- as part of a whole school wellbeing policy??
- **How policies are communicated to staff:** Work with SLT to help them to communicate change effectively, but sensitively/ realistically to meet staff needs/ anxieties

Promoting a work-life balance

- **"Leave work at work"**: Could strategies for doing this be discussed in working parties? Or gathered through staff wellbeing audit? Advice provided as flyers for staff/endorsed by SLT?
- **Promoting wellbeing at home / out of work:** How can colleagues be encouraged to look after their own wellbeing? Posters/literature/ information about sports/clubs/ things to try. Would staff welcome organised events to socialise with each other? Use staff wellbeing audit to find out?

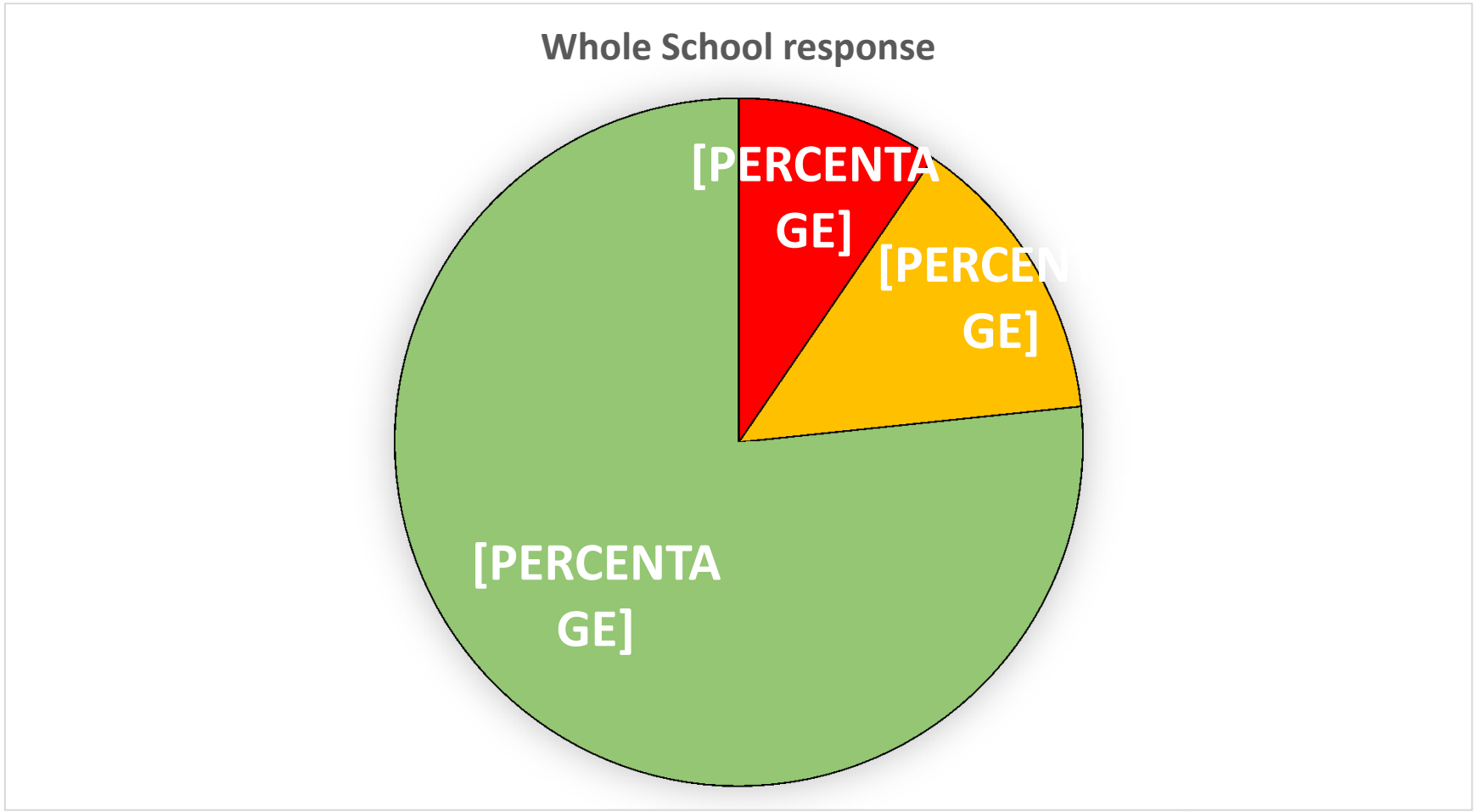
Supporting the mental health of staff

- **Line Managers/ supervision:** Do these systems need to be reviewed (in terms of effective relationships/ expectations of roles) - assess with staff audit? Share literature on how to support staff MH with Line Managers
- **Group supervision/solution gr'ps:** Could introduce/ EP to model?
- **Feedback from staff:** When and how can staff voice their feelings? Gather through staff wellbeing audit
- **Signposting for self-help:** Share details of contacts/signposting with staff

