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

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| **Date:-** | **Thursday, 18th October, 2018** | **Venue:-** | **Town Hall, Moorgate Street, Rotherham S60 2TH** |
| **Time:-** | **10.00 a.m.** | | |

# HEALTH SELECT COMMISSION AGENDA

1. To determine whether the following items should be considered under the categories suggested in accordance with Part 1 of Schedule 12A (as amended March 2006) of the Local Government Act 1972

2. To determine any item(s) which the Chair is of the opinion should be considered later in the agenda as a matter of urgency

3. Apologies for absence

4. Declarations of Interest

5. Questions from members of the public and the press

6. Minutes of the last meeting (Pages 1 - 13)

7. Communications

## For Discussion

8. Child and Adolescent Mental Health Services Update (Pages 14 - 22)
   Nigel Parkes, Rotherham Clinical Commissioning Group, and Partners to report

9. Social Emotional and Mental Health Strategy - Progress Report (Pages 23 - 48)
   Jenny Lingrell, Children and Young People's Services, to report

10. Health Select Commission Performance Sub-Group Feedback (Pages 49 - 53)

## For Information

11. Healthwatch Rotherham - Issues

12. South Yorkshire, Derbyshire, Nottinghamshire and Wakefield Joint Health Overview and Scrutiny Committee Update (Pages 54 - 107)

13. Health and Wellbeing Board

14. Date and time of next meeting
Thursday, 29th November, 2018, commencing at 10.00 a.m.

## Membership 2018/19

Chairman:- Councillor Evans
Vice-Chairman:- Councillor Short

Councillors Albiston, Andrews, Bird, Cooksey, R. W. Elliott, Ellis, Jarvis, Keenan, Rushforth, Taylor, John Turner, Williams and Wilson.

Co-opted Member:
Robert Parkin (Rotherham Speak Up)

Sharon Kemp.

Chief Executive.

# HEALTH SELECT COMMISSION
## 6th September, 2018

Present:- Councillor Evans (in the Chair); Councillors Andrews, Bird, Cooksey, R. Elliott, Ellis, Jarvis, Rushforth, Short, Taylor, John Turner, Williams and Wilson

Apologies for absence were received from Councillor Albiston and Keenan and Robert Parkin (Speakup). Councillor Roche, Cabinet Member, had also submitted his apologies.

The webcast of the Council Meeting can be viewed at:-
https://rotherham.public-i.tv/core/portal/home

**26. DECLARATIONS OF INTEREST**

Councillor Jarvis made a non-pecuniary Declarations of Interest in relation to Minute No. 33 (The Rotherham Foundation Trust Quality Priorities 2919-20) as she was a Governor of The Trust.

**27. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS**

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

**28. MINUTES OF THE LAST MEETING**

Consideration was given to the minutes of the previous meeting of the Health Select Commission held on 19th July, 2018.

Resolved:- That the minutes of the previous meeting held on 19th July 2018, be approved as a correct record.

Arising from Minute No. 16 (62 day wait for treatment for cancer), the Trust had focussed on addressing this atypical dip in performance and at the quarterly briefing with health partners in July reported that it appeared to be back on track so far in Quarter 2.

Arising from Minute No. 19 (savings from Integrated Sexual Health Service), it was noted that the Chair was to provide feedback to the Overview and Scrutiny Management Board at its 12th September meeting.

Arising from Minute No. 20 (Adult Residential and Nursing Care Homes), all Select Commission members had been emailed the recent “Guide to Residential and Nursing Care for Older People”.

Arising from Minute No. 21 (Health Select Commission Draft Work Programme), it was noted that further work on co-production was taking place on the Autism Strategy so would now be submitted to the Commission later in the year.

It was also noted that Councillor Keenan would be a representative on RDaSH as well as YAS.

## 29. COMMUNICATIONS

There were no communications to report.

## 30. UPDATE ON HEALTH VILLAGE AND IMPLEMENTATION OF INTEGRATED LOCALITY WORKING

Nathan Atkinson, Assistant Director Strategic Commissioning, presented the following 2 powerpoint presentations, the second on behalf of Chris Holt, Director of Strategy and Transformation, TRFT:-

**Health Village – Update on Integrated Working in Rotherham**

Key Activity Under Development

- Integrated Point of Contact – alignment of Single Point of Access (SPA) and Care Coordination Centre (CCC)
- Integrated Discharge Team
- Intermediate Care and Reablement - “Home First” strapline
- Integrated Rapid Response – better triage
- Integrated Care Home Support – Red Bag, End Of Life pilot, named GP, links to Quality Board
- Developing Integrated Pathways as the default

What is Working Well

- Clear priorities and vision, agreed by all partners
- Shared agendas and the ‘right conversations’ taking place
- Governance framework in place
- Momentum building in a number of areas
- Changes happening on the ground (Single Point of Access, Care Co-ordination Centre, Integrated Discharge Teams, Integrated Rapid Response)
- Technology

What are we Worried About

- Balancing (often competing) priorities
- Capacity to deliver – balance of new vs existing
- Engagement, communications and language
- Organisational development across all parties
- Capturing key milestones and measures from a very comprehensive data set across the system

What needs to happen next

- Continue to develop areas of practice where joint outcomes can be achieved
- Develop an Unplanned Care Team
- Focus on Home First and new delivery models

- Preparation as a system for Winter Plan requirements to meet NHS England requirements and applying learning from 2017/18 plan outcomes

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

- There would be a multi-disciplinary team approach in the community as to which professionals would visit a client in their home, rather than a stay in a nursing home, depending upon their individual requirements. The Winter Plan would factor in the issue of capacity as it was quite a sea change. It was acknowledged that there was an element of risk as it was easier to identify a building/number of beds compared to multi-disciplinary teams in the community. Incremental steps were being taken to mitigate having sufficient resources

- Acknowledgement that capacity was an issue and there were challenges in recruitment across Health as well as the independent sector. A key piece of learning from the Health Village pilot was that you could not transform if members of staff came with existing work and caseloads that they could not exit from; a phased approach was required. Healthwatch and similar organisations were key in referring in issues/difficulties in the system

- Capacity was the biggest concern. It was known that there were gaps in the Hospital in terms of staffing and that there were challenges around recruitment. A full complement of staff within staffing budgets to deliver maximum capacity was required, at the hospital and to deliver the new models.

- It was imperative that the key milestones for the implementation of locality working were set and agreed as soon as possible because they had to be held to account and measurable; each organisation had its own particular drivers and finding the crosscutting drivers that were consistent across every piece of the pathway was the challenge

- There was a commitment from the Council and partners to influence the change for integrated working

- With regard to cohesion and coordination between services there was a commitment from the Council and partners to influence the change for integrated working but there was still a way to go. Shadowing and “stepping into other shoes” at all levels helped to build an understanding of other job roles.

- Numbers of readmissions to hospital and reasons for these – statistics to follow

**Progress Report – Locality Working**

What have we learned about Locality Working

- The Health Village Pilot was a great start
- There is evidence of a positive impact on emergency admissions from locality working
- All localities saw an increase of 0.7% in emergency admissions between 2015/16 to 2016/17, excluding the Health Village. The Health Village saw a 2.1% decrease however between these periods
- All localities excluding the Health Village, seeing a 3.5% and 11% increase in 65+ and 85+ respectively. Emergency admissions from the Health Village locality however saw lower increases 1.8% (65+) and 9.5% (85+)

The Emerging Model

- Re-alignment of GP practices across 7 localities
- Localities split into 3 partnerships areas
- Community Nursing working directly into 7 localities
- Adult Social Care and Community Health Teams (including Mental Health) working across 3 partnerships North, Central and South
- Information sharing via Rotherham Health Record
- Integrated Management (Partnership level)
- Integrated MDT approach – some still more virtual at present

What will be different

- Develop a joint culture of prevention – early work has been more reactive and focused on frailty and long term conditions
- 'Blurring' of professional boundaries
- Develop new ways of supporting Primary Care
- Enhanced Social Care Assessment and Care Management
- Management of Long Term Conditions
- Focus on the needs of Physical and Mental Health
- Work into hospital-based services to reduce length of stay
- Improved opportunities for post-discharge follow-up

Timelines and Implementation

0 to 6 Months

- Teams aligned/co-located
- Baselines agreed
- Outcome Framework agree
- Joint caseloads developed
- Ways of working outlined
- Team configuration defined
- Leadership team in place
- 1 Partnership/2-3 localities model 'operational'

6 to 24 Months

- Pooled budget principles agreed
- Outcomes being 'realised'
- Outlying performance addressed

- Transition model (Phase 3) being defined
- 3 Partnerships/7 localities 'operational'

>24 Months

- New models and transition defined
- Organisational alignment clear
- Integration of teams
- Pooled budgets and investment

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

- There were benefits from co-location but there also had to be an understanding of the pathways and dealing with the caseloads/management. There had been some real positives and relationships built up from the pilot but there had also still been some divisions because of the physical building.

- The Trust would be able to provide information as to how work had progressed on finding possible locations for hubs. The CCG were leading on colocation which was a priority.

- There was some blurring of professional boundaries but it was anticipated that a Social Care Green Paper would be announced in the autumn. Some of the legislation was in place as part of the Greater Manchester Devolution Deal but there was recognition across the system that the legislative frameworks would have to be reviewed as the agencies all operated from slightly different guidance. Some roles needed clinical supervision and required certain levels of training and health and social care assessments were different.

- To assist with the blurring of boundaries with regard to decision making, Rotherham had appointed a joint role holder to oversee the work in an attempt to remove some of the boundaries and recognise that hierarchy and matrix management would need to take place. Regarding professional boundaries, it might not be appropriate for a manager who knew absolutely nothing about a particular area or who has no clinical oversight to make a clinical decision and that was part of the challenge. There was a lot of practical things that could be done and was being done in the virtual teams but the ambition was to have new roles but it would take time

- Clear timescales were required for the implementation of locality working as the presentation only had broad blocks – detail to follow

- The Select Commission had previously recommended that it was important to capture the deeper more qualitative data based on patient experience to supplement the quantitative measures. What was presented was a systemic overview. Was this data being captured and recorded and could the Select Commission have a

formal response that summarised and presented data that the Commission could scrutinise in more detail at a later date? – to go back to Chris Holt to respond

- In terms of outcomes for the Health Village, was there evidence to show that diagnostics such as blood tests were being received quicker?

- Given the volume of different tests that must be requested, how many staff worked in the laboratories on the tests? Was there a central laboratory?

Nathan Atkinson was thanked for covering both presentations.

(1) To note the presentation and progress made on integrated working.

(2) That the findings feed into the development of the Select Commission performance sub-group's work programme.

(3) That the progress on locality working and plans for implementation be noted.

## 31. RDASH ESTATE STRATEGY

Dianne Graham, Director of Rotherham Care Group, RDaSH, and Rachel Cadman, Transformation Lead for Rotherham Care Group, RDaSH, presented the following powerpoint presentation:-

Rotherham Estates Consultation
- Aim – To seek stakeholder views on the two preferred options within the estates transformation plans"
- Part of wider consultation, 700 staff, service users, other stakeholders events

Outcomes
- Improved access for local people
- Aligned to GP surgeries
- Part of place based plans
- Integrated mental health, all age, Learning Disability Services
- Town centre facility
- More efficient use of resources

Present Estates
- Badsley Moor Lane – Learning Disability Services
- Ferham Clinic – Adult Mental Health
- Clifton Lane – Improving Access to Psychological Therapy (IAPT)
- Howarth House – Older Persons Mental Health (OPMH) and Dementia Clinics
- Swallownest Court – Adult Mental Health (AMH) inpatient/community

- Woodlands – OPMH inpatient

Proposed Estates
- Swallownest Court – South services
- Woodlands – Borough-wide/front end services
- Clearways – Town centre facility/clinics and base for IAPT team
- Then:
  North Services
  Option 4 – Badsley Moor Lane (BML) (plus Ferham annex)
  Option 5 – Ferham (plus Ferham annex)

Buildings we will no longer require
- Reduce buildings from 6 to 4
- No longer require Clifton Lane (IAPT)
- No longer require Howarth House (OPMH)
- Impact of agile working

Options considered
- Riverside (local authority building)
- The Bank
- Rawmarsh Health Centre
- Maintain status quo

Key Messages
- Best use of Rotherham pound
- Best value out of estates
- Reducing from 6 to 4 buildings
- Providing town centre clinic based services
- Services will continue to be delivered

The estate plans were temporary with some moves for one to 2 years and further consideration with partners about a possible health clinic in the North for integrated health, mental health and social care. Savings would be around £100,000 for RDaSH but there were other benefits from co-location and greater integration and possibilities for other efficiencies, so it was a stepping stone.

Discussion ensued with the following issues raised/clarified:-

- Work was taking place to identify whether Ferham or Badsley Moor Lane was the best option. Both facilities compared favourably with regard to cost and both were accessible to their localities. It had formed part of the stakeholder consultation with questions asked as to what it was like for them in terms of accessibility, environment, how difficult it was to get to both places, with the outcome being that Badsley Moor Lane was the preferred building. Having said that Ferham had not been discounted. Ferham Clinic Annex would remain whatever the final option was

- Whilst recognising the ambitions behind the review in terms of joint working and close working with GPs, in the days of austerity how much was financial pressures or was it purely just reconfiguring services? It was both. RDaSH needed to be much more integrated. It was the vision that in the future all Mental Health and Learning Disability Services would be provided in every Health and Social Care setting in Rotherham. Progress had been made to provide that particularly at front end services and there were a range of examples outside the estate strategy:-

  - RDaSH was also integrated with the Care Co-ordination Centre and Local Authority Single Point of Access
  - a ward which was a joint venture between the Hospital and RDaSH for people with Dementia with physical health staff and mental health staff
  - IAPT staff were in GP surgeries working with people with long term physical health conditions as well as mental health conditions
  - working with Police in the Central Neighbourhood Team to try and integrate mental health in the Police and Local Authority
  - Peri-Natal mental health working with the Hospital, District Nurses and Health Visitors
  - Hospital Liaison Service which was an integrated service with the Hospital making sure Mental Health, Alcohol Liaison and Learning Disability Services were integrated into the Hospital

- The Efficiency Strategy was not looking at reducing staffing levels and in fact NHS England had put extra funding into Mental Health Services over the last few years as part of the 5 year plan. There was an increasing workforce but there were concerns about the change and transformation in Mental Health Services and the numbers of new people coming into the health system to cope with the pace of change

Dianne and Rachel were thanked for their presentation.

Resolved:- That the presentation be noted.

## 32. RESPONSE TO RECOMMENDATIONS FROM SCRUTINY REVIEW- DRUG AND ALCOHOL TREATMENT AND RECOVERY SERVICES

Further to Minute No. 25 of the Cabinet and Commissioners Decision Making Meeting held on 6th August, 2018, Anne Charlesworth, Head of Public Health Commissioning, gave an update on the recommendations and corresponding actions arising from the Scrutiny Review of the Drugs and Alcohol Service Treatment and Recovery Services.

Rotherham's new Adult Substance Misuse provider, Change, Grow, Live (CGL), had been providing the Service since 1st April, 2018. Mobilisation from a client perspective had been very smooth, staff transferred from RDaSH to CGL and they had managed the Service very well. Work was progressing on the pathways.

Monthly meetings were held with CGL to consider all the key performance indicators. Progress so far had been steady, as had been requested, for the first 3 months. 6 clients had exited the Service positively in the first few weeks of the new contract due to being drug free. It was now back to its normal 2/3 new clients a month. CGL would now be looking in more detail of who now was ready to exit the Service.

Since the new Service started, there had been 8 deaths of clients in Service; 5 had died in Hospital as a result of long term conditions and not directly their substance misuse, 2 had died as a result of overdoses but not directly attributable to the drugs they were in receipt of from the Service and the Coroner's verdict was awaited for the 8th. None of the 8 clients would have been aged under 18 as the Service was for those aged 18 years and over; and there were none who were aged under 30.

The following update was given on each of the Review's recommendations:-

1. A full suite of Performance Indicators was to be submitted to the November Select Commission meeting

2. As stated above, monthly meetings took place and so far progress was good

3. More suicide prevention and self-harm work would take place as and when funds became available

4. MECC training was going quite well; as of yesterday 215 people had attended the training so the alcohol message was getting out. There was a clear pathway that those who received MECC training understood they also got Health Rotherham services as first point of contact but then screening tool then referred people into CGL

5. As mentioned at a previous meeting, drugs and alcohol soft marketing testing had taken place but needed to ensure that it happened in all the commissioning. Work was taking place with procurement to make it part and parcel of what agencies did

6. There was a new pathway around notification of death. A concern from the NHS, if the Service was no longer a NHS Service, was that it would stop some level of scrutiny, however, CGL reported all deaths on the national template, did their own death investigation and were reporting deaths to the CQC, Public Health and the Head of Service for Safeguarding, so a decision could be made as to brief the Adult Safeguarding Board about them. There would be a written pathway by the end of September

7. CGL's processes around risk assessment for suicide were very thorough and nationally agreed. They had supplied them to Authority and were to meet with RDaSH and ensure that all bases were covered. Both RDaSH and CGL's processes followed NICE Guidance. It would form part and parcel of the pathway that was currently being agreed

8. Safety and safeguarding had already been touched upon.

Discussion ensued with the following issues raised/clarified:-

- Had consideration been given to using Ward-based funding rather than the Community Leadership Fund? This would be fed back.