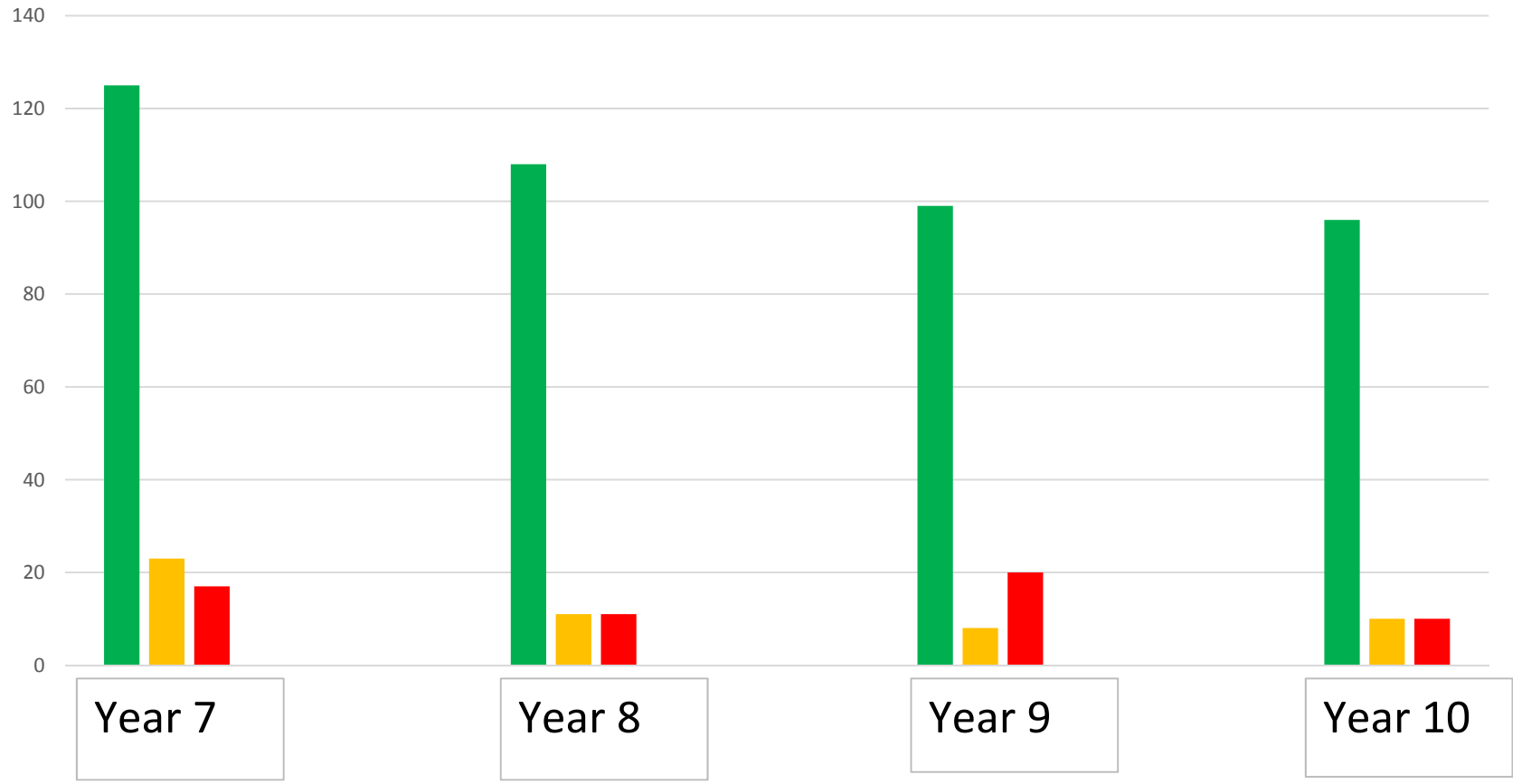
and then…..

- EHWB week – 24th April 2017
  - Assembly, tutor activity, SDQ to all year groups
    - To allow a snap shot
- Analysed the main themes

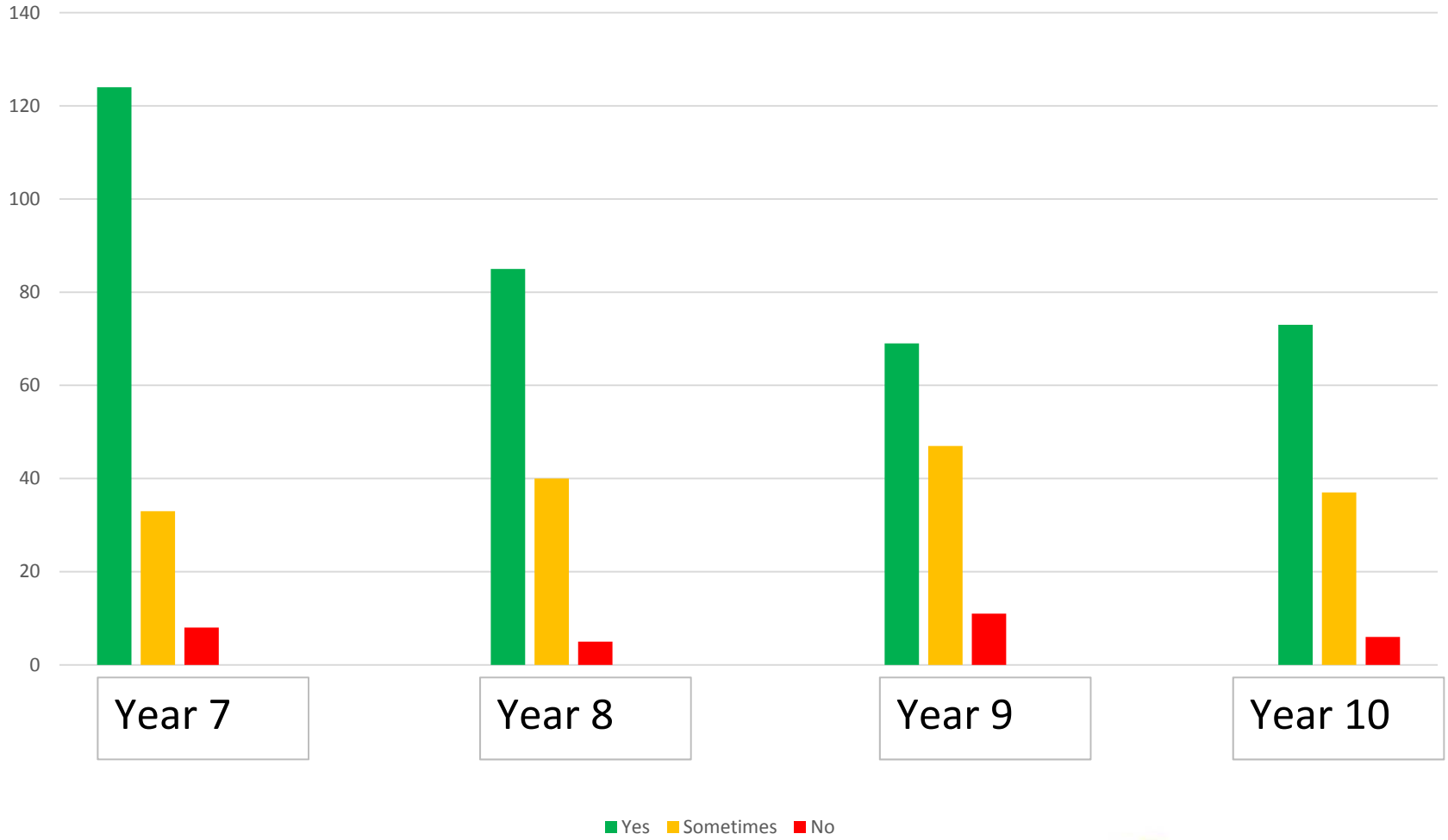
Results:



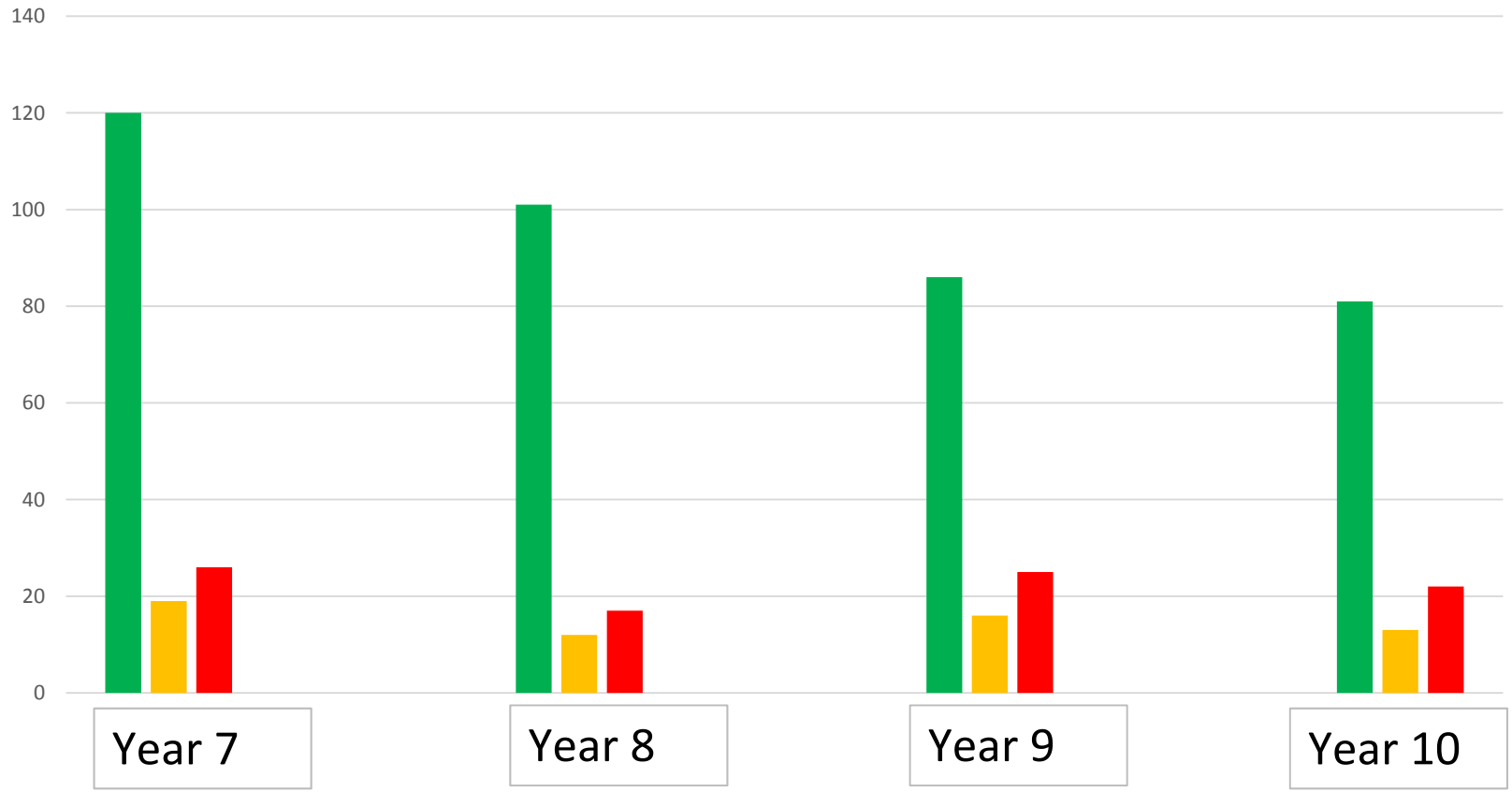
Emotional



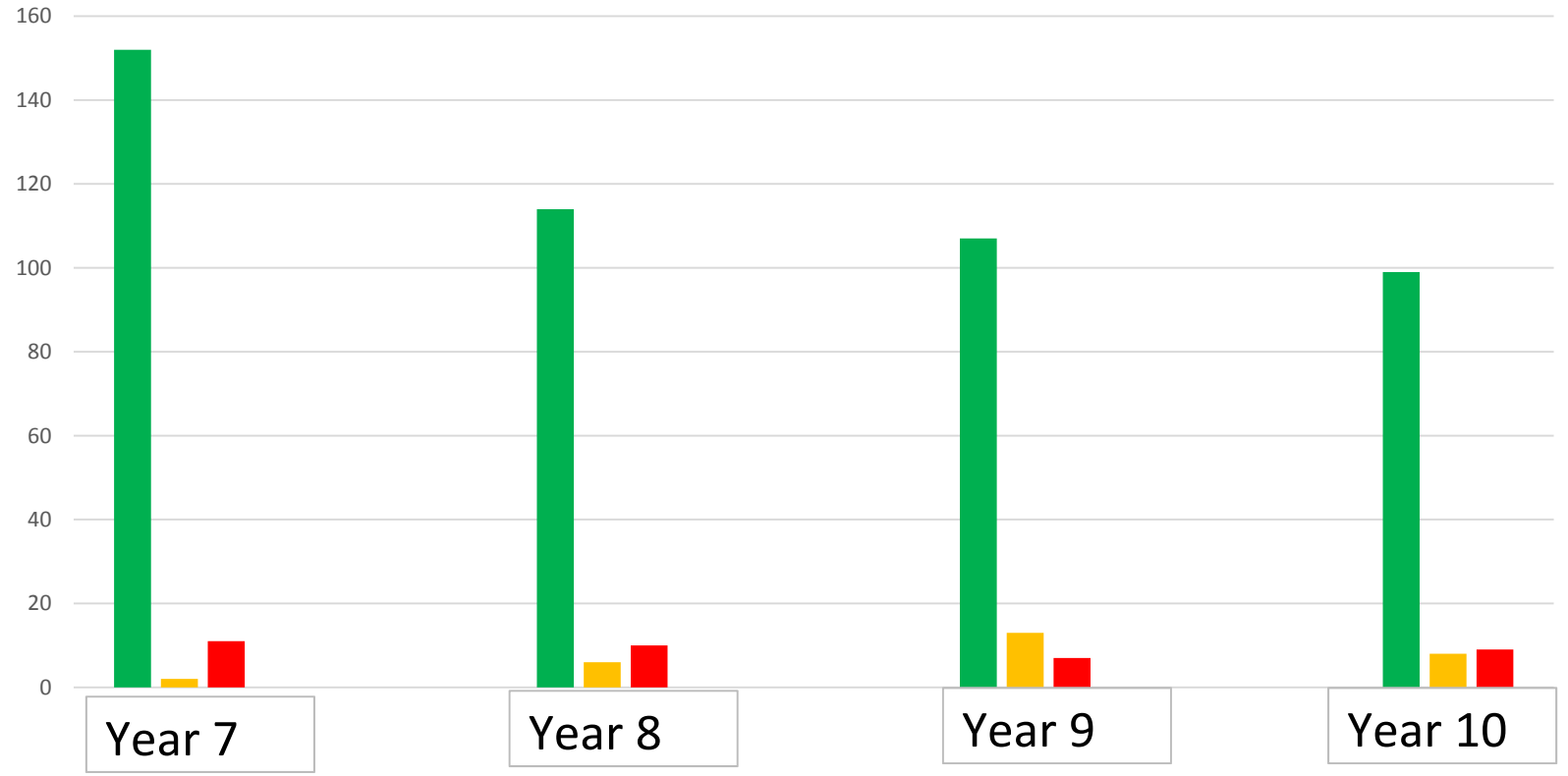
Talk to…?