- £500K had been awarded to South Yorkshire and Bassetlaw Integrated Care System for suicide prevention work. It was understood that some progress had been made on the devolved monies and what it could be spent on but no specific details as yet, however, Rotherham had been a warded an allocation

- Hellaby Ward had ordered the posters that contained the helpline number for people to ring and the beer mats. They were to be distributed on the Hellaby Industrial Estate

- What type of treatment was a client offered? Were they get referred to the Consultant? The CGL Service was a clinical service headed up by a Consultant Psychiatrist. Clients received the same level of clinical assessment as they would have previously. Work was taking place to agree the boundary of when someone's problem became more Mental Health than substance misuse which agency they should access to remove any uncertainty as to which Service should be leading that package of care

Resolved:- That the response to the recommendations of the Scrutiny Review of Drug and Alcohol Treatment and Recovery Services be noted.

## 33. THE ROTHERHAM FOUNDATION TRUST QUALITY PRIORITIES 2019-20

Janet Spurling, Scrutiny Officer, presented the following powerpoint presentation on The Rotherham NHS Foundation Trust Quality Priorities 2019/20.

It was noted that TRFT was to hold a public consultation event on their Quality Priorities, however, it clashed with a meeting of the Select Commission. It had been agreed that the Select Commission's discussion would feed into the consultation.

Quality Improvement Priorities

- Every year The Rotherham NHS Foundation Trust developed a set of Quality Improvement Priorities for the year ahead
- These priorities helped ensure that there was a continuous drive to improve the quality of care provided for patients
- Each of the priorities had a lead who developed the details for each and what the aims, objectives and measures would be

Reminder for 2918/19 Priorities

- Patient Safety
  - Missed or Delayed Diagnosis
  - Deteriorating Patient (including Sepsis) (new focus)
  - Medication Safety
- Patient Experience
  - End of Life Care
  - Discharge
  - Learning from the views of Inpatients (new)
- Clinical Effectiveness
  - Improving the quality of services provided through preparing for Care Quality Commission (CQC Inspection (new)
  - Mental Capacity Act (increasing staff knowledge and awareness)
  - Effective outcomes for women and baby (new)

Initial Quality Priorities for 2019/20

- Patient Safety
  - Embedding the use of the National Early Warning Score (NEWS2)
  - Improving the assurance regarding the implementation of national safety alerts
  - Improving the learning and changes in practice arising from action plans from Serious Incidents and Inquests
  - Improving the safety of care provided to patients requiring respiratory support
  - Embedding the ambition of zero avoidable pressure ulcers
- Patient Experience
  - Improvement in Patient and Public Involvement and Engagement
  - Improving the experience of children receiving care in non-paediatric focused services
  - Embedding the treatment of all patients in an equal and diverse manner
  - Improving the experience of patients transitioning from Children to Adult Services
  - To be identified following the outcome of the Patient Experience Framework (NHS Improvement June 2018) and Trust Wide Diagnostics

- Clinical Effectiveness
  - Improving the quality of services provided through implementing the findings from the CQC Inspection
  - Effective outcomes for women and babies
  - Improving conversations about public health matters
  - Improving the outcomes from the Sentinel Stroke National Audit Programme (SSNAP)
  - Improving the outcomes from a National Audit (exact audit to be confirmed)

With regard to a query regarding Sepsis, Janet Spurling, Scrutiny Officer, reported that there had been a national focus on this, not just Rotherham Hospital, and training had taken place with YAS telephone call handlers. Janet would follow this issue up. Further information would be sought.

Councillor Andrews provided more details about the National Early Warning Score tool for recording patient observations.

Resolved:- (1) That the Select Commission feedback their views to TRFT through Janet Spurling, Scrutiny Officer.

(2) That the Quality Account Sub-Group meet in December to discuss the final set of priorities as part of the half year update.

## 34. SOUTH YORKSHIRE, DERBYSHIRE, NOTTINGHAMSHIRE AND WAKEFIELD JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE UPDATE

Janet Spurling, Scrutiny Officer, presented papers requested by JHOSC at its previous meeting for information regarding progress with the implementation of Children's Surgery and Anaesthesia and the designation process and an overview of the South Yorkshire and Bassetlaw ICS areas of future scrutiny.

When the papers for the next JHOSC meeting were published these would be circulated to all Select Commission Members with regard to identifying any questions or issues to raise through the Chair.

Resolved:- That the information be noted.

## 35. HEALTHWATCH ROTHERHAM - ISSUES

No issues had been raised.

## 36. HEALTH AND WELLBEING BOARD

Consideration was given to the submitted minutes of the Health and Wellbeing Board held on 11th July, 2018.

Resolved:- That the minutes of the Health and Wellbeing Board held on 11th July, 2018, be noted.

Arising from Minute No. 3 (Questions from Members of the Public and Press), it was clarified that the original application for a Judicial Review had been for the Hyper Acute Stroke Services which was rejected as it was also on appeal.

## 37. DATE AND TIME OF NEXT MEETING

Resolved:- That a further meeting be held on Thursday, 18th October, 2018, commencing at 10.00 a.m.

**BRIEFING PAPER FOR HEALTH SELECT COMMISSION**

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| **1.** | **Date of meeting:** | **18 October 2018** |
| **2.** | **Title:** | **Child and Adolescent Mental Health Services Update** |
| **3.** | **Directorate/Agency:** | **Rotherham Clinical Commissioning Group** |

## 4. Introduction

4.1 This paper provides an update to the Health Select Commission on the delivery of specialist Child and Adolescent Mental Health Services (CAMHS) within Rotherham and the ongoing review of the Local Transformation Plan (LTP). It also provides an update against specific key themes identified from previous scrutiny reviews.

## 5. Background and context

5.1 In May 2015, the Government issued the 'Future in Mind' document, which set out its ambitions for CAMHS to the year 2020. Following the publication, Rotherham Clinical Commissioning Group (CCG) was required to produce a CAMHS Local Transformation Plan (LTP), which would outline the key actions to be taken in Rotherham to implement the recommendations of the report. This was undertaken in conjunction with key partners. The CAMHS LTP was signed off by the Health & Wellbeing Board, submitted in October 2015 and signed off by NHS England. A CAMHS LTP Action Plan was also produced, reflecting the 'Local Priority Schemes' outlined in the LTP, and detailing how these schemes would be implemented.

5.2 The CCG produced a refresh of the original LTP in October 2016 and October 2017 and is in the process of preparing a further refresh by the end of October 2018. In addition, the CCG produces a quarterly update for NHS England detailing progress with the Rotherham CAMHS LTP. The CAMHS Strategy and Partnership Group is accountable for delivering the LTP.

5.3 In December, 2017 the Government published the 'Transforming Children and Young People's Mental health: A Green Paper'. This outlined three key elements:

- To incentivise and support all schools to identify and train a Designated Senior Lead for Mental Health with a new offer of training to help leads and staff to deliver whole school approaches to promoting better mental health

- To fund new Mental Health Support Teams, supervised by NHS children and young people's mental health staff, to provide specific

extra capacity for early intervention and ongoing help within a school and college setting

- To trial a four week waiting time for access to specialist NHS children and young people's mental health services.

Rotherham CCG was invited to submit an 'expression of interest' bid to be a 'Trailblazer' site to implement the second two elements (see also 7.1).

## 6. Key issues

6.1 The following represents an update on progress relating to the key themes (Local Priority Schemes) outlined in the Rotherham CAMHS LTP. An update against the key themes agreed by the Health Select Commission is provided at Appendix 1.

- A **CAMHS Intensive Community Support Service** was funded to ensure that children & young people (C&YP) are able to be supported in the community and not have to be admitted to an inpatient facility. The team also facilitates earlier discharge from Tier 4. Incorporated into this team is also an improved crisis response and an Interface & Liaison post which works closely with The Rotherham NHS Foundation Trust (TRFT) to manage admissions. CAMHS consistently meets the target of ensuring that all C&YP admitted to TRFT during normal working hours have a plan in place.

- Following feedback from services and service users, an **Autism Family Support Team** (AFST) was commissioned from RMBC to specifically support families with C&YP who have Autism, in the home environment. This was designed to complement the service provided in the school environment through the Autism Communication Team (ACT). The AFST receive referrals from either the Child Development Centre or CAMHS relating to C&YP with a new ASD diagnosis. In Quarter 1 of 2018/19 the total number of referrals to the AFST were 52. The team provides various workshops and courses for families and has distributed sensory equipment to schools.

- Funding was provided to the **Rotherham Parent Carers Forum** (RPCF) to develop their peer support service. Since it began in January 2016, 153 families have been supported in various ways including by telephone, face to face, email and facebook. The RPCF also actively works with other stakeholders including CAMHS, the CCG and the AFST and holds a weekly drop-in session for families. The peer support service has been recognised as an example of good practice.

- Some funding from the LTP is used to support **Looked After Children** who are placed out of Rotherham and need access to the local CAMHS.

- A **C&YP's advocacy service** is provided by Healthwatch. At any one time this service supports between 10 and 15 clients. This is generally relating to CAMHS, but also covers other services for C&YP.

- Specific funding was identified to support **C&YP affected by Child Sexual Exploitation** (CSE) and this is achieved through direct support to the C&YP as well as support for staff from services who provide support. In quarter 1 of 2018/19, the service provided 13 first contacts and 163 follow-up contacts directly to C&YP and 32 contacts to support staff in other services.

- An **eating disorder service** has been established for C&YP in Rotherham. This is being provided by RDaSH as a 'Hub & Spoke' model across its 'footprint' of Rotherham, Doncaster & North Lincolnshire. The service is being provided in accordance with the NICE Eating Disorder guidelines published in May 2017.

- Funding from the CAMHS LTP is also being used to support the delivery of **Care Education and Treatment Reviews**. These are reviews that are designed to support C&YP with Autism and/or Learning Disabilities who are at risk of being admitted to an inpatient facility (Tier 4). The reviews look at a number of Key Lines of Enquiry including; Can the young person be looked after safely in the community?, Is the use of medication appropriate?, Are family involved in decision making? etc. Seven of these reviews have been undertaken in the last year and more are planned. The CCG works very closely with RMBC in undertaking these reviews and they can relate to C&YP who are placed out of area.

- In 2017/18 the CCG committed to the recruitment of two **Children's Psychological Wellbeing Practitioners** (PWPs) by RDaSH. The training of these PWPs was funded by Health Education England and from 2018/19 the CCG has picked up their funding from the LTP. The posts deliver outcome focused, evidence based interventions to C&YP experiencing mild to moderate mental health difficulties.

## 7. Next steps

7.1 Trailblazer Bid – Rotherham CCG worked with partners, including; RMBC, RDaSH and organisations from the third sector, to develop a bid to be part of the first wave of sites to implement the proposals of the Green Paper. The bid was made jointly with Doncaster CCG, in view of the fact that both CCGs share the same mental health provider and also for NHS England to be able to make a comparison between the two CCGs due to slightly different models being proposed for the two areas. In the bid, the Rotherham area will have two Mental Health Support Teams, covering five learning communities, two colleges and two Pupil Referral Units (PRUs). The learning communities will include five secondary schools and their feeder primary schools. The bid was submitted on 17 September and it is expected that a decision will be made by late autumn.

7.2 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.

## 8. Actions arising

8.1 That the monitoring of progress against the key themes outlined in Appendix 1 is noted and discussed.

8.2 That the general update regarding the delivery of CAMHS services in Rotherham is noted and discussed.

## 9. Name and contact details

Report Author(s)

Nigel Parkes, Senior Manager – Contracts Mental Health & Learning Disability
Rotherham Clinical Commissioning Group

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 2018)**

| | Theme | Progress Update October 2017 | Progress Update October 2018 |
|---|---|---|---|
| 1 | **Impact of Single Point of Access (SPA)** | *Pilot for integration of RDaSH SPA with Early Help began in 2017. Slight delay in progress due to management changes within CAMHS but revisited and progressing positively.*<br><br>*The CAMHS SPA attend the Early Help access team twice weekly to discuss referrals across the two service areas.*<br><br>*The SPA has improved the delivery of advice and consultation to young people, families and universal services.* | RDaSH and CYPS<br><br>There are robust systems in place so that the Rotherham CAMHS service are meeting target timescales and triaging effectively; when referrals are signposted the service is contacting families to advise of this and give an explanation why. The changeover to the new electronic records system has positively supported this. The service is considering if there can be electronic referrals from GP's within the system to improve access for GPs, alongside exploring how the service can increase access via self-referral.<br><br>There have been changes to the front door access to the early help services and in the current time, the services agree strategically considering how the service developments fit together and review how improved working across agencies can continue to build.<br><br>Exploration of how the CAMHS and 0-19 service SPA can consider working more closely together.<br><br>Integration of the RDaSH SPA and Early Help access point is a key milestone in the refreshed Rotherham Integrated Health and Social Care Plan (Quarter 4 2018-19). |
| 2 | **Impact of locality working** | *Positive links with schools and early help colleagues. A GP event held in September supported primary care understanding of the recent advice and consultation approach.*<br><br>*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.* | RDASH<br><br>Two Children's Well-being Practitioners have completed their training and are now an integral part of the Rotherham team. The role specifically is to work with young people experiencing mild to moderate anxiety and depression. The staff are engaging with young people in the local communities and are beginning to develop group work and provide self-help guidance and support. The initial group work will be focussed on supporting parents of younger children by utilising a Cognitive Behavioural Therapy (CBT) approach with them.<br><br>The locality workers are engaging with the wider community and |

| | Theme | Progress Update October 2017 | Progress Update October 2018 |
|---|---|---|---|
| | | *Services are delivered from Kimberworth Place if either protected therapeutic space or a controlled environment for standardised assessment and interventions is required.*<br><br>*Awareness raising events have been held - how to access CAMHS and self- help information and materials for young people.* | supporting services through direct and indirect work with families and the partners supporting them.<br><br>Additional awareness sessions have been delivered, alongside CAMHS having a higher presence within the wider community, including stalls at Rotherham show, local colleges, World Mental Health Day events etc. |
| 3 | **Training and development for staff across the wider CAMHS workforce** | *Mapping of current training provision and feedback will go to the January 2018 CAMHS Strategic Partnership meeting.*<br><br>*Links have been made with C&YP's Partnership and their work on identifying appropriate skills/training for the workforce.*<br><br>*Safe Talk (Suicide prevention) training sessions were held in March 2017*<br><br>*Referral Guidance for universal services seeking support on emotional well-being (Universal Tops Tips)*<br><br>*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.*<br><br>*Sessions are 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. Plus localised training to* | All partners<br><br>Work is ongoing but is making slow progress.<br><br>An initiative has started with Sheffield, Barnsley, Doncaster and Rotherham CCGs to commission a review of workforce issues and specifically consider:-<br><br>• Staffing and Skills mix<br>• Review of current workforce<br>• Development of a workforce strategy<br><br>Wales High School chose not to participate in the Yorkshire & Humber Clinical Network 'In It Together'- A Social Emotional Mental Health Competency Framework for Staff Working in Education. They felt they were doing a lot of this work already through their Whole Schools work. We are waiting to see how the pilot went and have asked for feedback so we can look at how this work might be incorporated in Rotherham.<br><br>Youth Mental Health First Aid training has been delivered to the Parent Carers Forum and a group of BME women working with Rotherham United Community Sports Trust.<br><br>Rotherham's own CARE about suicide prevention training has been delivered on request to staff working with young people. |

| | Theme | Progress Update October 2017 | Progress Update October 2018 |
|---|---|---|---|
| | | *individual organisations when requested.*<br><br>*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.* | Educational Psychology offers a variety of courses relating to a young person's emotional wellbeing and mental health. |
| 4a | **Performance Management Information – performance framework** | *A performance framework was tested with wider mental health service providers but feedback suggested it would be difficult to implement, even following a redesign..*<br><br>*The CCG collects annual baseline data from the wider mental health service providers to inform the LTP and JSNA – interventions and activity, workforce capacity and investment from schools, early help services, RMBC and third sector services.*<br><br>*A CAMHS Section 75 Agreement between RMBC and Rotherham CCG commenced in November 2017 and will strengthen joint performance management and measurement of outcomes.* | RMBC<br><br>Verbal update to be given at the meeting. |
| 4b | **Performance Management Information – outcome measures** | *CAMHS capture personalised goals for young people, alongside using routine outcome measures. Over 95% have a personalised goal relating to interventions offered, alongside a plan of care.*<br><br>*RDaSH CAMHS will have a new electronic records system and this will be developed to support the capture and reporting of routine outcome measures in the future.* | RDaSH<br><br>The service has successfully transferred electronic records system in December 2017, the service is now reviewing the reporting availability through the new system and new reports with clear outcome measures attached is underway. The service developments in reporting is wider than the use of goals and includes use of symptom trackers to measure changes in symptoms alongside how the issues are impacting on a young person. |