140
120
100
80
60
40
20
0
Year 7
Year 8
Year 9
Year 10
Yes
Sometimes
No

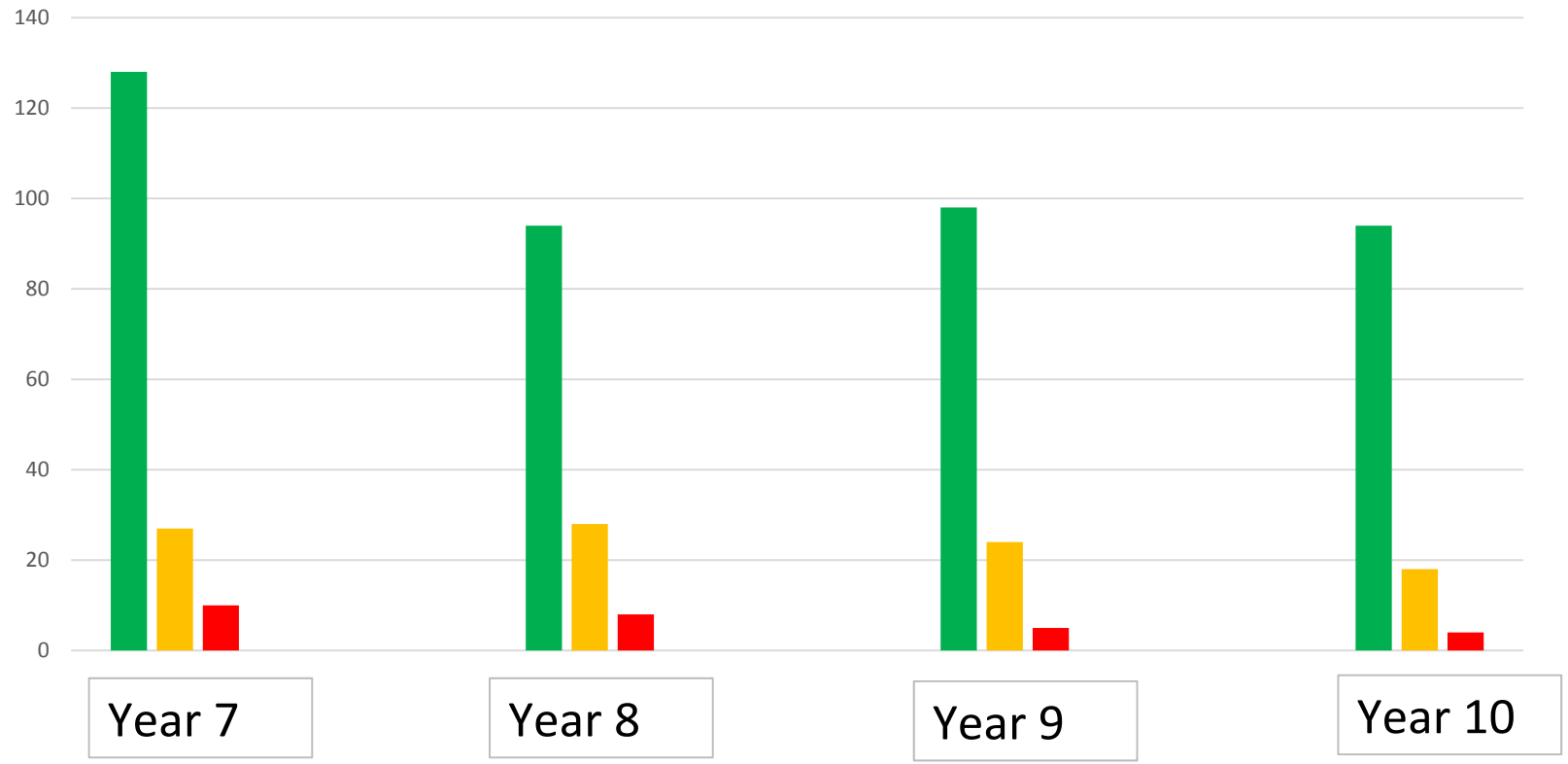
Hyperactivity



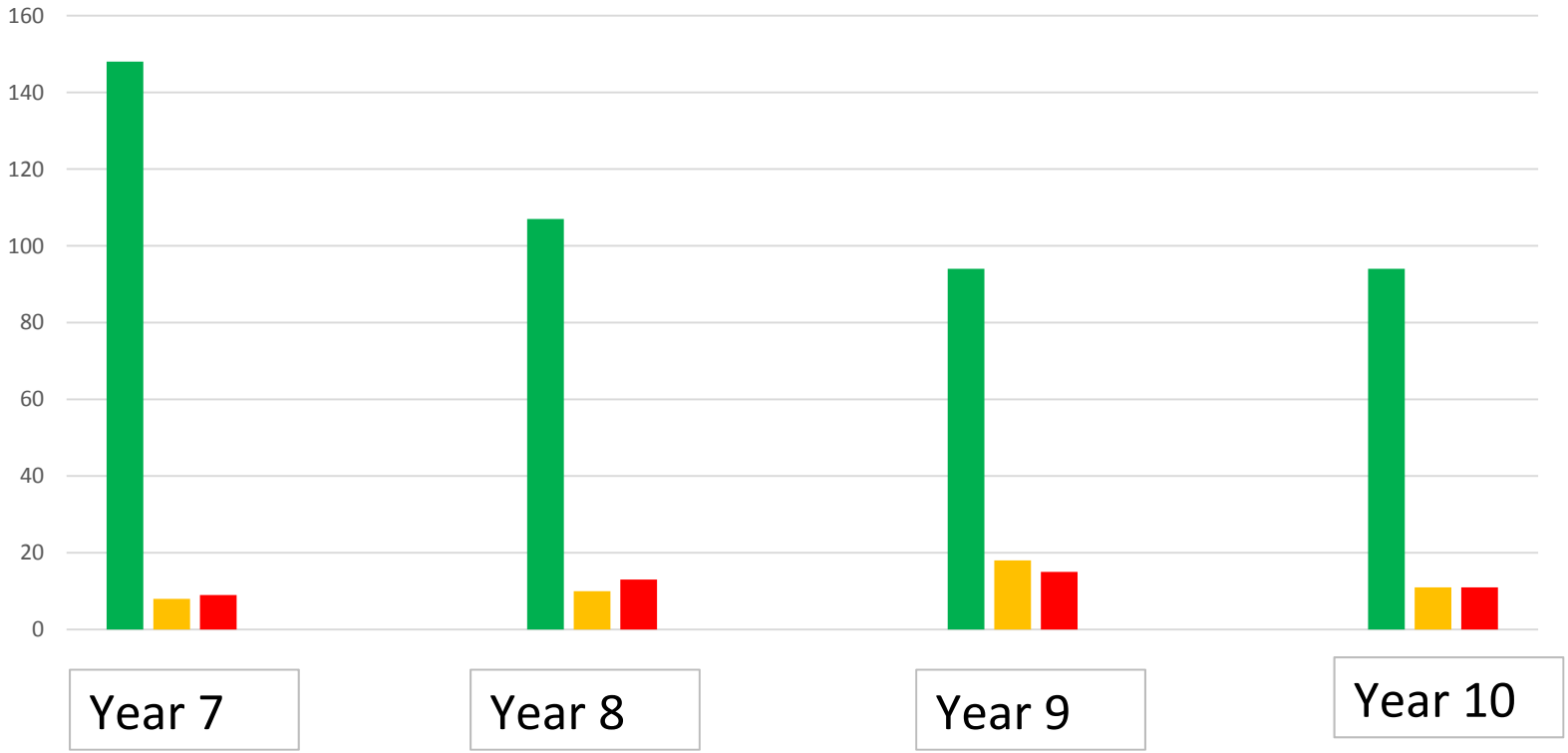
Conduct



Peer Problems



Prosocial



Now what?

- Process of creating whole school strategies for each red group – handbook
- Tutor based activities to back up and support
- Pupil voice work with pro social group to highlight issues to feed into strategies
- Y7 to complete the SDQ
- Audit of staff – snap shot of their EHWB

Sustainability

- EHWB week every year to coincide with WMHD
- #HelloYellow
- Identification of key pupils who want to be ambassadors

Sustainability

- Drop in Tutor time session – direct pupils there
- Small things that make a big difference
- Work spaces
- Subliminal messages
- Making staff aware of where they can access support

Rotherham Metropolitan Borough Council

Public Report
Health Select Commission

Summary Sheet

Committee Name and Date of Committee Meeting

Health Select Commission – 26 October 2017

Report Title

Response to Scrutiny Review: Child and Adolescent Mental Health Services – monitoring of progress

Is this a Key Decision and has it been included on the Forward Plan?

This is not a key decision

Strategic Director Approving Submission of the Report

Ian Thomas, Strategic Director, Children & Young People's Services

Report Author(s)

Beki McAlister, Commissioning Manager, Children and Young People's Service

Ward(s) Affected

All Wards

Summary

This report provides an update against the recommendations the Scrutiny Review of Child and Adolescent Mental Health Services (CAMHS) in December 2015.

The principal focus of the review was Rotherham Doncaster and South Humber (RDaSH) NHS Trust CAMHS, however, the review acknowledged that these services are not provided in isolation but are part of a complex system of service commissioning and provision.

The update focusses on:

- The impact of the single point of access;
- The impact of locality working;
- Training and Development for the wider CAMHS workforce;
- Performance Monitoring and outcomes;
- Waiting times; and
- Transitions

Recommendations

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

List of Appendices Included

Appendix 1 – Update on Child and Adolescent Mental Health Services – Key Themes (October 2017)

Background Papers

Scrutiny Review report and appendices
Minutes from HSC meetings in October 2016 and March 2017.

Consideration by any other Council Committee, Scrutiny or Advisory Panel

The Overview and Scrutiny Management Board at its meeting on 11th December 2015 delegated the ongoing monitoring of the Scrutiny Review to the Health Select Commission.

Council Approval Required

No

Exempt from the Press and Public

No

Response to Scrutiny Review: Child and Adolescent Mental Health Services – monitoring of progress

1. Recommendations

1.1 That the monitoring of progress against the responses to the Scrutiny Review of Child and Adolescent Mental Health Services be noted and discussed.

2. Background

2.1 In December 2015 the Overview and Scrutiny Management Board noted the main findings and made recommendations of the Scrutiny Review of Rotherham, Doncaster and South Humber NHS Trust (RDaSH) Child and Adolescent Mental Health Services (CAMHS).

2.2 The Overview and Scrutiny Management Board delegated the monitoring of progress against the recommendations to the Health Select Commission. The Health Select Commission considered progress against the 12 recommendations of the Scrutiny Review in October 2016 and in March 2017. This report provides progress against six key themes agreed for future updates.

2.3 The recommendations of the Scrutiny Review 2015 were incorporated into the Rotherham CAMHS Transformation Plan (known as the Local Transformation Plan or LTP) - as the local response to NHS England's Future in Mind Report. The LTP was approved by the Chair and Vice-Chair of Health and Wellbeing Board on 14 October 2015 and the refreshed LTP was approved on 28 October 2016. The annual refresh of the LTP is due for completion at the end of October 2017.