| | Theme | Progress Update October 2017 | Progress Update October 2018 |
|---|---|---|---|
| 5 | **Waiting time data – assessment and treatment** | *Consistent achievement of 100% against the target of 100% for urgent referrals assessed within 24 hours.*<br><br>*At Aug 2017 66.7% of non-urgent referrals were assessed within 3 weeks (20.7% in June) and 88.9% within 6 weeks (65.5% in June)*<br><br>*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* | RDaSH<br><br>The services have continued to triage referrals on the same day and see urgent referrals on the same day as presenting. The waiting times for initial contact and assessment from the service has also reduced to below 6 weeks on a more consistent basis.<br><br>The challenges in meeting an increased demand in requests for ASD assessments have impacted on this pathway and remains a concern to the service and commissioners, both acknowledging that this is not an acceptable state, but working towards addressing how this can be overcome.<br><br>RDaSH are preparing a full report, by the end of October, which will outline how they will address the issues, including:-<br><br>• How the pathway will be reviewed (including with Healthwatch, The Rotherham Parent Carers Forum, CCG etc.).<br>• The current waiting list, waiting time and capacity.<br>• Current staffing of the pathway<br>• How the pathway operates relative to the latest NICE guidance.<br><br>Review of the RDaSH CAMHS ASD/ADHD diagnosis pathway is a milestone in the refreshed Rotherham Integrated Health and Social Care Plan (Quarter 4 2018-19) |
| 6 | **Transition from RDaSH CAMHS**<br><br>(includes transition from children's to adult mental health services if | *RDaSH has taken a 'Listening into Action' approach to explore transition processes between CAMHS and adult mental health. Monthly meetings of the two services take place and a psychiatrist from adult services works into CAMHS 1 day per week.*<br><br>*LTP funding used for 4 'transition raising awareness' events with C&YP through the Different But Equal Board. It was also* | RDaSH<br><br>RDaSH has continued to fund a post for a care coordinator who spans the two services (adult and children's) in order to support transition. The post introduction has greatly improved the communication between services and supported young people to be referred to the most appropriate team, alongside helping the young person to understand the offer and expectation they can have from adult services. |

| | Theme | Progress Update October 2017 | Progress Update October 2018 |
|---|---|---|---|
| | there are ongoing service needs or transition when discharged out of RDaSH CAMHS) | *agreed to look at potential support for the project from RDaSH mental health services, Early Help and the SEND group.*<br><br>*The CCG is also working with VAR on a 'Health & Wellbeing' funding bid which may support this work.* | |
| 7 | **Ensuring young people's voice and influence** | *A mapping/action planning template resulted from the external Voice and Influence review to increase young people's involvement.*<br><br>*RDaSH engages regularly with Rotherham Youth Cabinet , who have had input into the website design and taken part in interviews for practitioners.* | RDaSH<br><br>Rotherham CAMHS have undertaken a comprehensive participation, voice and influence programme since October 2017. The service is a national trailblazer through the Young Minds Amplified Program that is supported by NHS England. The current issues that are being addressed are surrounding the physical environment at Kimberworth Place, and how the environment can be better suited to the children and young people who visit the centre for their therapeutic appointments. Young people have worked closely with CAMHS practitioners to developing an understanding of the therapeutic services offered by Rotherham CAMHS. There are long term plans to work with young people in monitoring and reviewing the services offered, in particular how young people can access services, both in a physical sense and through electronic media such as self-referral via telephone or email. Through this there have been discussions with young people in how they can become better involved in the decision making process in service development. Young people have attended conferences and contributed to events such as world mental health week alongside Rotherham CAMHS practitioners to further develop relationships and better ways that children and young people can be engaged in service developments. |

Rotherham Metropolitan Borough Council

Public Report
Health Select Commission

**Committee Name and Date of Committee Meeting**
Health Select Commission – 18 October 2018

**Report Title**
Progress Monitoring Report on the Social, Emotional and Mental Health Strategy

**Is this a Key Decision and has it been included on the Forward Plan?**
No

**Strategic Director Approving Submission of the Report**
Jon Stonehouse, Strategic Director, Children and Young People's Services

**Report Author(s)**
Jenny Lingrell, Joint Assistant Director of Commissioning, Performance & Inclusion
01709 254836 jenny.lingrell@rotherham.gov.uk

**Ward(s) Affected**
Borough-Wide

**Report Summary**
In 2015, Rotherham Metropolitan Borough Council published a strategy to address Social, Emotional and Mental Health (SEMH) Needs in Schools. This arose from the need to address the rising number of both fixed term and permanent exclusions across both primary and secondary schools. This issue was not unique to Rotherham; it was also identified locally, regionally and nationally.

Schools have worked together to reduce the number of exclusions in the borough and the overall trend has been a decrease in both fixed term and permanent exclusions. However, last year, whilst overall, the number of fixed term exclusions continued to decrease, there was a slight increase in permanent exclusions. However, the challenge of responding to the needs of children with SEMH needs continues to be felt keenly across education settings.

In October 2017, Health Select Commission considered information presented by Rotherham schools with details of their response to children and young people with social, emotional and mental health needs (SEMH). Further to this report, the Commission requested a further progress monitoring report on the Social, Emotional and Mental Health Strategy.

There has been significant progress made in delivering the Local Transformation Plan to improve Child and Adolescent Mental Health Services. More recently a trailblazer bid has been submitted which would further support schools and CAMHS to work together to address the presenting need.

It is now timely to develop a new strategy; this will underpin a new multi-agency approach to ensure that children's needs are met effectively and as early as possible. To achieve this we will need a thorough understanding of the levels of need that are being experienced across the system matched with agreed pathways to respond that are well articulated, well understood and properly resourced. Work to date has identified six key areas of focus for the strategy:

I. SEMH Sufficiency: developing a better understanding of need
II. SEMH Partnerships: ensuring arrangements are consistent and transparent
III. Developing alternative and flexible provision to meet need
IV. Developing and communicating a multi-agency graduated response to match need and avoid duplication or confusion
V. Supporting the workforce
VI. Delivering value for money

The Joint Assistant Director of Commissioning, Performance and Inclusion started in post in September 2018 and has commenced work to co-produce a new Social, Emotional and Mental Health Strategy for Rotherham. The new Assistant Director of Education for Children and Young People's Services will advise on this work. To be effective there must also be engagement with leaders across the system, including CAMHS, the voluntary and community sector, social care and Early Help.

The Committee is recommended to note the progress that has been made since November 2017 and support the development of a SEMH Strategy, with a final draft in place by January 2019.

**Recommendations**

1. That the committee notes the progress that has been made to address the needs of children with social, emotional and mental health needs

2. That the committee supports the development of a multi-agency SEMH Strategy, with a final draft in place by January 2019

**List of Appendices Included**
Appendix 1 Rotherham Exclusion Figures 2013-2018

Appendix 2 Rotherham SEMH Phased Thresholds – Graduated Response Guidance

**Background Papers**
Rotherham Strategy for Pupils with SEMH Needs, November 2015

**Consideration by any other Council Committee, Scrutiny or Advisory Panel**
n/a

**Council Approval Required**
No

**Exempt from the Press and Public**
No

**Progress Monitoring Report on the Social, Emotional and Mental Health Strategy**

## 1. Background

1.1 In 2015, Rotherham Metropolitan Borough Council published a strategy to address Social, Emotional and Mental Health (SEMH) Needs in Schools. This arose from the need to address the rising number of both fixed term and permanent exclusions across both primary and secondary schools. This issue was not unique to Rotherham; it was also identified locally, regionally and nationally.

1.2 Schools have worked together to reduce the number of exclusions in the borough and the overall trend has been a decrease in both fixed term and permanent exclusions. However, last year, whilst overall, the number of fixed term exclusions continued to decrease, there was a slight increase in permanent exclusions. However, the challenge of responding to the needs of children with SEMH needs continues to be felt keenly across education settings.

1.3 In October 2017, Health Select Commission considered information presented by Rotherham schools with details of their response to children and young people with social, emotional and mental health needs (SEMH). Further to this report, the Commission requested a further progress monitoring report on the Social, Emotional and Mental Health Strategy.

## 2. Key Issues

### What's Working Well

2.1 The SEMH Strategy, subtitled as '5 steps to collective responsibility' has been in place for three years. It has delivered the following substantive areas of work and development:

2.2 The Pupil Referral Units (Rowan and Aspire) have been re-configured both in terms of physical premises and offer to better meet the needs of Rotherham's children and young people. There is increasing expertise to respond to SEMH needs within these settings.

2.3 Aspire is now operating under new leadership, management and governance and is working closely with a range of stakeholders including the Local Authority to secure and develop provision that meets the needs of both pupils at risk of or who have been permanently excluded as well as pupils whose SEMH needs can be met in Rotherham with an Education Health and Care Plan.

2.4 Rowan was inspected by Ofsted in March 2018 and maintained a 'Good' judgement, with personal development, welfare and behaviour rated as 'Outstanding'. *"As a result of effective leadership, teaching is good and pupils make good progress from their starting points."*

2.5 School-based SEMH partnerships have been developed for both primary and secondary age children. These partnerships take responsibility for identifying further sources of advice and support for children and young people through peer moderation and peer challenge, using the 'SEMH Graduated Response to Need' document (Appendix 2). This partnership work includes identification and discussion of referrals to Aspire PRU, with the involvement of staff from both Aspire and the Educated Other Than At Schools (EOTAS) Exclusions Team. Seed funding devolved from High Needs Block Funding has enabled some of the partnerships to successfully establish further alternative provision, often resulting in children and young people avoiding permanent exclusion.

2.6 The Secondary Fair Access Protocol (FAP) was revisited and consultation took place with school leaders. This has resulted in FAP becoming embedded within the secondary SEMH Partnerships. This is indicative of the high levels of mutual trust and accountability that have developed between schools and with the Local Authority within this period.

2.7 An Educated Other Than At School (EOTAS**)** exclusions team structure has been established. The team operate closely with the SEMH Partnerships at both primary and secondary level, providing advice, support and challenge to ensure that legal processes are appropriately adhered to and that the young person's needs and best interests are focussed on at all times.

2.8 Inclusion Department staff are delivering a rolling programme of SEND training to colleagues in education, health and social care to ensure they are familiar with the requirements of the SEND code of practice, including in relation to SEMH and to signpost to relevant Local Authority and health services.

2.9 Young Inspectors are currently completing an inspection of the exclusion experience in Rotherham from the experience of young people. The EOTAS exclusion team are supporting this work. The report should be completed by December 2018.

2.10 A one day SEMH conference for school leaders was held in June 2018 which was very well received. 17 workshops were provided by Rotherham practitioners and services from education, health, care and the private and voluntary sector to promote the range of local SEMH expertise and support available to enable schools to manage and meet the diverse range of needs and behaviours pupils present with, without the need to resort to exclusion.

2.11 Schools Forum agreed funding changes to establish a non-traded Primary Outreach Team to begin in April 2019. This team will replace the currently fully traded SEMH team and secure an equitable offer to all primary aged children deemed at risk of exclusion; working in collaboration with other key stakeholders within services, including CAMHS and Early Help. The team will align their work with that of the SEMH school partnerships, including transition work to the secondary schools.

**What Are We Worried About?**

2.12 Despite sustained effort and having established an agreed and shared vision, Rotherham's exclusion figures, both for fixed term and permanent exclusions, having initially decreased are now rising once more, particularly within the secondary sector.

2.13 Appendix 1 illustrates the five year trend 2012 – 2018. This picture is again mirrored locally, regionally and nationally.

2.14 The secondary SEMH Partnerships do not have a consistent success rates or a consistent operating model.

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2.15 The primary SEMH partnerships are less developed and have less robust systems and practice, resulting in a diminished graduated response to need. The launch of the non-traded Primary Outreach Team in April 2019 will go some way to supporting primary schools.

2.15 The graduated response document is used primarily within education settings. To be effective it needs to be aligned with a multi-agency approach across all age-groups and taking account of the work of CAMHS, social care and Early Help.

2.16 Primary, Infant and Early Years settings are finding the complex SEMH needs of a number of very young children to be very challenging. A more holistic approach is required that involves a number of stakeholders' support. Preparatory discussions have begun to take place to address this area of work.

2.17 The Green Paper 'Transforming Children and Young People's Mental Health Provision' has implications for Rotherham. Rotherham and Doncaster Clinical Commissioning Groups (CCG) have submitted a trailblazer bid to establish Mental Health Support Teams to work in conjunction with schools. If the bid is successful this will add much-needed resources to the system and allow us to test new ways of working.

## 3. Options considered and recommended proposal

3.1 A Rotherham SEMH Strategy will be co-produced with partners and stakeholders during the autumn term of 2018. The work will be led by the Joint Assistant Director of Commissioning, Performance and Inclusion, with support from the Assistant Director of Education.

3.2 The SEMH Strategy will underpin a new multi-agency approach to ensure that children's needs are met effectively and as early as possible. To achieve this we will need a thorough understanding of the levels of need that are being experienced across the system matched with agreed pathways to respond that are well articulated, well understood and properly resourced. Work to date has identified six key areas of focus for the strategy:

- 3.2.1 SEMH Sufficiency: developing a better understanding of need
- 3.2.2 SEMH Partnerships: ensuring arrangements are consistent and transparent
- 3.2.3 Developing alternative and flexible provision to meet need

3.2.4 Developing and communicating a multi-agency graduated response to match need and avoid duplication or confusion
3.2.5 Supporting the workforce
3.2.6 Delivering value for money

3.3 If the Trailblazer bid is successful, in phase 1 or 2 of the process, this will provide much needed to capacity to test new approaches and define what works to deliver the Strategy.

3.4 Progress will be accelerated if the Trailblazer bid is successful but work will commence in key areas immediately.

## 4. Consultation on proposal

4.1 The SEMH Strategy will be available in final draft in January 2019. The draft will be co-produced with key stakeholders and informed by the voices of children and young people.

4.2 The final draft of the SEMH Strategy will be subject to a consultation process, which will include children, young people and their parents.

## 5. Timetable and Accountability for Implementing this Decision

5.1 The final draft SEMH Strategy will be available in January 2019.

## 6. Financial and Procurement Advice and Implications

6.1 There are no direct financial and procurement implications for this report. However, a clear strategy that sets out the vision, principles and priorities for developing the SEMH offer in Rotherham will inform future decisions about how Rotherham Council and its partners can work together to meet the needs of children and young people and support them to achieve positive outcomes.

## 7. Legal Advice and Implications

7.1 There are no direct legal implications for this report. The SEN Code of Practice sets out the statutory framework to respond to the needs of children and young people who have special educational needs, including social, emotional and mental health needs.

## 8. Human Resources Advice and Implications

8.1 There are no direct human resources implications for this report. The SEMH strategy will identify the importance of having a workforce that is trained and supported to respond to the needs of children with social, emotional and mental health problems.

## 9. Implications for Children and Young People and Vulnerable Adults

9.1 The SEMH strategy is how we will work in Rotherham to support some of our most vulnerable children and young people to make progress and achieve positive outcomes.

9.2 Preparation for Adulthood for children and young people with Special Educational Needs is a key area that requires focussed attention. The SEMH strategy will complement the all-age autism strategy, and the Preparation for Adulthood strategic plan.

## 10. Equalities and Human Rights Advice and Implications

10.1 Ensuring that the Council meets its equalities and human rights duties and obligations is central to how it manages its performance, sets its priorities and delivers services across the board. The equalities and human rights implications are considered throughout work with individual children and young people and their families

## 11. Implications for Partners

11.1 The SEMH Strategy will be co-produced with partners, in particular, children, young people and their parents, the commissioners and providers of Child and Adolescent Mental Health Services and education partners across all phases in the borough.

## 12. Risks and Mitigation

12.1 Without a clear strategy in place, there is a risk that the system will not respond effectively to children and young people with social emotional and mental health problems and they will not make progress or achieve positive outcomes. Furthermore, if the approach is not well coordinated and well understood there is a risk that the provision offered will not deliver value for money.

12.2 Without a clear SEMH sufficiency plan, there is a risk that the needs of children cannot be met effectively within mainstream school or within the local area. An increase in placements in specialist provision and out of authority will lead to an increase in costs.

## 13. Accountable Officer(s)

Jon Stonehouse, Strategic Director of Children and Young People's Services

*Report Author:* Jenny Lingrell, Joint Assistant Director of Commissioning, Performance & Inclusion

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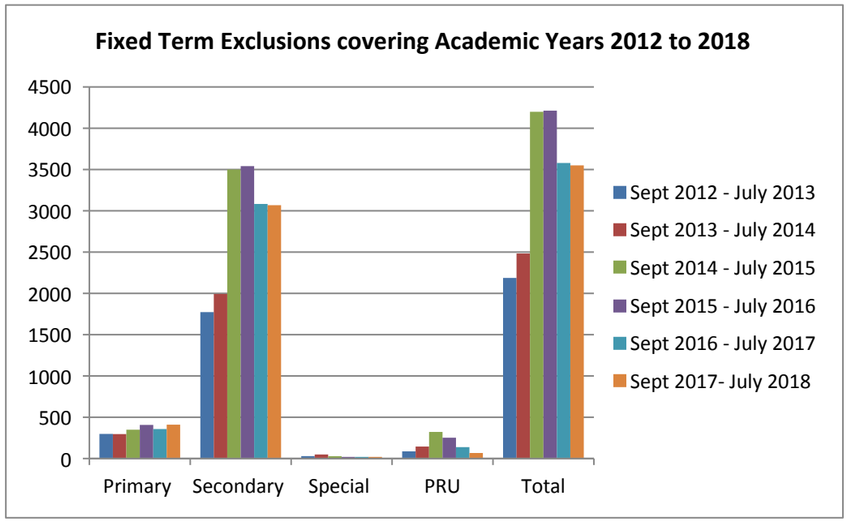
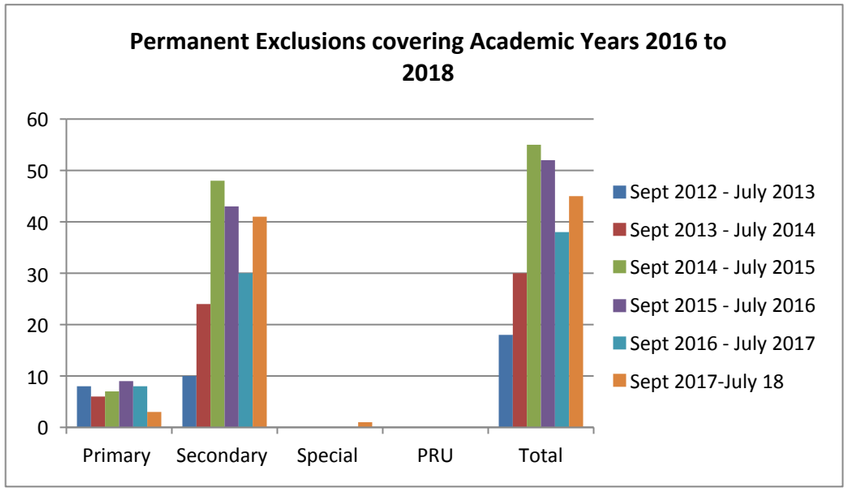
https://moderngov.rotherham.gov.uk/ieDocHome.aspx?Categories=

| Fixed Term Exclusions covering Academic Years 2012 to 2018 | | | | | |
|---|---|---|---|---|---|
| | Primary | Secondary | Special | PRU | Total |
| Sept 2012 - July 2013 | 298 | 1773 | 29 | 87 | 2187 |
| Sept 2013 - July 2014 | 296 | 1993 | 49 | 145 | 2483 |
| Sept 2014 - July 2015 | 349 | 3500 | 28 | 322 | 4199 |
| Sept 2015 - July 2016 | 407 | 3541 | 13 | 252 | 4213 |
| Sept 2016 - July 2017 | 357 | 3083 | 1 | 138 | 3579 |
| Sept 2017- July 2018 | 410 | 3068 | 5 | 67 | 3550 |

| Permanent Exclusions covering Academic Years 2012 to 2018 | | | | | |
|---|---|---|---|---|---|
| | Primary | Secondary | Special | PRU | Total |
| Sept 2012 - July 2013 | 8 | 10 | - | - | 18 |
| Sept 2013 - July 2014 | 6 | 24 | - | - | 30 |
| Sept 2014 - July 2015 | 7 | 48 | - | - | 55 |
| Sept 2015 - July 2016 | 9 | 43 | - | - | 52 |
| Sept 2016 - July 2017 | 8 | 30 | - | - | 38 |
| Sept 2017- July 18 | 3 | 41 | 1 | | 45 |



Appendix 2

# Rotherham SEMH Phased Thresholds

## Graduated Response Guidance



Version 1 2016-7

**SEMH Threshold frequency and severity report to be used as indicators to levels of need:**

| Name of Student | Date of Birth | Name of School | Name of referring teacher |
|---|---|---|---|
| **LAC** | **SEND Support** | **EHCP** | **Attendance** |
| **Name of person completing document** | | **Contact details** | |

| **Summary of Student Behaviours** | |
|---|---|
| **Summary of Support at Each Phase** | **Impact of Support at Each Level** |
| Phase 1 | |

| | |
|---|---|
| Phase 2 | |
| Phase 3 | |

# Rotherham SEMH Phased Thresholds

**It is not expected that all children and young people will automatically have the basic social, emotional and learning skills they need to succeed. We understand that context plays a key role in behaviour and that the duty of all settings is to provide a learning environment designed to promote positive behaviour and relationships. Key aspects that need to be in place are:an effective whole school policy for behaviour and inclusion, reviewed and shared with all stakeholders, consistently applied and rigorously monitored; a restorative ethos; a creative and engaging curriculum and learning opportunities.**
**All students who are discussed at Partnership Cluster Groups should have had significant support in addition mainstream lessons. The support should be strategic, time managed with referrals made to the relevant agencies.**

| PhaseOne Descriptor | Assessment | Organisational Adjustments (grouping,timetable,staffing) | Curriculum and Teaching Methods | Specialist Resources/ Intervention Strategies |
|---|---|---|---|---|
| **A student may present as**<br><br>Low level/low frequency of social and emotional behavioural difficulties which interrupt learning in some situations. May include:<br>• Difficulty in following whole class instructions<br>• Occasional refusal to follow reasonable requests<br>• Poor concentration<br>• Difficulties working in groups, sharing and taking turns<br>• Some signs of disruptive behaviour<br>• Possible developmental delay<br>• Possible signs of stress or anxiety<br>• Continued difficulties following routines<br>• Emerging patterns of reluctance to following reasonable instructions<br>• Little regard for school rewards and consequences<br>• Risk of fixed term exclusion<br><br>Underdeveloped social skills may create difficulties in getting along with others<br>• Some difficulties forming positive relationships with | **Assessment**<br>• ☐Part of normal school and class assessments. SENDCo or trained staff may be involved in more specific assessment and observations<br>• ☐Pupil self-assessment–pupil friendly SMART targets set for behaviour/social skills in line with school policy<br>• ☐Records kept to include observations assessment of context, structured, unstructured times, frequency, triggers<br>• ☐Simple solutions given for difficult times of the school day<br>• ☐Progress should be a measured change in their behaviour and learning following each review cycle<br>• ☐Recognition of learning styles and motivational levers<br>• ☐PASS profile or other attitudinal assessment<br>• ☐Detailed and targeted observation ie interval sampling<br>• ☐Use and analysis of assessment tools<br>• Assessment related to intervention strategy<br>• ☐Pupil self-assessment | • ☐Mainstream class with attention paid to organisation and pupil groupings<br>• ☐Opportunities for small group work on identified need e.g. listening/thinking/social skills.<br>• ☐Time limited mainstream classroom programme of support, which relates to assessments<br>• ☐Small group work to learn appropriate behaviours and for associated learning difficulties<br>• ☐Individual programme based on specific need<br>• ☐A quiet area in the classroom may be useful for individual work<br>• ☐Create opportunities to work with positive role models<br>• ☐In addition to the provision at level 1 identified daily support to teach social skills/dealing with emotions to support the behaviour learning targets<br>• ☐Mainstream class with regular targeted small group support<br>• ☐Time-limited programmes of small group work based on identified need<br>• ☐On-going opportunities for | • ☐Access to QFT<br>• ☐In class differentiation of the curriculum and supporting materials enabling full access to the curriculum<br>• ☐Strategies developed shared with school staff, parent/carer<br>• ☐Increased differentiation by presentation and/or outcome<br>• ☐Simplify level, pace, amount of teacher talk/ instructions<br>• ☐Increased emphasis on identifying and teaching to preferred learning style<br>• ☐Opportunities for skill reinforcement/revision/transfer and generalisation<br>• ☐Some use of specific group or 1:1 programmes<br>• ☐Preparation for any change and the need for clear routines.<br>• ☐Cross Reference and CPD<br>• ☐Seating Plan if appropriate<br>• ☐Modify level/pace/amount of teacher talk to pupils' identified need.<br>• ☐Plan opportunities for skill reinforcement/revision/transfer and generalisation<br>• ☐Individual targets within group programmes and/or 1:1 | The use of positive targeted strategies that might include<br>• ☐Consultation with other colleagues in school<br>• ☐P scales PSD targets<br>• ☐ABC charts<br>• ☐Pupil profile<br>• ☐Observation schedules<br>• ☐Reward systems involving regular monitoring and support<br>• ☐Monitoring diaries<br>• ☐Use of behaviour targets within the classroom/playground, prompt cards<br>• ☐Lunchtime club<br>• ☐Visual systems/timetables<br>• ☐Regular small group work/resilience, concentration skills/ social skills/listening skills/conflict resolution<br>• ☐Short-term individual support<br>• ☐Support that uses solution focused/motivational approaches<br>• ☐Develop friendship groups<br>• ☐Access to additional circle time activities<br>• ☐Low stimulus sensory area.<br>• ☐Access to ICT and specialist equipment |

| | | | | |
|---|---|---|---|---|
| peers and/ or some teachers<br>• Possibly isolated or withdrawn<br>• Bully or victim role<br>• Low attendance<br>• Some patterns of stress/anxiety in specific situations<br>• Possible signs of self harm<br>• Isolated/withdrawn<br>• Unpredictability, inconsistency<br>• Sexualised language<br>• Increased frequency or severity of aggressive or confrontational behaviour<br>• Increased absence/lateness<br>• Reported anti-social behaviour in the community<br><br>• **Staff Will**<br>• Use a multi-sensory approach<br>• Offer support and reassurance<br>• Respond where possible to student interest<br>• Retain a sense of humour<br>• Deflect and Redirect behaviours<br>• Model expectations and behaviours | extended to inform IEP/IBP<br>• ☐More detailed recording, monitoring of frequency, intensity<br>• ☐Wider assessments for learning/other SEND<br>• ☐Determine engagement of necessary education/ non-education support services possibly leading to CAF or review of the PEP<br>• **Planning**<br>• ☐Individualised programme of support related to assessments implemented. Key worker identified (significant other)<br>• ☐Parents involved regularly and support targets at home<br>• ☐Pupils involved in setting and monitoring their targets<br>• ☐Pupils response to social/ learning environment informs cycle of IEP/PEP/PSP<br>• ☐Curriculum plan reflects levels of achievement and includes individually focused IEP targets e.g. specific behaviour targets related to assessment: consideration of adapted timetable<br>• ☐Additional steps taken to engage pupil and parents as appropriate<br>• ☐Identifying non educational input<br>• ☐Requires effective communication systems enabling all involved to provide consistent support<br>• ☐Early Help processes determine holistic support plan | 1:1 support focused on specific IEP targets<br><br>**Staffing**<br>• ☐Main provision by class/subject teacher and resources usually available in the classroom.<br>• ☐Support/advice from SENDCo/inclusion manager with assessment and planning<br>• ☐Additional adults routinely used to support flexible groupings, differentiation and some 1:1<br>• ☐Close monitoring to identify “hotspots”<br>• ☐Support for times identified by risk assessments<br>• ☐Close liaison and common approach with parents/carers<br>• ☐Main provision by class/subject teacher with advice and support from SENCO and/or designated teacher<br>• ☐Additional adult, under the direction of teacher, provides sustained targeted support on an individual/group basis<br>• ☐May include a time-limited withdrawal (buddy system)<br>• ☐Additional daily support provided within school to support learning and behaviour (ie checklists, monitoring, routine, time out pass)<br>• ☐Increased parental/carer involvement<br>• ☐Encouragement and inclusion in extra-curricular activities<br>• ☐Identification of ‘key worker’ with clear specification of role | • ☐Teaching approaches should take account of the difficulties in the understanding of social rules and expectations within the classroom<br>• ☐Emphasis on increasing differentiation of activities and materials and take account of individual learning styles<br>• ☐Short term individual support focusing on listening, concentration, social skills, solution focused approaches<br>• ☐Regular small group work with an increasing emphasis on relationships, emotions, social skills, conflict resolution<br>• ☐Consideration of differentiated curriculum that allows flexibility to teach according to emotional needs, not chronological age, play, creative activities, drama | • ☐Pupil Voice boxes<br>• ☐Playground leaders feeling cards/ charts<br>• ☐Consideration of external agency support as mentioned in assessment column<br>• ☐Investigation by SENDCo to investigate additional/ other needs. |

| Phase Two Descriptor | Assessment | Organisational Adjustments (grouping,timetable,staffing) | Curriculum and Teaching Methods | Specialist Resources/ Intervention Strategies |
|---|---|---|---|---|
| Significant and persistent social, emotional and mental health difficulties.<br>No significant or sustained improvement of target behaviours.<br>• Persistent non-compliance<br>• Learning of self and others significantly interrupted by withdrawn or disruptive behaviours<br>• Uncommunicative, significantly withdrawn, struggles to contribute.<br>• Overly keen, regular interrupters, "needy."<br>• Risk of repeated fixed term exclusion*<br><br>Significant difficulties with social interaction- deteriorating relationships with adults and/or peers. May include:<br>• Inappropriate language/communication (inability to adapt to context)<br>• Inappropriate and/or risk taking behaviours<br>• Possible sexualised behaviour towards others<br>• Instances of aggressive/violent behaviour increase in frequency and severity<br>• Deteriorating attendance<br>• Significantly withdrawn<br><br>*For a Child In Care provision from Day 1 of an exclusion must be in place - Virtual school involvement. | **Assessment**<br>• ☐As Level 2 plus more systematic application of assessment tools<br>• ☐Involvement of education and non-education professionals as appropriate through early help processes<br>• ☐Early Help Assessment<br>• ☐Review of measurable progress against targets in IEP/PEP/PSP<br><br>**Planning**<br>• ☐Behaviour and curriculum plan closely tracks levels of achievement and all IEP targets are individualised, short term and specific<br>• ☐More frequent involvement of parent/carer to engage pupil<br>• ☐Access to additional resources are accurately accounted for<br>• ☐Prevention support plan managed through advice joint school/Learning Centre/PRU support programme/Virtual school.<br>• ☐Early Help-Multi-agency planning processes specify contribution of individual services and lead practitioner. Inter-agency communication established and maintained<br>• ☐Referrals/request for advice from external agencies are time appropriate<br>• ☐Discussed and considered at the Partnership for advice and guidance. | • ☐ Continued difficulties following routines<br>• ☐Emerging patterns of reluctance to following reasonable instructions<br>• ☐Little regard for school rewards and consequences<br>• ☐Risk of fixed term exclusion<br><br>**Staffing**<br>• ☐Main provision by class/subject teacher with support from SENDCo and advice from education and non-education professional as appropriate<br>• ☐Daily access to staff in school with experience of SEMH, eg behaviour support worker, lead behaviour professional, SENDCo<br>• ☐Additional adult, under the direction of the teacher, supports pupil working on modified curriculum tasks<br>• ☐Increased access to a combination of individual, small group and whole class activities<br>• ☐Outreach support and advice<br>• ☐Staff training in restorative approaches/attachment and trauma/PDA<br>• ☐Increased parental/carer involvement and multi-agency support services to plan and regularly review IEPs/PEP/ PSP | • ☐Teaching focuses on both curriculum and SEMH outcomes throughout the school day<br>• ☐Tasks and presentation personalised to pupil's needs.<br>• ☐Individualised level/pace/ amount of teacher talk<br>• ☐Learning style determines teaching methods<br>• ☐1:1 teaching for the introduction of new concepts and the reinforcement of classroom routines and expectations<br>• ☐Small steps targets within group programmes and/or 1:1 work tasks<br>• ☐Targets are monitored with the pupil daily targets<br>• ☐Accessing mainstream lessons for most of the time with complimentary access to internal support arrangements and interventions<br>Personalise the day, consider alternatives to the structure of the day and the lessons currently offered.<br>• ☐Consideration of an alternative, differentiated curriculum that allows flexibility to teach according to emotional needs, not chronological age, play, creative activities, drama | The use of positive targeted strategies that might include:<br>• ☐Further learning assessments and support if necessary e.g. Nurture Group; Learning Mentor Programmes<br>• ☐P scales PSD targets<br>• ☐Pupil profile<br>• ☐Programmes<br>• ☐Observation schedules<br>• ☐Reward systems involving regular monitoring and support<br>• ☐Monitoring diaries<br>• Use of behaviour targets within the classroom/playground, prompt cards<br>• ☐Visual systems/timetables<br>• ☐Regular small group work/concentration skills/social skills/listening skills/conflict resolution, SEAL<br>• ☐Short–term individual support<br>• ☐Support that use solution focused/restorative/motivational approaches<br>• ☐Circle of friends<br>• ☐Access to additional circle time activities<br>• ☐Access to ICT and specialist equipment<br>• ☐Individual SEMH programme<br>• ☐All additional resources referenced in a personalised provision map<br>• ☐Implementation of Learning Centre intervention<br>• ☐Consideration of external specialist services<br>• ☐Referral to SEMH team |