3. Key Issues

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

3.2 The principal focus of the Scrutiny Review was RDaSH CAMHS, however the review acknowledged that these services are not provided in isolation but are part of a complex system of service commissioning and provision. The six key themes included in this update have an impact on this wider system.

4. Options considered and recommended proposal

4.1 An update against the six key themes agreed by the Health Select Commission is provided at Appendix 1. In summary:

- Impact of the CAMHS Single Point of Access – The CAMHS Single Point of Access is now well established. Integration with the Early Help Single Point of Access was agreed in 2016 and began a pilot phase in 2017, however there was delay in progressing this work as a result of changes to management within CAMHS. As a result of the new management arrangements in place

within CAMHS the Single Point of Access has now been revisited alongside Early Help and the work is progressing positively. Strategic discussions are underway to enhance integrated working with the Early Help single point of access.

- Impact of CAMHS Locality Working – there is now an established and active presence in local communities. Feedback is now regularly sought to evaluate and improve the locality approach.

- Training and Development for the wider CAMHS workforce – Strategic links are being made within RMBC and pilot work has commenced with Yorkshire & Humber Clinical Network around a competency framework for school based staff.

- Performance Monitoring and Outcomes – The CCG is undertaking an annual baseline data collection to inform the October re-fresh of the LTP and feed into the Joint Strategic Needs Assessment (JSNA). RDaSH are implementing a new electronic records system that will improve reporting against outcomes.

- A CAMHS Section 75 Agreement will commence from 1st November 2017. The agreement between Rotherham Metropolitan Borough Council and Rotherham Clinical Commissioning Group (CCG) will strengthen joint performance management and measurement of outcomes linked to the delivery of the LTP.

- Waiting Times – Improvement on all key performance indicators in August 2017 compared to March 2017.

- Transitions – transition events are being planned with the Different But Equal Board (facilitated by Voluntary Action Rotherham), within RDaSH there are monthly transitions meetings between CAMHS and adult mental health services.

5. Consultation

5.1 Evidence gathering as part of the Scrutiny review comprised of presentations, round table discussion and written evidence from health partners, RMBC officers, Rotherham Youth Cabinet and desktop research.

6. Timetable and Accountability for Implementing this Decision

6.1 It is anticipated that once the report has been noted and discussed by the Health Select Commission, the recommendations will continue to be taken forward within the timescales outlined and further progress updates will be made to the Health Select Commission.

6.2 The CAMHS Partnership Group is accountable for delivering the LTP and the Scrutiny Review recommendations. The Partnership Group draws together commissioners, providers of mental health services for children and young people and other key stakeholders to deliver the LTP and improve outcomes.

6.3 The LTP is updated every 2 months, a full appraisal is undertaken every 6 months. There is also an annual re-fresh and quarterly update to NHS England. The LTP will be published on NHS Rotherham CCG website to ensure transparency and accountability.

7. Financial and Procurement Implications

7.1 The financial implications of implementing the Scrutiny review recommendations have been met through monies made available by NHS England to implement the CAMHS Transformation Plan and through the re-allocation of existing resources by RDASH as part of their service reconfiguration.

8. Legal Implications

8.1 There are no identified legal implications.

9. Human Resources Implications

9.1 There are no identified human resource implications.

10. Implications for Children and Young People and Vulnerable Adults

10.1 The Scrutiny review recommendations aim to impact positively on children and young people, through enhancing current mental health service provision.

11 Equalities and Human Rights Implications

11.1 There are no negative impacts identified as a consequence of taking forward the recommendations identified within this report. The recommendations will bring about a positive contribution to promoting equality through improving access into mental health provision from disadvantaged and vulnerable groups.

12. Implications for Partners and Other Directorates

12.1 The recommendations arising from the Scrutiny Review have implications for RMBC, Rotherham Clinical Commissioning Group and RDASH CAMHS. These responsibilities are outlined within Appendix 1.

13. Risks and Mitigations

13.1 Accessible and high quality mental health care is essential for children and young people in all parts of the borough to achieve improved health outcomes and reduced health inequalities for our community.

13.2 The consequences of poor mental health are well documented and include poorer academic achievements, face higher unemployment, premature morbidity and long term physical and mental health problems.

13.3 Commissioners and providers across the whole system will continue to work together to develop appropriate and bespoke whole care pathways that

incorporate models of effective, evidence based interventions for vulnerable children and young people.

14. Accountable Officer(s)

Approvals Obtained from:-

	Named Officer	Date
Strategic Director of Finance & Customer Services	N/A	
Assistant Director of Legal Services	N/A	
Head of Procurement (if appropriate)	N/A	
Head of Human Resources (if appropriate)	N/A	

Report Author: Beki McAlister, Commissioning Manager

This report is published on the Council's website or can be found at:-

http://moderngov.rotherham.gov.uk/ieDocHome.aspx?Categories=

Appendix 1 **Update on Child and Adolescent Mental Health Services – Key Themes (October 2017)**

	Theme and Context	Position at last update in March 2017	Progress October 2017
1	**Impact of Single Point of Access (SPA)** *Developing a SPA was part of the response to the original scrutiny review recommendation, which was:* *RDaSH should review and evaluate the recent changes made to the CAMHS Duty Team to identify successes and any areas for further improvement.* *The SPA also links in with the wider strategic intention to focus on prevention and early intervention.*	The SPA receives all referrals and triages for urgency on the same day and is available as a point of contact for anyone to ring with any concerns. Self- referral is still in place. CAMHS pathways have changed since the development of the SPA, enabling smoother access. RDaSH workers work alongside Early Help triage. Schools/other workers can refer young people to the SPA, where they have a more holistic assessment of their needs. Locality Workers see children at an earlier stage and the children are going in to RDaSH CAMHS who meet their criteria, with others getting earlier support through Early Help. An impact had been seen with Early Help, for example, a reduction from 122 people signposted in Quarter 1 to 81 in Quarter 3. Closer working between CAMHS and Early Help services has reduced the number of referrals being inappropriately signposted between the services - reduced from 25 in October to six in January.	The single point of access within RDaSH CAMHS has been well-established, with some in reach into the Early Help point of access. Integration with the Early Help Single Point of Access was agreed in 2016 and began a pilot phase in 2017, however there was delay in progressing this work as a result of changes to management within CAMHS. As a result of the new management arrangements in place within CAMHS the single point of access has now been revisited alongside Early Help and the work is progressing positively. Strategic discussions are underway to enhance integrated working with the Early Help single point of access. The CAMHS SPA attends the Early Help access team twice weekly to discuss referrals across the two areas of service provision. In addition to the SPA in CAMHS, there are established locality workers in each area so there are multiple points of access to advice and support. The single point of access has improved the delivery of advice and consultation to young people, families and universal services.