| Phase Three Descriptor | Assessment | Organisational Adjustments (grouping,timetable,staffing) | Curriculum and Teaching Methods | Specialist Resources/ Intervention Strategies |
|---|---|---|---|---|
| Severe and persistent SEMH issues. Complex social and emotional needs.<br>• Persistent leading and instigating of disruptive behaviours.<br>• Behavioural incidents and fixed term exclusions increasing.<br>• Sustained non-engagement in school life e.g. persistent absence/truancy<br>• Risk of permanent exclusion<br>• Inability or complete refusal to follow school routines and instructions<br>• Non-engagement with school rewards and consequences<br>• Inability to sustain positive relationships with adults and/or peers<br>• Mainstream setting has a detrimental effect on health and well-being<br>• High risk of permanent exclusion<br>• Requires access to specialist provision for SEMH/SEN<br><br>Increasing difficulties in forming positive relationships, interacting appropriately with adults and/or peers<br>• Increasing patterns of behaviour which place themselves or others at risk of serious harm e.g.<br>• use of weapons to harm or threaten<br>• Violence<br>• Self harm<br>• Severe and sustained bullying<br>• Refusal to communicate<br>• Significantly withdrawn | **Assessment**<br>• ☐Increasedinvolvement of a range of professionals<br>• ☐Early help processes define nature and extent of support needs<br>• ☐Consider other traded services such as Educational Psychologist , SEMH team, MIND/ MAST.<br>• ☐Consider EHCP if the student needs 'significant different from and additional to' mainstream education.<br>• ☐Referral to Partnership<br>- prior co-ordination of Learning Centre placement<br><br>**Planning**<br>• ☐IEP or PSP detailing provision and strategies with appropriate short term targets<br>• ☐Planning meetings include parents and multi-agency where appropriate<br>• ☐Early help processes determine contribution of Children's Services<br>• ☐Partnership Alternative Provision<br>• ☐Partnership Managed Move<br>• ☐Personalised plan with appropriate time limited interventions<br>• ☐EHCP Statutory Assessment determines future placement | • ☐Pupil taught for a significant amount of the time in small groups outside of the mainstream curriculum<br>• ☐Some opportunities for Alternative Provision but these are time limited.<br>One or more of the following will have been tried:<br>• ☐Opportunities for student to engage in alternative provisions for part of the week<br>• ☐Managed move where appropriate<br>• ☐Learning Centre placements<br><br>**Staffing**<br>• ☐Pupil is supported in most or all of those lessons that they do attend<br>• ☐Daily access to staff with experience and training in meeting the needs of students with SEMH<br>• ☐Increased access to specialised SEMH<br>• ☐Managed move may have been tried and failed<br>• ☐Pupils are successful on a managed move and after an agreed time by both schools become on roll at that the 'new school.'<br>• ☐Managed Move fails and the student goes back to the initial school.<br>• ☐Agreement is made by the partnerships that student becomes dual registered between school and the PRU.<br>• ☐Student gets permanently excluded and alternative provision has to be sourced. | • ☐As at Phase 1 and 2<br>• ☐Some aspects of the curriculum may be taught out of mainstream in either small groups or 1:1<br>• ☐Pupil's curriculum is personalised and pupil may be dis-applied from some aspects of the national curriculum<br>• ☐Activities focus on key skills and Social, Emotional, Behaviour al outcomes throughout the school day.- SEAL skills embedded in curriculum<br>• ☐Balance shifts to most lessons accessed with some support<br>• ☐Pupil requires an alternative to mainstream education<br>• ☐Learning experiences and support address significant social, emotional and behavioural needs/learning needs. | • ☐Targeted intervention employing a range of strategies<br>• ☐Individual Social, Emotional, Behaviour skills programme<br>• ☐1:1 and small group teaching<br>• ☐Alternative provision appropriate to need<br>• ☐All additional resources and exceptional arrangements are referenced in a personalised provision map, necessary evidence for requesting statutory assessment<br>• ☐Learning Centre or PRU placement following decision by inclusion/management group panel<br>Personalised to the specific needs of the pupil<br>• ☐Advice available from relevant specialist services<br>• ☐Placed in PRU or special school<br>• ☐Out of Area in **exceptional** circumstances |

**Note**
This document, inspired by Education Bradford's Behaviour Support services ESB/Five level model, was produced to meet the demand for a greater consensus and consistency in identifying and providing for social, emotional and mental health needs. When considering pupils for provision beyond the school, the criteria met should be evidenced and discussed at Partnership levels with advice and guidance from the SEMH team/ Exclusions Team and ASPIRE Pupil Referral Unit.

- Phase 1 should be managed by schools in addition to the school Behaviour and Inclusion Policies
- Phase 2 should be managed by schools, with referrals early help/ other agencies. A range of wider assessments should be considered and undertaken to support the student.
- Phase 3 should be managed by schools, the partnership, AP and PRU.

Appendix 3

Rotherham Metropolitan Borough Council
Where Everyone Matters

# "5 Steps to Collective Responsibility"

## Rotherham Metropolitan Borough Council's Strategy for Young People with Social, Emotional and Mental Health Difficulties (SEMH)

## 1. Developing a new strategy for young people with Social Emotional and Mental Health difficulties in Rotherham

Schools, partners and the local authority in Rotherham, have developed a new strategy for children and young people with social emotional and mental health (SEMH) needs. This strategy is based on the principle of collective responsibility and has resulted from a period of review, research, discussion and debate.

A review of arrangements in Rotherham for young people with SEMH difficulties was initiated in May 2015. The scope of the review considered the suitability of Rotherham MBC's services and provision for children and young people with SEMH needs. It explored whether the current arrangements provide quality outcomes for children and young people with SEMH needs, which are cost effective and provide value for money.

The focus of the review included the following areas:

- Research into national guidance, initiatives and good practice.
- The role and remit of the four Pupil Referral Units (PRUs) called Aspire
- The nature of partnership working between the local authority and schools and its partners
- Consideration of options aimed at improving the service offer for this vulnerable group of learners
- Consultation with key partners who work and make provision in schools. This has included:
  - focus group meetings with schools
  - individual meetings with secondary head teachers
  - dialogue with the Aspire PRU leadership team
  - dialogue with senior leaders within the Local Authority

## 2. National context

It is widely recognised that children and young people with SEMH needs often experience considerable difficulties in making the most of opportunities that the education system provides.

These young people may also affect the ability of schools to provide a calm and well-managed learning environment, which has a corresponding impact on the learning experience of their peers.

Nationally, local authorities make a variety of arrangements to support the learning of this group of vulnerable but challenging young people through partnerships with schools and other partners.

The Department for Education has published three important publications over the previous 18 months. These publications have promoted a national debate and re-evaluation of services and provision for young people who are at risk of permanent exclusion as a result of their SEMH needs. These are:

- Special Educational Needs and Disability Code of Practice: 0 to 25 years (updated May 2015)
- National Schools Exclusion Trial (July 2014)
- Mental Health and Behaviour in Schools: Departmental advice for school staff (March 2015)

***SEND Code of Practice: 0 to 25 years*:** This helpfully defines a new category of special educational needs relating to those children with SEMH difficulties.

Paragraph 6.32 of the Code of Practice describes broad areas of need and provides the following definition for this type of special educational need:

*"Children and young people may experience a wide range of social and emotional difficulties which manifest themselves in many ways. These may include becoming withdrawn or isolated, as well as displaying challenging, disruptive or disturbing behaviour. These behaviours may reflect underlying mental health difficulties such as anxiety or depression, self-harming, substance misuse, eating disorders or physical symptoms that are medically unexplained. Other children and young people may have disorders such as attention deficit disorder, attention deficit hyperactive disorder or attachment disorder".*

This definition refocuses attention on the causes of challenging or disruptive behavior and is aimed and encouraging interventions which address the identified need.

***National Schools Exclusion Trial*:** This trial explored new ways of working with children who were at risk of permanent exclusion. An evaluation of schools involved in the trial identified a number of benefits, including:

- increased use of partnership working and collective decision making through the use of panels, e.g. district panels, fair access panels
- enhanced quality assurance, accreditation systems and service level agreements for providers of alternative provision (AP)

- increased collaboration between schools, e.g. pupils transferred to another school for a trial period; an increase in managed moves
- revised commissioning procedures; more early intervention programmes to prevent exclusion
- use of time-limited AP (to avoid permanent exclusion)
- closure of PRUs.

Local Authority lead officers and teachers agreed that the level of partnership working had increased as a result of the trial, particularly where managed moves were undertaken. Processes were considered to be more transparent and rigorous, and there was an improvement in information about pupils and the ability to track their progress.

Schools were able to more effectively use data to identify patterns of behaviour in order to put in place appropriate support for pupils.

Learning support units, inclusion coordinators, and revised school timetables were considered to be effective in relation to:

- preventing exclusions
- improving attendance
- improving attainment
- improving behaviour.

Those pupils designated as being “at risk” changed during this trial. Schools’ judgements of pupils at risk of exclusion were reviewed regularly and adjusted. The provision put in place to support many of these pupils was deemed to be effective due to their removal from the “at risk” list.

Teachers reported that on average, fewer children had been permanently excluded from those schools involved in the trial when compared to similar schools. However, it was difficult to identify improvements in specific positive outcomes for learners within the time scale of the trial.

***Mental Health and Behaviour in Schools: Departmental advice for school staff***: The guidance acknowledges that all pupils benefit from learning and developing in a well ordered school environment that fosters and rewards good behaviour and sanctions poor and disruptive behaviour.

The guidance also suggests that schools should consider whether continuing disruptive behaviour might be as a result of unmet educational or other needs. The non-statutory advice clarifies the responsibility of the school, the role of the school in supporting a child or young person whose behaviour - whether it is disruptive, withdrawn, anxious, depressed or otherwise - may be related to an unmet mental health need.

Additionally, the guidance contains helpful advice on systems and processes that schools should put in place to improve their arrangements.

## 3. Local context

There are a number of aspects to Rotherham's local context:

1) The history of SEMH provision in Rotherham
2) The number of exclusions
3) The current model of provision
4) The cost of this model of provision as a result of high levels of displacement.

Rotherham MBC has tried a number of approaches over the last five years to manage the numbers of children who are permanently excluded from schools. Approximately five years ago a new strategy was embarked upon whereby the Local Authority's Pupil Referral Units (PRUs) were managed by schools and the flow in and out of the PRU was controlled through decisions reached by schools working in locality partnerships.

There was some disagreement about the success of this approach and it was abandoned much to the dismay of the schools at the time. Since then there has been a lack of trust and partnership between schools and the Local Authority on this matter. It is perceived by many that the current levels of exclusion are as a result of this period of distrust and disappointment.

In the following months and years the levels of exclusion have increased year on year

| Permanent exclusions in Rotherham's Primary and Secondary Schools 2010 -2015 | | |
|---|---|---|
| **Primary** | **Year** | **Total** |
| | 2014/15 | 7 |
| | 2013/14 | 6 |
| | 2012/13 | 8 |
| | 2011/12 | 12 |
| | 2010/11 | 5 |
| **Secondary** | **Year** | **Total** |
| | 2014/15 | 50 |
| | 2013/14 | 24 |
| | 2012/13 | 10 |
| | 2011/12 | 13 |
| | 2010/11 | 13 |
| **Total Primary & Secondary** | **Year** | **Total** |
| | 2014/15 | 57 |
| | 2013/14 | 30 |
| | 2012/13 | 18 |
| | 2011/12 | 30 |
| | 2010/11 | 18 |

Rotherham MBC compares with the national funding picture as follows:

- National average (England only) spend on the high needs block of funding is 13% of the Dedicated Schools Grant (DSG)
- In Rotherham this equates to 9% of the DSG and amounts to £22 million.
- High needs block funding provides for pupils with Special Educational Needs (SEN) and this includes SEMH arrangements.

Rotherham Borough Council's current arrangements for young people with SEMH needs are shown below:

| SEMH provision | Cost (£ million) | Number of pupils | Average cost per place |
|---|---|---|---|
| Other LA special schools | 0.052 | 5 | £10,600 |
| 4 Aspire PRU's | 2.00 | 114 | £18,000 |
| | | | |
| | | - | - |
| Out of borough placements | 1.73 | 29 | £59,000 |
| **Total** | **£3.78** | **154** | **£24,564** |

- Rotherham Council has 4 PRUs covering Primary and Secondary phases of education collectively called Aspire.
- The Aspire Primary PRU is offered across two provisions and accommodates 24 learners.
- The Aspire Secondary PRU is based on two sites and accommodates 90 learners.
- Rotherham does not have a specialist school for pupils with SEMH needs.
- Rotherham places 34 young people who have SEMH needs in educational establishments which are not maintained by Rotherham MBC. This is a relatively low number of pupils but the cost of this provision is high. There are 5 young people placed in other local authority special schools for pupils with SEMH needs. There are 29 pupils placed in a variety of independent non maintained settings for young people with complex needs.
- The majority of learners with SEMH needs require assistance with their travel arrangements. This varies from individual taxi arrangements, a place on a commissioned mini bus, or the provision of a bus pass which enables the young person to use public transport.

- In 2014/15 a total of 154 pupils received education outside the normal offer as a result of their SEMH needs. The total cost of this offer was £3.78 million.

Very few young people now attend alternative provision outside the PRU . There are a limited number of established or available providers of alternative education in Rotherham . Some schools manage their own “in house AP” , but this is described as being at risk as a result of funding shortages.

School based colleagues on the SEMH focus groups described the current set of arrangements in the following way;

- There is a lack of clarity about resources and outcomes for learners.
- There are high levels of exclusion from a small number of schools.
- There is high usage of the PRU facilities causing stress and strain on the system.
- There is lack of collaboration between schools, LA and partners
- There is some good practice in pockets in Rotherham
- There is a lack of capacity to respond speedily in a crisis.
- The is little sense of moral responsibility
- There is a lack of clear strategy
- There are a limited number of providers of alternative education.
- There is lack of clarity about statutory duties

## 4. Rotherham’s new approach for young people with SEMH Needs

Creating a new approach to Rotherham’s arrangements for pupils with SEMH needs has been a priority for the Schools Forum. Discussions have taken place with groups of head teachers and with individual head teachers. There has been a particularly strong consensus that arrangements in Rotherham need to change. Early in the discussions a shared moral purpose was established as follows;

*Rotherham Borough Council, its partners and Schools will take collective responsibility for children and young people with SEMH difficulties in order that they thrive, achieve and that the local offer for this vulnerable group represents value for money.*

The moral purpose is underpinned by a group of agreed principles which are as follows;

**Principles of Collective Responsibility for Children and Young People with Social Emotional and Mental Health (SEMH) difficulties.**

**Rotherham’s new arrangements should;**

1. Be based on the equitable use of resources which is affordable, with realistic expectations and clearly defined outcomes, with regular reports to schools forum;

2 Be a whole Borough response which is informed by transparent information and data and knowledge of local and national good practice;

3 Recognise the importance of early intervention and be family and person centred;

4 Recognise the importance of collective responsibility, which includes education, health and care partners and be based on a shared understanding of what is expected of all parties;

5 Provide a graduated response with thresholds to prevent escalation into expensive out of borough provision;

6 Provide local and flexible solutions which are developed and managed by schools;

The following recommendations are as a result of the discussions and have become known as “5 steps to collective responsibility”.

## Five Steps to Collective Responsibility

### Step 1: Create a new role and remit for the Aspire PRU

Currently, it is agreed that the Aspire PRU is a problematic environment in which to work and learn. The number of pupils being admitted is too high. Many pupils arrive without any previous planning and without helpful information from schools to support a successful transition into the Aspire PRU. Attendance is approximately 60%.

*We need to:*

- reduce numbers of permanently excluded pupils attending the Aspire PRU
- relocate Aspire PRUs into smaller scale units
- develop vocational PRU centres
- develop a specialism within the PRU system offer for young people from the Slovak community
- ensure that good quality information is available to the staff at the Aspire PRU prior to any admission
- assess the needs of pupils and where appropriate, promote the reintegration of pupils attending the Aspire PRU back into a mainstream school, alternative provision, college or specialist provision.
- Develop the Rowan site as a Therapeutic Intervention Centre

*We know we will have been successful when:*

- the number of pupils attending the Aspire PRU reduce to agreed levels
- the Aspire PRU is a safe place to learn and work

- attendance levels increase
- the outcomes for learners improve
- pupils access a range of vocational opportunities
- where appropriate, learners transfer to a more suitable school or learning placement.

**Step 2: Establish a Menu of Alternative Provision in Rotherham**

Currently there are very few alternative models of educational provision available to young people in Rotherham.

*We need to:*

- appoint an Alternative Provision development officer
- arrange a market place event for alternative providers
- encourage competition in the market place
- develop school based alternative provision
- establish a quality assurance system for alternative providers
- develop Rotherham's online menu of alternative provision.

*We know we will have been successful when:*

- the number of alternative providers available in Rotherham increases
- there is a menu of Alternative Providers available to schools and the local authority
- any provision on the menu has been quality assured
- young people access alternative provision and progress into employment or training
- young people are highly engaged with their alternative learning experience.

**Step 3: Establish locality SEMH partnerships**

Currently there is little evidence of collaboration between schools and between schools and the Local Authority. Local clusters of schools will need to be established in order to manage a new set of arrangements which could include:

- managed moves
- short breaks
- alternative provision
- links to the PRU system
- CPD
- identification of good practice.

*We need to:*

- identify which schools will work in partnerships
- appoint partnership development officers from schools in partnerships

- develop a local menu of options
- develop local partnerships with a wider group of partners across early help, health, social care and education providers.
- Develop new models of working with CAHMS

*We know we will have been successful when:*

- schools meet on a regular basis and partners from other agencies" sit around the table" to help find local solutions
- the partnership has made a local plan
- there is a local menu of options
- there are local CPD opportunities
- the partnership retains the majority of its learners in its learning community.

**Step 4: Develop a commissioning model for PRU, Alternative Provision and partnership working**

Currently admissions to the Aspire PRU are not effectively controlled and there is no cap on the use of Aspire PRU provision. The existing model of Aspire PRU provision is financially unsustainable and does not provide value for money.

*We need to:*

- introduce a system for allocating a quota of Aspire PRU places for partnerships
- introduce a commissioning charge for places at the Aspire PRU which exceed the agreed quota
- develop a mechanism for devolving "released " funding to partnerships
- agree a memorandum of understanding between school partnerships and the Local Authority which establishes a long term commitment to bring about the required change.

*We know we will have been successful when:*

- the number of permanent exclusions reduce
- the size of the Aspire PRU population reduces
- schools have developed effective partnerships to which the Council can confidently devolve funding, resources and responsibility
- Parents and young people feel more engaged with learning.

**Step 5: Develop Rotherham's Fair Access Protocol and permanent exclusion arrangements**

Currently, the FAP is emerging as a useful forum for making decisions about pupils who are hard to place. The FAP agreement needs to be amended and ratified with agreements relating to managed moves and reintegration from the Aspire PRU. Schools are interpreting exclusion regulations differently and there is a lack of clarity in guidance.

*We need to:*

- establish locality agreements on managed moves
- establish locality agreements on short breaks
- further develop Rotherham's FAP and consult on the role and remit of the Fair Access Panel.

*We know we will have been successful when:*

- a new FAP agreement is place
- schools feel confident in the new arrangements
- young people have a school place identified without delay
- pathways out of the Aspire PRU into mainstream school settings and other alternatives are available when appropriate
- revise guidance for exclusions.

## 7 Implementation Timelines

It is recommended that the key steps required to deliver the necessary change to enable young people with SEMH difficulties to achieve their full potential are part of a phased implementation as follows:

- The new arrangements will be agreed by **December 2015**.
- Schools will have formed their partnership clusters by **December 2015.**
- Funding will be devolved to partnerships by **April 2015.**
- A menu of Alternative Provider options will be available by **September 2016**

**Notes from HSC Performance Sub-Group** **26/09/2018**

**Adult Social Care Outcomes Framework provisional year end performance 2017-18**

Present: Cllrs Andrews, R Elliott, Ellis, Evans, Jarvis
Presentation: Scott Clayton and Charna Manterfield

Apologies: Cllr Bird
Notes: Janet Spurling

Focus of session – Provisional year end performance on the Adult Social Care Outcomes Framework (ASCOF), including a RAG based thematic review under the headings of prevention and delay; independence; personalisation; and perception and experience, linking in the relevant ASCOF measures.

This was the provisional report, rather than the final version as national and regional benchmarking data would not become available until the end of 2018. In terms of direction of travel, performance on eight indicators had improved, three had stayed the same and 16 had declined. Any changes in the relative position of Rotherham compared with other local authorities would be reported in January.

In addition, although the service user survey is annual the carer survey is only undertaken every two years (government decision). The last survey was in 2016-17 so there was no data for 2017-18 and the service was preparing for the survey to go out in November or December. Carer Survey measures are ASCOF 1D/1Iiii/3B/3C/3D part 2.

**Theme 1 Prevention and Delay**

- Outcomes from Reablement are good. High percentage living at home without formal support
- Continued positive trend in numbers of older people admitted to long term residential/nursing care

ASCOF 2D/2A Part 2

- Expansion of offer in Single Point of Access to include; access to Social Work, Voluntary Sector, and Occupational Therapists which has enabled an improved offer for information, advice and guidance

ASCOF 3D Parts 1&2 link in

- Worsening trend in delayed discharges from hospital – performance remains above regional average on social care delays
- Volume of young people in transition to adult care is considerable

ASCOF 2C Parts 1-3

- Numbers offered Reablement remains low. One of the lowest in Rotherham's peer group.
- High numbers of younger adults in residential and nursing care.

ASCOF 2Bii/2A Part 1

- Permanent admissions to residential care – improving performance to reduce numbers but it is a question of balance according to needs.
- Reablement – numbers offered the service are low but the outcomes are good for those who do have the service. Hospital data used to calculate this figure will be refreshed nationally prior to publication and would be added for the final report.
- Delayed Transfer of Care (DTOC) ASCOF 2C – this had been impacted by staff being on annual leave during the summer.

- 18-64 admissions are mainly with regard to mental health or people with physical disability such as an acquired head injury.
- Single Point of Access for information, advice and guidance (IAG) – this links to demand management so that needs may be met by other means rather than bringing people into service. Access is mainly by telephone.

*The IAG PI does seem to be one where we have struggled from looking at reports on the Council Plan performance.* - It is hard to see the offer through the website and there is a mismatch between PI and performance.

*Risk of digital exclusion for certain cohorts of service users/carers as the Council moves to digital by default in terms of equality of access and access to IT.*

*Carers who do and don't receive services – can there be more information or access through GPs?* - *I age well detail on GP screens*

*Additional survey question possible to ask about preferred ways of receiving information?*
- Some leeway is possible for local questions to be added to the national survey.

*Why is the reablement offer low?*
- Increased resources have been put in this year and the intention is to increase the offer. It includes community enablers and intermediate care. The default position would be to put enabling in for someone but if it is not available that would lead to a commissioned service, possibly over the longer term, which would not count towards the measure.

*If someone on a commissioned service goes into hospital, would they then go back on to that commissioned service once discharge or would they have reablement?*
- It depends on how long they were in hospital but that service could be suspended and then re-picked up subject to the outcome of the assessment. The SALT return keeps records of enablement /commissioned services.

**Theme 2 Independence**

- Flexibility of direct payments to promote independence
- My front door….. providing and supporting people with learning disabilities to live a life rather than solely accessing traditional services.

ASCOF 1C/1E/1G

- Embedding of strength based approach supported by wellbeing forums
- Transitions – Coordinated approach "pathways to adulthood". Strong working relationship with colleagues in Children's

- Historic traditional based approach to assessment/service provision – Higher than regional average numbers who receive service after formal assessment

- Numbers supported in employment continues to decline.
- Decline in numbers of working age adults in receipt of secondary mental health services living independently

ASCOF 1E/1F/1H

- Settled accommodation – the measure does not include people living in residential care i.e. people need to have their own front door/key and funded
- Transitions – broadening out the work and trying to meet needs more upstream. It is a small number but there can be costly care packages, so it is important to have young people on the radar early.
- Position on assessments – for new customers the trajectory is on the move from traditional services to the new strength-based approach. Impact of the legacy of the previous approach is still there and it is about having a mature range of alternative options.
- There had been a steady decline in adults with learning disabilities on long term service in employment (ASCOF 1E) over the last four years from 6% to 4.13%.

*Members drew attention to feedback from the public/service users regarding reviews and reassessments.*

**Theme 3 Personalisation**

**Carers**
- improved performance on carers accessing support by Direct Payment (DP) (ASCOF 1C part 2B)
- access to Carer's Support officers at single point of access (SPA) (ASCOF 3D part 2)
- refreshed methodology for carer's assessment measure in Council Plan

**Service users**
- improved take up of offer of a personal budget
- targeted review of managed DP
- high cost services impact on spend – right sized packages

- Carers assessments – changed methodology as now done in carer's own right not jointly with the cared for person. There is no impact on payments as a result.
- Managed accounts – similar to being on a commissioned service so reviews will discuss moving to either a full direct payment or to a commissioned service.

**Theme 4 Perception and Experience of Care and Support**

- improved social care quality of life (ASCOF 1A)
- more service users feel safe (ASCOF 4A)
- service users feel they have choice and control (ASCOF 1B)
- more people have as much social contact as they would like (ASCOF 1Ii) – 48%
- decline in satisfaction with care and support services (ASCOF 3A)
- decreased numbers of service users who find it easy to access information about support (ASCOF 3D part1)

- Social contact – this measure had been increasing over time and to provide some context the provisional range of scores for this measure was 41-54%.

*Members commented on the seeming dissonance between the self-reported increase in choice and control on one hand but reduced satisfaction with services/fewer people who found it easy to access information about support on the other. They recalled that last year it had been suggested that service transformation and uncertainty had had an impact on perception measures.*

- It was important to tease out reasons around service users/carers perceptions and if they were linked to any key events or changes. Other dialogue and engagement takes place with service users throughout the year and there are non-perception measures, including for carers, in the ASCOF. There were also possibly links to make to contract management and quality assurance.

**Additional issues explored by Members**

*Average contract lengths and issues around continuity of care and provider stability.*
- Commissioning questions were more appropriate to direct to the Assistant Director of Strategic Commissioning (AD). Following a restructure performance, including for ASC and Housing (but not CYPS) has been within the ACX directorate for several months although the team still provides data for the directorate. The AD receives all the performance data and used to manage the team so is well versed on the data and the performance, which is also discussed at DLT meetings.

*Ability to compare performance of in-house and external residential/nursing care provision?* - Only for older people, not for 18-64s.

*Other reporting and scrutiny of performance data?*
- Some measures are included in other workstreams and are reported to the Cabinet Member and relevant boards and linked in with the MTFS, but probably not all of them. Several ASCOF measures are included within the Council Plan and performance of that is scrutinised by OSMB quarterly.

*Links with housing if people have changing care needs?*
- The Scrutiny Officer reported that in a presentation at a recent Health and Wellbeing Board meeting on the refresh of the housing strategy it was indicated that there would be closer links between housing, health and social care.

**Follow up actions**

1. HSC to consider undertaking a more focused piece of work on reablement/enablement in its work programme.
2. To further clarify areas for OSMB and HSC scrutiny of ASC performance - OSMB had previously recommended that HSC would monitor the impact of the changes regarding intermediate care.
3. To check attendance of HSC members at OSMB for update from Principal Social Worker
4. The sub-group to consider the final year end report in January 2019 – date tbc.

**Recommendations and Response**

1. Officers to explore the possibility of adding a survey question this year to ask about people's preferred way of receiving information.

   *Response: This needs to go through various local and national governance steps to be an 'approved – non biased format', this would not be possible for this year's survey which is already in progress but can be explored in respect of the next scheduled biennial survey due in 2020/21.*

2. Future reporting of carer perception measures to be reported side by side over a number of years.

3. To include more narrative in future reports around factors that have contributed towards a decline in performance on any of the performance measures.

4. To develop a table collating all adult social care measures and where these are reported.

*Response: These will be factored in from the next report in January to run alongside the benchmarking of the national data that will be reported.*

**Paper for**
**South Yorkshire and Bassetlaw, Wakefield, North Derbyshire and Hardwick CCG Governing Bodies**
**and SYB, Mid Yorkshire and Chesterfield Foundation Trust Boards**
**on the**
**Strategic Outline Case on Hospital Services**
August 2018

## 1. Summary

In May, the Hospital Services Review (HSR) published its final report. Boards, Governing Bodies, and members of the public have now given their feedback on the recommendations in the report.

The feedback has been used to inform a Strategic Outline Case (SOC), which is the system's statement of intent around how it will take forward the recommendations of the HSR.

The SOC largely accepts the recommendations of the HSR, with two main changes:

- it emphasises the transformation of the workforce more than the HSR did
- it outlines that the Clinical Working Groups on maternity and paediatrics will be asked to explore clinical models that could satisfy interdependencies between maternity and paediatrics, as a possible alternative to moving to a Standalone Midwifery Led Unit.

***CCG Governing Bodies are formally invited to sign off the Strategic Outline Case and agree to its publication, in line with their statutory responsibilities in relation to leadership of service change as described in NHS England's*** **Guidance on Planning, Assuring and Delivering Service Change for Patients (2018).**

***Trust Boards are asked to confirm their agreement to the publication of the Strategic Outline Case.***

## 2. Background: responses to the HSR

The final report of the independent Hospital Services Review was published on 9th May 2018.

Governing Bodies and Trust Boards, stakeholders and the public were invited to comment on the report by 12th July (this was not a formal public consultation). Responses were received from trusts and CCGs; 1 local authority; and 2 members of the public. All responses received as of 21st August are at Annex B.

The responses from the CCG Governing Bodies and Boards broadly supported the recommendations. Some points were raised which were addressed in the drafting of the SOC (section 3 below).

In July NHSE also provided input through Gateway 1 of the NHSE assurance process. NHSE approved the process thus far, and laid out the areas which will need further work if the system takes forward the recommendations.

## 3. The Strategic Outline Case

Up to May, the HSR was an independent review. The vehicle for the system to confirm its response to the recommendations, and publicly state its next steps, is the Strategic Outline Case (SOC).

**Content of the SOC**

The draft SOC lays out the overall direction for the SYB Integrated Care System (as SYB defined in the Sustainability and Transformation Plan) with Mid Yorkshire and North Derbyshire; the case for change; and the response to the HSR recommendations. The document says that the system will take forward work in three areas:

- **Shared working between acute providers**: through developing Hosted Networks and a system-wide Health and Care Institute, alongside an Innovation Hub
- **Service transformation**: building on and supporting the shift of activity out of hospital into the primary and community care sectors; and transforming workforce roles and clinical pathways
- **Reconfiguration**: modelling options for reconfiguration of maternity and paediatrics on 1-2 sites; considering moving to 3-4 sites for emergency GI bleeds out of hours; and looking at options to support stroke services on sites which only have an Acute Stroke Unit through joint working, while standardising access to e.g. Early Supported Discharge and stroke rehabilitation across the trusts.

The 5 trusts of SYB, plus Chesterfield Royal Hospital NHS Foundation Trust will participate in all of these workstreams. Mid Yorkshire Hospitals NHS Trust will consider whether they want to be part of the Hosted Networks and service transformation workstreams as these develop; they are not part of the reconfiguration workstream.

**Changes between the HSR and the SOC**

In response to the comments received, the following key changes have been made between the HSR and the SOC. A more detailed point by point response to each of the replies received is at Annex B.

- **A greater focus on transformation** has been introduced, in particular a stronger role for Clinical Working Groups in redesigning job roles and clinical pathways. This is now a workstream in its own right.
- **The timeline has been lengthened**, to allow more time to develop the transformation of the workforce roles before modelling reconfiguration, and to allow more time for Boards and Governing Bodies to engage.
- **On maternity and paediatrics**, several organisations raised concerns about interdependencies and Standalone Midwifery Led Units. The SOC says that the Clinical Working Groups will be asked to explore alternative ways of addressing interdependencies between maternity and paediatics, without moving to a SMLU. Any models which are proposed would be scrutinised by the Clinical Senate.
- **On elective services**, the HSR recommended that the next stage of work should look at some elective services. CEOs and AOs agreed that this should not be a part of the next stage of work on hospital services, although work on improving quality of elective services will continue through the elective workstrand.
- **In relation to Chesterfield**, the SOC makes it clearer that the SYB ICS will work with the Derbyshire STP in developing proposals and mitigations.
- **Where a reconfiguration option would result in some patients moving to trusts which are not within SYBND,** the SOC says that the team will do due diligence around any quality issues while the options are being modelled, and the quality implications will be assessed against the evaluation criterion on quality.
- **The data in the financial analysis** has been slightly updated. Some updated numbers on activity levels were provided by some trusts too late to be included in the HSR. They make

only a very marginal difference and do not change the decision making but in the interests of completeness they will be published alongside the SOC.

- **Local Authorities** requested that they should be more closely involved in the development of the next stage of work. This is being taken forward formally through the context of the wider ICS governance review. On an informal level, the hospital services team will engage more closely with Local Authority colleagues going forward.
- **Members of the public** raised a number of concerns. The detailed response to the points raised is at Annex B, and clarifications (e.g. around the intention to retain all existing A&Es, and to engage with transport organisations) have been provided in the SOC where possible.