	Theme and Context	Position at last update in March 2017	Progress October 2017
		The CAMHS SPA Team were spending two days a week within the Early Help Team at Riverside House. Full integration was due to take place by May 2017 and evaluation of effectiveness in Sept 2017.	
2	**Impact of locality working** *The associated original scrutiny review recommendation was:* *Following the work to build links between RDaSH CAMHS and GPs, locality work should now be rolled out by RDaSH into schools, youth centres and other community settings as a priority.*	Locality Teams undertake assessments and brief interventions (6-8 sessions). They liaise with and support other services such as GPs, schools, Early Help, for example supporting schools on techniques and enabling smoother referrals into CAMHS. For the RDASH locality workers, closer working with the local authority means it will be easier to know if other workers are already involved with a family, with the Locality Workers then supporting those other workers, so services are more streamlined. Robust key performance indicators KPIs for locality working are being developed and will be further informed by the evaluation of the Locality Worker Model in May 2017. The model is monitored through RDASH contract monitoring meetings and progress will be further evaluated through consultation with locality based services. (May 2017)	The identified locality workers have developed positive links with the schools and early help colleagues. A GP event held in September supported the primary care understanding of the advice and consultation approach being undertaken more recently. The locality workers are working with individuals within their local community, seeing young people in schools, GP surgeries, homes and wherever young people choose to be seen. Feedback is now regularly taken to evaluate and improve the service. There remain some services delivered from Kimberworth Place as these require either protected therapeutic space or a controlled environment for standardised assessment and interventions. The CAMHS locality staff and service pathway leads were actively engaged in World Mental Health day, Rotherham show and other events in order to raise the awareness of the CAMHS service, how to access and provide some self- help information and materials for young people. There is a new Children's Well-being Practitioner

	Theme and Context	Position at last update in March 2017	Progress October 2017
			(CWP) role supported via the CCG. The two posts are currently training posts and they will complete this in April 2018. The roles are specifically to work with young people who are experiencing mild to moderate anxiety and depression. It is anticipated that these CWP staff will engage with young people in the local communities and develop some group work and further self-help guidance and support.
3	**Training and development for staff across the wider CAMHS workforce** *This wider training was part of the response to the original scrutiny review recommendation, which was:* *RDaSH training and awareness raising with partner agencies and schools should include a focus on improving the quality of information provided in referrals to RDaSH CAMHS Duty Team to reduce delays in making an assessment.*	CAMHS Top Tips reviewed and changed as necessary. Regular meetings held within localities with schools, early help etc. and invitations for GPs to have meetings with locality staff. Training sessions run by RDaSH CAMHS, including to school nurses, Early Help, SENCO meetings to present the current service and pathways, how to access etc. Plus individual consultation sessions arranged within localities. An initial framework for workforce development was shared with the CAMHS Partnership Group. At the same time NHS England, North (Yorkshire & the Humber) started leading on a Schools Competency Framework for mental health and emotional wellbeing. Staff from Rotherham are inputting into this framework. It is envisaged that this Y&H competency	Mapping of current training provision is and feedback will go to the January 2018 CAMHS Strategic Partnership meeting. Links are being made with the Rotherham's Children and Young People's Partnership Workforce and Development Sub-group and the work they are doing around identifying appropriate skills and training for the workforce. Safe Talk (Suicide prevention) training sessions were held in March 2017 these were primarily aimed at those working/caring for young people. Referral Guidance for universal services seeking support on emotional well-being (Universal Tops Tips) has been welcomed by services and is due for renewal at the end of 2017. Wales High School is a pilot school for the Yorkshire & Humber Clinical Network 'In It Together'- A Social Emotional Mental Health Competency Framework for Staff Working in Education. The framework itself is

	Theme and Context	Position at last update in March 2017	Progress October 2017
		framework will have three tiers of skills; a core/universal level followed by a more intermediate level and a third level enhanced level. These levels would apply to staff in early years settings, schools and colleges. The timescale is to produce a framework for launching with schools by September 2017. The Rotherham framework will incorporate this Y&H framework, extending it to cover the wider CAMHS workforce.	comprised of four components: • Groups of competencies: core, enhanced and targeted • Suggestions of staff roles for whom each group of competencies is most likely to be relevant • A self-assessment tool • Suggested training options to gain the needed skills and knowledge There have been a number of sessions offered to Early Help, schools (SENCOs etc), GP events etc to raise the awareness of RDaSH CAMHS services, how to access and promote the locality working model. In addition to the awareness-raising of the services, there has been opportunity to deliver some localised training packages to individual organisations when there are specific requests. The advice and consultation approach to locality working is also supporting the understanding and knowledge of universal services around mental health issues, interventions and presentations on a case by case basis personalised discussion.
4a	**Performance Management Information – performance framework**	February 2017 - common performance framework developed for the full mental health system, which includes counselling in schools and Early Help counselling (formerly Youthstart) as well as RDaSH. Framework also meets national reporting	Following the update in March 2017, the performance framework was tested with wider mental health service providers in line with agreed timescales. However feedback suggested it would be difficult to implement in its current form.