***CCG Governing Bodies are formally invited to sign off the Strategic Outline Case and agree to its publication, in line with their statutory responsibilities in relation to leadership of service change as described in NHS England's*** **Guidance on Planning, Assuring and Delivering Service Change for Patients (2018).**

***Trust Boards are asked to confirm their agreement to the publication of the Strategic Outline Case.***

Alexandra Norrish
Programme Director, Hospital Services Programme
24 August 2018

# South Yorkshire and Bassetlaw Integrated Care System

# Strategic Outline Case on Hospital Services

# Presentation to Governing Bodies and Boards



**August 2018**

# The final report of the Hospital Services Review was published in May

**The Hospital Services Review was set up to ensure people across South Yorkshire and Bassetlaw, Mid Yorkshire and North Derbyshire (SYBMYND), continue to receive excellent hospital services now and in the future.**



It made recommendations focused on 5 services (see purple box) which:

- Are facing significant difficulties with workforce and quality; and
- have a significant impact on the service as a whole

- **Urgent and Emergency Care**
- **Maternity**
- **Care of the Acutely Ill Child**
- **Gastroenterology and Endoscopy**
- **Stroke**

## Hospital Services Review

- An independent Review, chaired by Prof. Chris Welsh
- Made recommendations around
  - how Trusts can work together; and
  - configuration of services

**Comments** by Boards, Governing Bodies, Local Authorities, members of the public; **assurance** by NHSE

## Strategic Outline Case

The statement by the health and care stakeholders in SYBMYND which

- lays out SYBMYND's response to the recommendations; and
- lays out the agreement by commissioners and trusts as to how SYBMYND will take forward work in these areas

# The three main principles of the HSR are also the main principles of the SOC:

1. There will continue to be a hospital in every Place: we are not closing any District General Hospitals;

2. Most patients will receive most of their hospital-based care at their local DGH;

3. We need the staff we have – we do not expect that the work of the Review will lead to any redundancies, although we may need to work differently.

# The SOC lays out three main workstreams

**1. Shared working**

Developing Hosted Networks to support co-operation between trusts and improve conditions for staff.

Support for workforce and innovation through a Health and Care Institute and Innovation Hub

**2. Transformation**

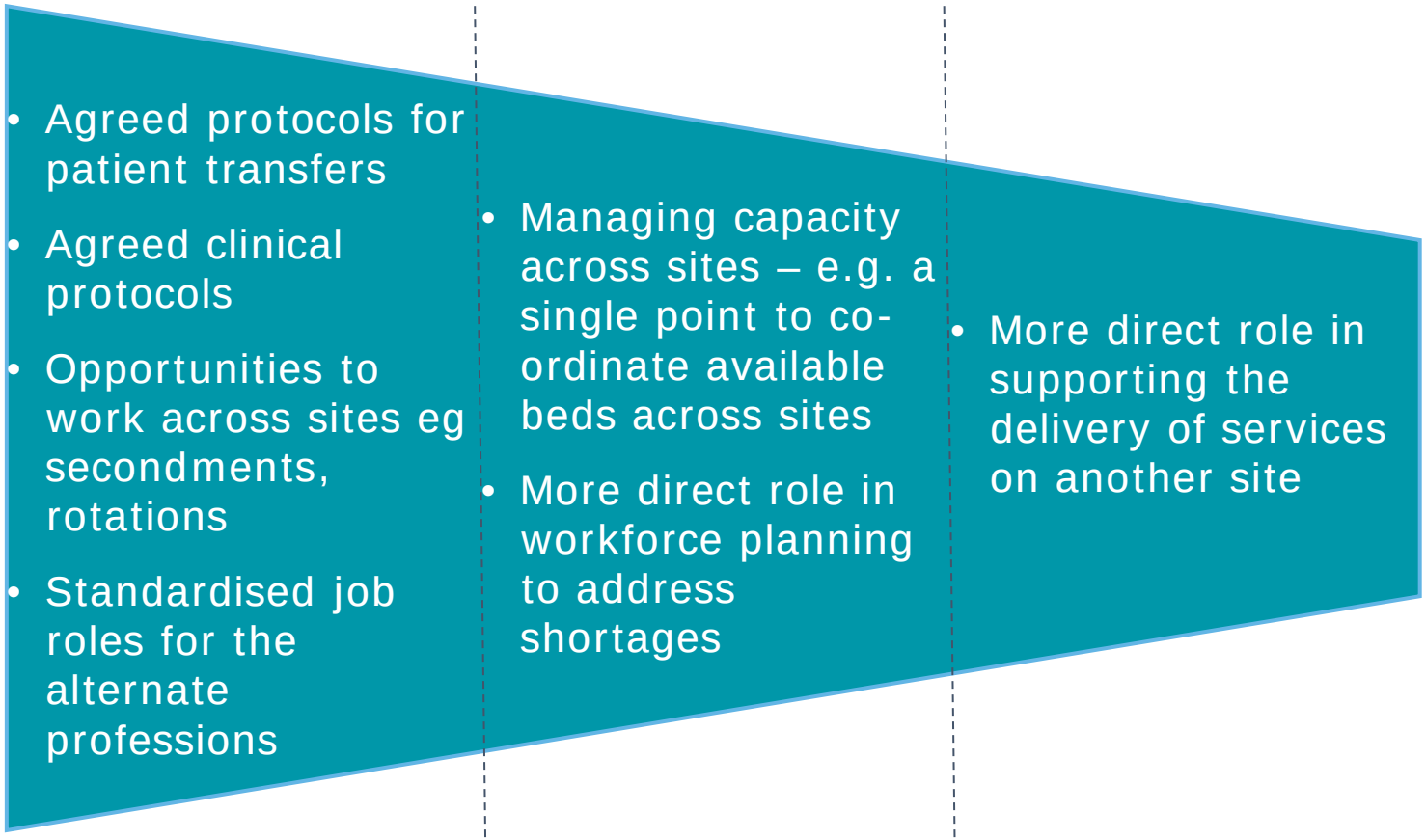
Shifting activity from the acute sector to primary and community care, where appropriate

Transforming the workforce, e.g. by changing job roles

**3. Reconfiguration**

Exploring options around how services are configured, for maternity, paediatrics and gastroenterology.

# The proposal for Hosted Networks is formal collaborations between trusts




**All trusts, for all specialties**

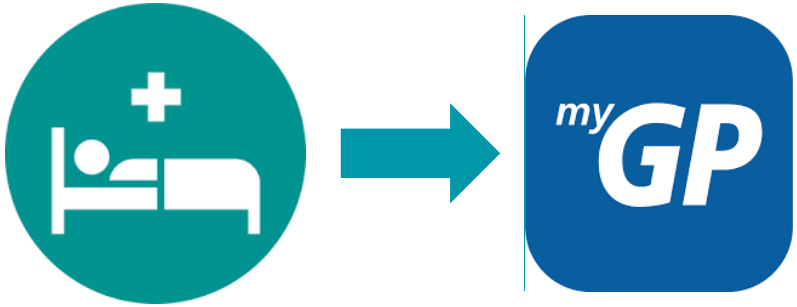
**All trusts, for some specialties**

**Some trusts, for some specialties**

**The host could be any of the SYB trusts (and potentially Mid Yorks / Chesterfield in long term)**

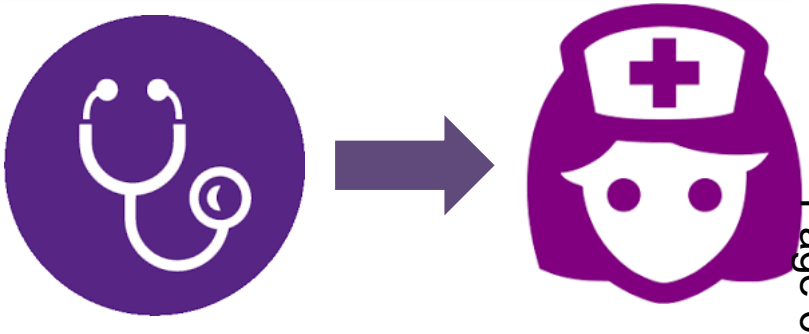
# Transformation is focused on making the best use of our workforce and buildings

## Delivering care in the right setting




- The 2016 Sustainability and Transformation Plan identified that some patients are receiving care in hospital which could better be delivered elsewhere
- The Clinical Working Groups will look at shifts of activity in their own specialties, supporting existing work in Places

## Making the best use of our workforce



- The HSR recommended that hospitals should work together to redesign the workforce, for example around making more consistent use of Advanced Nurse Practitioners and Physicians' Associates
- The Clinical Working Groups will look at the options in their own specialties

Patient and public input will be sought on any recommendations the CWGs put forward

# On reconfiguration, we will explore options for maternity, paediatrics and gastroenterology

## A&E

- Maintain 6 consultant led A&Es (plus the consultant led paediatric A&E at Sheffield Children's)

## Maternity

- Increase choice: home births; all hospitals have midwifery led services for low risk women
- Could replace 1 or 2 obstetric units with MLUs. But we will explore other options to meet requirements for interdependen-cies with paediatrics.

## Acutely ill children

- More care for children at home / in community
- Explore focusing 24/7 paediatric units on fewer sites: 1 or 2 could become Paediatric Assessment Units open 14/7. We will explore options to meet interdependen-cies with obstetrics

## Stroke

- Standardised approach to Early Supported Discharge, TIA and rehab services
- Consultants on Sites which will have a Hyper Acute Stroke Unit support services on those sites which have Acute Stroke Unit

## Gastroenter-ology

- Explore consolidating evening and weekend cover onto 3 or 4 sites: so that all sites have formal access to 24/7 GI bleed cover at all times, if necessary on another site

# Responses to the Hospital Services Review

Some changes have been made in response to feedback on the HSR.

## Greater emphasis on transformation

Trusts requested that we make it clearer that the acute work is built on transformation of the workforce and moving care out of hospital. We have made this a piece of work in its own right. Reconfiguration work will be based on the transformed workforce.

## Interdependencies between maternity and paediatrics

Some concerns were raised about moving to standalone Midwifery Led Units. The SOC says that we will explore other options around meeting interdependencies between paediatrics and obstetric units.

## Patients travelling out of area

Some concerns were raised about the impact on patients who might move to a non-SYB Trust. The ICS team will look at the quality implications of this and assess against the evaluation criterion on quality at evaluation stage.

## Involvement of Local Authorities

LAs asked to be more engaged going forward. The governance of the ICS is being reviewed, and the hospital services team will engage with LA colleagues.

## Public feedback

A key theme of transport was raised, which we will explore further in a dedicated transport group. The SOC outlines public feedback and how comments have been addressed.

## Refreshing modelling

Some updated data on activity was provided too late to be included in the HSR final report. We have refreshed the modelling to include it; the changes are marginal and do not change the recommendations.

# Next steps

The shared working and transformation workstreams will require public engagement. Any reconfiguration options will require formal consultation which requires a longer timeframe. These timescales are provisional.

| ***Sep – Dec 2018*** | ***Jan – May 2019*** | ***Jun – Sept 2019*** | ***Oct ->*** |
|---|---|---|---|
| **Shared working:** Development and implementation of the hosted networks, Health & Care Institute, Innovation Hub | | | |
| **Transformation:** CWGs identify out of hospital shift, workforce changes | | | |
| **Reconfiguration:** develop evaluation criteria, the model and the longlist of options | Continue modelling, work on travel and transport | Signoff by Governing Bodies, NHSE Gateway 2, finalise Business Case | ***Public consult-ation*** |
| ***Public engagement on all workstrands*** | | | |

# Thank you

# South Yorkshire and Bassetlaw, Mid Yorkshire and North Derbyshire: Hospital Services Programme

## STRATEGIC OUTLINE BUSINESS CASE

August 24th 2018

# CONTENTS

# 1 EXECUTIVE SUMMARY

Health and care organisations in South Yorkshire and Bassetlaw, Mid Yorkshire, and North Derbyshire (SYBMYND) have formed strong partnership working over a number of years with a reputation for delivering long term improvement to health and care for all of our local populations.

This joint working covers primary care, community care, mental health, acute and specialist care and our thinking starts with where people live, in their neighbourhoods, focussing on people being enabled and supported to stay well. Our ambition is to introduce new and improved services, to develop better coordination between those which already exists, to provide support for people who are at most risk and to adapt our workforce so that we are better meeting people's needs.

Prevention will be at the heart of everything we do, and investing in and reshaping primary and community services and integrating mental and physical health will ensure people are supported as close to home as possible. At the same time we have an ambition that everyone should have improved access to high quality care in hospitals and that no matter where people live they should receive the same standards of care. Key to this success will be developing innovative models of care building on the work of the Working Together Acute Care Vanguard.

Following the publication of the South Yorkshire and Bassetlaw system plan the South Yorkshire and Bassetlaw Health and Care Partnership, through its Partnership Board, voluntarily initiated an independent review of Hospital Services. The Hospital Services Review (HSR) was published in May 2018 and it made a number of recommendations including ways in which acute trusts could work together more effectively to meet the needs of patients and how services are designed across SYBMYND.

Partners, including all health commissioners and acute providers across SYBMYND, have now considered the report and provided feedback on its recommendations. The independent review together with its recommendations was well received and broad support was given from system partners to take the work to the next stage.

This Strategic Outline Case (SOC) describes how SYBMYND partners will take the review and its recommendations forward to support realisation of shared ambitions set out in the System Plan published in November 2016.

Below is a summary of the key recommendations which will be taken forward and which the system will build on in the next stage.

## 1.1 SHARED WORKING BETWEEN ACUTE PROVIDERS

- **Acute, community and primary care providers should continue to work together**, at Place level, to ensure that services are delivered as close to patients' homes as possible. This should be supported by standardisation of which services are being provided nearer to where people live rather than in acute hospitals.
- **The acute hospitals should work together more closely**. 'Hosted Networks' should be established, initially for the 5 services included in the Independent Review. They will drive collaboration, improve workforce planning development and deployment, standardise clinical protocols to improve outcomes, and identify and roll-out cost-effective quality-improving innovations across the system.

- **System partners should establish a Health and Care Institute and an Innovation Hub** to provide a system-wide central support for workforce and innovation across the system.

## 1.2 TRANSFORMATION OF SERVICES

- **Moving care into primary care and community care.** The individual Places within SYB and ND are developing an Out of Hospital Strategy to enable people and patients to be cared for outside a hospital setting where this is appropriate, and as close to home as possible. To support this, the Clinical Working Groups will work jointly with colleagues in primary care and community care to identify care pathways and services which could be delivered in non-acute settings.

- **Transformation of clinical models and workforce roles**. In order to ensure that we are making the best use of our staff, and providing care as efficiently as possible, we will ask the Clinical Working Groups to develop new workforce models and new clinical service models. The reconfiguration modelling will take account of these new clinical workforce and clinical service models, to ensure that reconfiguration options are fit for the future and sustainable.

## 1.3 RECONFIGURATION

- **District General Hospitals will be maintained in every place**, each with its own service portfolio comprising a core and specialist offer, working in a networked way across the region.
- **Providers and commissioners will consider consolidating** some services onto fewer sites, in order to improve the quality of care that can be provided to patients and make the best use of available workforce:
    - **All Emergency Departments** should remain open and continue to provide 24/7 care
    - **Paediatrics**: The system will consider the consolidation of full-time inpatient paediatric units from six sites onto four or five, maintaining part-time short stay paediatric assessment units in those places that consolidate their paediatric inpatient units.
    - **Maternity**: the system will consider service models that can support changes to the paediatric services available onsite. This should include the possibility of maintaining standalone Midwifery Led Units on sites which do not have inpatient paediatrics. However we will also look at other options that can address the interdependencies between inpatient paediatrics and obstetric services.
    - **Gastrointestinal bleeds**: Given the difficulty in sustaining out-of-hours rotas for GI bleeds, the system will model consolidating its services from five (currently not all full-time) rotas to three or four full-time out-of-hours rotas.
    - **Stroke**: Hospitals should adopt a paired approach to collaborative working to deliver stroke services, whereby sites with a combination of Hyper Acute Stroke Unit (HASU) and Acute Stroke Unit (ASU) services work with sites that have only ASU/in-patient rehabilitation services, to allow rotation of staff and exposure to more development opportunities.
- The system will establish a transport reference group with a remit to develop a system-wide transport strategy and the specific functions to support and deliver it

## 1.4 GOVERNANCE

- Commissioners, providers, NHS England and NHS Improvement and the Arms-length-Bodies have being developing a collaborative approach to shared working which they will build on. Commissioners and providers recognise that the current arrangements for decision making will need to evolve to support the scale of change that is included in this report.
- As the ICS develops, SYBMYND will review current governance arrangements in context of the existing legal framework and ensure these enable appropriate decision making to support the successful implementation of the recommendations in this report so that partners can improve outcomes and accessibility to services for people and patients.

This report sets out the case for change behind these agreed directions of travel, and how the system will take them forward.

# 2 STRATEGIC CONTEXT

## 2.1 VISION

This Strategic Outline Case recognises that South Yorkshire and Bassetlaw, Mid-Yorkshire and North Derbyshire (SYBMYND) are on a journey, which began several years ago with providers and commissioners choosing to work collaboratively, the publication of a system plan outlining the strategic ambition for health and care and which continues with the Hospital Service Review recommendations, We recognise that ways of working and approaches to collaboration will continue to evolve, as South Yorkshire and Bassetlaw (SYB) develops its role of becoming one of the first, and one of the largest, Integrated Care Systems (ICS) in the country.

Our vision focuses on people staying well in their own neighbourhoods, by integrating health and care services and developing a workforce that best meets people's needs.

The SYB ICS brings together commissioners, and acute, mental health, community, social care and primary care providers from our five places to work together to improve health and care services and outcomes to benefit our population.

Our vision for acute hospitals is to work together within networks rather than as individual, standalone providers. By working more closely together, we believe that we will provide better and more equitable care for our patients. We believe that we should have agreed standards and a shared way of doing things so that people can access the most appropriate care, no matter where they live.