	Theme and Context	Position at last update in March 2017	Progress October 2017
	The original scrutiny review recommendation was: *Through the CAMHS Strategy & Partnership Group service commissioners and providers should work towards improved and standardised data collection and information sharing on their service users and patients:* - *to help maintain a detailed local data profile of C&YP's mental health over time* - *to strengthen the C&YP's section of the Joint Strategic Needs Assessment*	requirements. Standardised data gathered covers numbers of contacts, caseloads and referrals, plus waiting times and interventions. Individual services collect data on demographics and geography and moving forward that information needed to be gathered. March - July 2017 Framework tested with mental health service providers, to inform any further enhancements. It will enable a deeper understanding of the support and specific interventions that C&YP are accessing - in schools, the community and within the CAMHS treatment service. This will drive the enhancement of service quality across the whole mental health system and help to ensure that C&YP are accessing the most appropriate advice, support and treatment.	The Performance Framework was reviewed and re-designed following feedback from service providers in September 2017. It was sent then out to providers to report against on a quarterly basis; however, further feedback from services providers suggested reporting requirements are not feasible. The CCG collects annual baseline data from the wider mental health service providers to inform the LTP. Baseline data includes activity/interventions, workforce capacity and investment from schools, early help services, the local authority and third sector based services. This data collection exercise will help inform the LTP October re-fresh and will feed into the on-going development of the JSNA. The lack of comprehensive and detailed data on levels of lower-level mental health need and the risk factors for poor mental health is a recognised national issue - most recently noted in the Children's Commissioners For England Mental Health Briefing October 2017 as a priority for the upcoming Green Paper on Children and Young Peoples Mental Health. A CAMHS Section 75 Agreement will commence from 1st November 2017. The agreement between Rotherham Metropolitan Borough Council and Rotherham Clinical Commissioning Group will strengthen joint performance management and measurement of outcomes.

	Theme and Context	Position at last update in March 2017	Progress October 2017
4b	**Performance Management Information – outcome measures** *The original scrutiny review recommendation was:* *Through the CAMHS Strategy & Partnership Group service commissioners and providers should work towards improved and standardised data collection and information sharing on their service users and patients:* *- to inform the development of local outcome measures for C&YP individually and with regard to reducing health inequalities in Rotherham*	RDASH had met the NHS Commissioning, Quality and Innovation (CQUIN) target of 95% of patients having recorded goals in quarters 1-3 (consistently performing over 95%). Under the CQUIN it was agreed to focus on goal scoring at clinically appropriate times within the 'Locality' and 'Intensive Home Treatment' teams with a view to achieving 95% goal scoring by end of March 2017. In quarter 3 73% patients scored their treatment suggesting they had received a positive outcome from working with CAMHS (up from approximately 60% in Q2). In quarter 3 from a random sample of 50 patients, each of whom had at least one goal, 45 showed an improvement between their first scored goal and their most recently scored goal. The remaining 5 showed maintenance between their first scored goal and their most recently scored goal.	The CAMHS services continue to capture personalised goals for young people, alongside using routine outcome measures. Over 95% of children and young people accessing CAMHS have a personalised goal set relating to interventions being offered by the service alongside a plan of care. The reporting of these goals and the demonstrated outcomes has been difficult with the current electronic records system. RDaSH CAMHS will be moving to a new electronic records system (which is the same system as used by around 60% of the GPs in Rotherham). The new records system will be developed to support the capture and reporting of routine outcome measures in the future.
5	**Waiting time data – assessment and treatment**	Position at March 2017 was: Waiting times for assessment and treatment continue to improve and are	Position at 31 August 2017: CAMHS is continuing to consistently achieve 100% against a target of 100% of appropriate urgent

<table>
<tr><th></th><th>Theme and Context</th><th>Position at last update in March 2017</th><th>Progress October 2017</th></tr>
<tr><td></td><td>The overall purpose of the original scrutiny review was to identify any issues or barriers which impact on children and young people in Rotherham accessing timely and appropriate RDaSH CAMHS services and in particular in having an assessment within three weeks.</td><td>monitored on a weekly basis by commissioners of service. The length of time awaiting ASD and ADHD assessment has significantly reduced.

At the beginning of February 2017 there were no people waiting for more than 10 weeks for initial assessment.

KPI 3 - Consistently achieved 100% against a target of 100% of appropriate urgent referrals assessed within 24 hours

KPI 5 – 31% of triaged referrals were assessed within the CCG stretch target of 3 weeks in January 2017. This is a 4.3% increase from the previous month's position of 26.7%.

When reported against the national 6 weeks target, 60.3% were assessed within 6 weeks in January 2017. The average waiting time is 49.6 days.

The CCG's stretch three week target is a challenging one but remained in 2017-18. Regarding C&YP starting treatment, the local target is 8 weeks but the national target is 18 weeks.</td><td>referrals assessed within 24 hours.

The table below give a summary of performance against the key targets.

<table>
<tr><th>Non-urgent Wait KPIs</th><th>Jun-17</th><th>Jul-17</th><th>Aug-17</th></tr>
<tr><td>% Non-urgent referrals assessed within 3 weeks</td><td>20.7</td><td>23.3</td><td>66.7</td></tr>
<tr><td>% Non-urgent referrals assessed within 6 weeks</td><td>65.5</td><td>70.0</td><td>88.9</td></tr>
</table>

<table>
<tr><th>National Average Wait KPIs</th><th>August</th></tr>
<tr><td>Average waiting time for assessment 6 weeks target</td><td>5.6 weeks</td></tr>
<tr><td>Average wait for treatment 18 weeks target</td><td>8 weeks</td></tr>
</table>

The services continue to be challenged by the high numbers of referrals for ASD assessment, but work continues to evaluate the process of these and ensure that the pathway is running as efficiently as possible.</td></tr>
</table>

	Theme and Context	Position at last update in March 2017	Progress October 2017
6	**Transition from RDaSH CAMHS** (includes transition from children's to adult mental health services if there are ongoing service needs or transition when discharged out of RDaSH CAMHS) *Although the original scrutiny review did not make a specific recommendation it had been recognised nationally as an issue, plus it was covered in one of the recommendations of the Youth Cabinet review.*	Y&H Clinical Network launched a transition toolkit in June 2016 and RDaSH carried out an initial draft scoping against the toolkit which was shared with the CCG. A Transition Policy was developed. A national CQUIN is in place for 2017-19 for transition from CAMHS which aims to improve the experience and outcomes for young people as they transition out of Children and Young People's Mental Health Services. A new transition board was being set up to be chaired by the Director of Adult Services.	There has been a 'Listening into Action' approach taken within RDaSH to explore the transition processes between CAMHS and adult mental health. There are monthly meetings held between the two services to identify those who are due to transition; alongside having a Psychiatrist working into CAMHS from the adult mental health services 1 day per week. RDaSH has recently agreed to fund a temporary post to pilot having a care coordinator who spans the two services (adult and children's) in order to support transition- this post is until the end of March 2018, when it will be evaluated and future plans agreed. LTP funding is being used to undertake 4 'transition raising awareness' events with C&YP through the Different But Equal Board. It was also agreed to look at potential support for the project from RDaSH mental health services, Early Help and the SEND group. The CCG is also working with VAR on a 'Health & Wellbeing' funding bid which may support this work.