In most cases, we anticipate that the majority of patients will continue to receive their care in their local hospital. We confirm our commitment to maintaining all of our local District General Hospitals.

Where patients have more complex needs, we anticipate they may access specialist care and treatment at another site within the network.

The networked approach will include Mid Yorkshire and Chesterfield hospitals, which are associate partners to the SYB ICS but have a long history of shared working with the SYB hospitals due to well established patient flows from the border areas of SYB.

## 2.2 INTEGRATED CARE SYSTEMS

Integrated Care Systems (ICSs) are systems in which NHS commissioners, providers, NHS England and NHS Improvement and other Arm's-Length-Bodies, working closely with GP networks, local authorities and other partners, agree to take shared responsibility (in ways that are consistent with their individual legal obligations) for how they use their collective resources to improve quality of care and health outcomes. ICSs are expected to make faster progress than other health systems in transforming the way care is delivered, to the benefit of the population they serve.

### 2.2.1 The SYB ICS

The SYB system is large and complex, comprising of five places: Barnsley, Bassetlaw, Doncaster, Rotherham and Sheffield. Within the SYB system are 208 GP practices, five local authorities, five clinical commissioning groups, five acute Foundation Trusts (two with integrated community services), four mental health providers and one ambulance service. The system is served by 72,000 staff and a health and care budget of £3.9bn each year. There are also two associate partner trusts: Chesterfield Royal Hospital NHS Foundation Trust and Mid Yorkshire Hospitals NHS Trust, and two associate CCGs: North Derbyshire CCG and Wakefield CCG.

### 2.2.2 The SYBMYND Collaborative

The five 'core trusts' are the members of the South Yorkshire and Bassetlaw Integrated Care System:

- Barnsley Hospital NHS Foundation Trust;

- Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust;
- Sheffield Teaching Hospitals NHS Foundation Trust;
- Sheffield Children's Hospital NHS Foundation Trust; and
- The Rotherham NHS Foundation Trust.

In addition to this, the neighbouring acute trust of Chesterfield Royal Hospital NHS Foundation Trust was fully included within the recommendations of the Review, and recommendations relating to shared working (though not to reconfiguration) also included the Mid Yorkshire Hospitals NHS Trust.

Their inclusion was due to a long history of joint working and clinical networks which support patient services, and the formal collaboration which has existed between the seven SYBMYND acute providers since 2014, when the Providers Working Together acute national Vanguard Programme was established.

However, going forward, work with Chesterfield will need to take account of Chesterfield's position within the Derbyshire Sustainability and Transformation Plan as well as its links to South Yorkshire and Bassetlaw.

## 2.3 The Hospital Services Review (HSR)

In 2017 the system commissioned a review of its acute services, recognising they faced significant sustainability challenges.

The HSR was undertaken over a 10-month period phased in three stages:

- June – August 2017: Identifying the services in scope for the Review
- September – December 2017: Detailed analysis of the issues facing the 5 core services
- January – May 2018: Development of options for the core services.

The Review was informed by a process of clinical engagement, through a series of Clinical Working Groups each of which met five times; and a public engagement programme which included both face to face and online communications. Concerted effort was made to engage seldom heard groups.

The Review team has published the notes of the clinical meetings, the reports of all the public engagement events, the findings of the Review and the detailed evidence for these at each stage of the Review. The reports and the supporting annexes can be found, along with the full set of Review documentation, at:

http://www.healthandcaretogethersyb.co.uk/index.php/what-we-do/working-together-future-proof-services/looking-at-hospital-services

This Strategic Outline Case outlines the system's agreed way forward following the receipt of the HSR recommendations. It draws on the HSR report, and on the responses to that Report (attached at **Annex A**).

# 3 CHALLENGES IN ACUTE SERVICES

A full case for change for the system is published as part of the HSR's website online. An updated analysis of the performance metrics of the Trusts in the system, and an overview of the challenges identified in the five services in scope of the review can be found in **Annex B – Case for Change.**

## 3.1 INTRODUCTION

The partners and associates of the South Yorkshire and Bassetlaw ICS commissioned the HSR in response to the challenges identified in the SYB Sustainability and Transformation Plan (STP) or System Plan.

SYBMYND has some of the best acute hospital services in the country, some of which have national and international reputations, including a specialist cancer centre, children's hospital and numerous high quality services in many locations. It also has one of the country's busiest accident and emergency departments. However, the system is under pressure from mounting demand and workforce pressures, both of which impact on the quality of care that patients receive. In addition there are inequalities of access and health outcomes across SYBMYND.

The current and future context will continue to challenge the system, as Trusts continue to respond to increasing demand and to national requirements around quality of care, equity of access and efficiency. The Review offered a unique opportunity to fundamentally change the way care is delivered in the system, and to consider options to transform the way trusts work together to sustain services.

Through tackling the challenges together, and considering the Report recommendations, SYBMYND aims to become one of the most innovative, safe, caring, responsive, effective, well led and efficient health and care systems in the country.

## 3.2 UNSUSTAINABLE SERVICES

The HSR spent the first three months of the Review assessing performance across all acute specialties in SYBMYND.

The findings of the assessment are published in the Stage 1A Report of the HSR, available at:

https://www.healthandcaretogethersyb.co.uk/application/files/7515/0903/4254/Hospital_Services_1a_Report.pdf

The HSR found that a number of acute services across SYBMYND were facing significant sustainability challenges. The HSR undertook a methodical prioritisation process to identify those services which were facing the most acute challenges, and from these it selected five significantly challenged services as the focus of the Review.

Details of how the services were identified are laid out in the 1A Report which is available on the website. In summary, the HSR considered a range of published metrics to provide an independent analysis; worked with Trusts to identify the services that they thought most unsustainable; and identified the level of interdependencies with other services.

The below table identifies the acute services identified as the most unsustainable. A high score indicates that not only was the service of high concern to individual Trusts across the system, but that this assessment was backed up by evidence, and that the service was critically interdependent in maintaining other hospital services.

| Rank | Service | Independent analysis | Trust self-assessment | Degree of clinical co-dependencies | Sustainability Score |
|---|---|---|---|---|---|
| **1** | Emergency Medicine | 13.6 | 16.0 | 16.0 | 15.2 |
| **2** | Gastroenterology | 10.8 | 13.0 | 15.0 | 12.9 |
| **3** | Urology | 13.5 | 12.0 | 13.0 | 12.8 |
| **4** | Stroke - HASU | 10.8 | 16.0 | 11.0 | 12.6 |
| **5** | Critical Care | 13.0 | 12.0 | 12.0 | 12.3 |
| **6** | ENT | 11.9 | 12.0 | 13.0 | 12.3 |
| **7** | Cardiology | 14.3 | 11.0 | 11.0 | 12.1 |
| **8** | Radiology | 11.8 | 12.0 | 12.0 | 11.9 |
| **9** | Acute Medicine | 11.2 | 11.0 | 12.0 | 11.4 |
| **10** | Dermatology | 14.3 | 18.0 | 0.0 | 10.8 |
| **11** | Paediatric Medicine | 9.4 | 11.0 | 11.0 | 10.5 |
| **12** | Orthopaedics | 14.3 | 8.0 | 8.0 | 10.1 |
| **13** | Endoscopy | 6.7 | 10.0 | 12.0 | 9.6 |
| **14** | Ophthalmology | 14.4 | 14.0 | 0.0 | 9.5 |
| **15** | Neonatology | 7.6 | 10.0 | 10.0 | 9.2 |

*Table 1: Assessment of service sustainability. Services taken forward for inclusion in the Hospital Services Review are highlighted*

In order to agree which of these very challenged services the Review should focus on, the HSR team invited input from the HSR Steering Group (including Medical Directors of all the trusts); patients and the public; and national organisations such as NHS England.

From the Steering Group, the following five services were identified for Review:

- Urgent and Emergency Care
- Acute Paediatrics (Care of the Acutely Ill Child)
- Maternity
- Stroke (the acute pathway, supporting HASU)
- Gastroenterology and Endoscopy

Four of these scored in the top fifteen most unsustainable services in SYBMYND (highlighted in orange in the table above). The fifth, maternity, was added because its interdependencies with paediatrics make it difficult to consider paediatrics in isolation, as well as its significance whilst considering the role of the District General Hospital (which was part of the HSR's terms of reference). Endoscopy and Gastroenterology were included together for the same reason.

## 3.3 The Main Challenges Facing the Five Core Services

The main challenges facing each of the five services were identified through the Clinical Working Groups, engagement with patients and the public, and performance and workforce data provided by the Trusts.

The main challenges that emerged in relation to the five services are as follows:

- **Workforce** – As is the case across the country, SYBMYND has a significant shortfall in the number of substantive staff in the system, with problems in both the recruitment and retention staff. The remaining workforce is therefore overstretched and there is a significant reliance on costly agency staff. Gaps in the workforce mean that staffing levels can fall below those required to provide a safe service for patients**.**
- **Unwarranted Clinical Variation** - Lack of standardised clinical protocols across the region means that patients with the same condition can receive different packages of care. This results in variation in clinical outcomes, both between and within Trusts. Reducing unwarranted variation is a key priority for the NHS nationally and was identified as a key challenge in the SYBMYND region.
- **Innovation** – Technology and digital infrastructure were flagged as being problematic. Outdated systems that were incompatible with one another, and slow adoption of new technologies across the region were hindering progress that could support the work of clinical healthcare staff.

Further detail on the challenges faced by the system and those faced by the five services in question is provided in **Annex B – Case for Change**.

A full report of the challenges identified by the HSR is available in the Stage 1B Report available at:

https://www.healthandcaretogethersyb.co.uk/application/files/9615/1809/8702/Hospital_Services_Review_1b_report.pdf

## 3.4 Future Work on Other Services

The five services identified above have formed the first wave of services. In the work over the next twelve months, neonatology will be included in the work on paediatrics because its interdependencies with maternity and paediatrics mean that it needs to be considered as part of any potential reconfiguration. In South Yorkshire and Bassetlaw and North Derbyshire, most neonatologists also work in paediatric units. This point has been raised frequently in feedback from stakeholders across the system including the maternity and paediatric Clinical Working Groups.

# 4 RECOMMENDATIONS OF THE HOSPITAL SERVICES REVIEW

## 4.1 THE RECOMMENDATIONS IN THE FINAL REPORT

Following as assessment of the sustainability of acute services in the SYBMYND, which involved significant clinical and public engagement throughout, the HSR made the following recommendations:

- **Acute, community and primary care providers should continue to work together**, at Place level, to ensure that services are delivered as close to patients' homes as possible. This should be supported by some standardisation across the acute services: there should be a defined range of services that will be moved out of an acute hospital setting, to be delivered in primary or community care, or patients' own homes.
- **All of the existing District General Hospitals should be maintained**, each with its own service portfolio, working in a networked way across the region.
- **The acute hospitals should work together more closely**. 'Hosted Networks' should be set up, initially for the 5 services included in the Review, with each capable provider taking the lead on one of the services. There will be three tiers of Hosted Networks. At the minimum, they will aim to drive collaboration and improve workforce planning, development and deployment; standardise clinical protocols to improve outcomes; and identify and roll-out cost-effective, quality-improving innovations across the system. For some specialties, the Host of the Hosted Network will co-ordinate capacity and workforce; and in the most developed model the Host may potentially support delivery of a service on other site(s).
- **System partners should establish a Health and Care Institute and an Innovation Hub** to provide a system-wide central support for workforce and innovation across the system. A Health and Care Institute should provide a central resource to support the recruitment, training and development of staff; the development of standardised clinical protocols; and the analysis and monitoring of trust performance, acting as a central intelligence function. An Innovation Hub should provide the capabilities to identify and roll-out cost-effective innovations across the system, working with local, regional and national partners.
- **Providers and commissioners should consider consolidating some services onto fewer sites**. Given the magnitude of the workforce challenge, both now and forecast in the do-nothing future scenario, collaborative working will not go far enough. As such, the HSR recommended that providers and commissioners should consider the consolidation of some services onto fewer sites, in order to make the most out of the available workforce and improve the quality of care that can be provided to patients.
    - **All Emergency Departments** should remain open and continue to provide 24/7 care
    - **Paediatrics**: The system should consider the consolidation of full-time inpatient paediatric units from six sites onto four or five, maintaining part-time short stay paediatric assessment units in those places that consolidate their paediatric inpatient units.
    - **Maternity**: The system should consider the consolidation of consultant-led birthing units from six sites onto four or five, maintaining standalone midwifery-led birthing units in those places that consolidate their CLU.
    - **Gastrointestinal bleeds**: Given the difficulty in sustaining out-of-hours rotas for GI bleeds, the system should consider consolidating its services from five (currently not all full-time) rotas to three or four full-time out-of-hours rotas.

- **Stroke**: Hospitals should adopt a paired approach to collaborative working to deliver stroke services, whereby sites with a combination of Hyper Acute Stroke Unit (HASU) and Acute Stroke Unit (ASU) services work with sites that have only ASU/in-patient rehabilitation services, to allow rotation of staff and exposure to more development opportunities.
- **Elective**: The system should develop models for the transformation and reconfiguration of elective services to support an improvement in quality of elective services, as well as to support changes to non-elective services, given unsustainability challenges in this area.

- **Access**: The system should establish a transport reference group with a remit to develop a system-wide transport strategy and the specific functions to support and deliver it
- **Governance**: Current arrangements between providers are unlikely to be fit for purpose when considering the scale of change that is included in this report. SYBMYND should review current governance arrangements and ensure these enable rapid decision making at pace to support the successful implementation of the recommendations in this report.

Full details of how the HSR developed these options are available in previous Stage 1A, Stage 1B and Stage 2 HSR Reports.

Final recommendations themselves can be found at:

https://www.healthandcaretogethersyb.co.uk/application/files/2515/2845/1016/25._HSR_Stage_2_Report.pdf

## 4.2 RESPONSES TO THE HSR RECOMMENDATIONS

Since publication of the final HSR in May 2018, its recommendations have been shared with CCG Governing Bodies and Trust Boards. Public engagement has also been ongoing to inform the public of developments while continuing to capture their thoughts.

There was broad support for the findings and recommendations of the Review, and as such this Strategic Outline Case outlines the Governing Bodies' intention to take on board the recommendations and commit to further work on the sustainability of acute services.

The feedback received to the HSR proposals is detailed in **Annex A – Responses to Feedback**, along with detailed responses to the individual points raised. This document outlines the system's agreed way forward following the receipt of these responses.

# 5 THE AGREED WAY FORWARD

CCGs, Trusts, Local Authorities and members of the public have given responses to the HSR recommendations (see **Annex A – Responses to HSR Feedback)**, and as a system we have developed our agreed way forward.

Overall, the South Yorkshire and Bassetlaw Integrated Care System, with Mid Yorkshire and North Derbyshire, agrees with the recommendations of the HSR. However, as a health system, the most vital focus for us going forward will be around developing shared working across the trusts, and transforming services, including through developing new workforce models. Only when we have understood the impact of both of these things will we consider changing the configuration of our services.

## 5.1 SHARED WORKING BETWEEN ACUTE PROVIDERS

Going forward, the acute providers will work together closely. We will set up Hosted Networks, as well as an infrastructure of a Health and Care Institute to support a shared approach to workforce and innovation.

### 5.1.1 Hosted Networks

- The system will work to establish a set of Hosted Networks across the five specialities identified in the HSR.
- The approach to Hosted Networks will consist of three tiers of Hosted Networks, with increasing levels of collaboration:
    - A basic Hosted Network will be responsible for standardising the approach to workforce functions; reducing clinical variation through setting agreed protocols; and rollout of specific identified innovations. It will be backed by agreed delegated decision making powers, accountability and monitoring.
    - A Co-ordinated Delivery Network will have the functions of a basic Hosted Network, with the Host having an additional co-ordinating role in identifying shortfalls in capacity and staff, and allocating resources to meet demand.
    - A Single Service Model will be explored, for some trusts and some specialties, whereby the Host may play a role in supporting the delivery of services on other sites. This arrangement is unlikely to cover every site in the network and would only occur if the support was requested by the receiving site.
- It is recognised that services are continually developing and evolving. As such, whilst we will work with service providers to determine the most appropriate level of network for each specialty, we acknowledge that this is dynamic and may change over time.
- The first step will be to work with providers and commissioners to develop a central framework on the networks' purpose, function and form that can be tailored to each service. The framework will outline the proposed form of the Hosted Networks and the lines of accountability between the Hosted Network, member trusts and the ICS. This will also lay out the responsibilities of both Hosts, and network members. An implementation plan will be drawn up to support this.
- The programme will engage providers and commissioners in developing a robust approach to equitably assigning Host organisations for each of the Hosted Networks. This will include developing criteria around what a Host must be able to provide, and the requirements that it must meet, in order to be eligible to host a service. This will ensure that whilst lead roles

are shared across the system, all Hosts have the resources and ability to perform the role of Host.

- Engagement will also be conducted to ensure staff have the opportunity to get involved and shape ways of working across the various organisations.
- The development of Hosted Networks will be alongside that of the Health and Care Institute and Innovation Hub, which will provide centralised analytical and human resource expertise for the Hosted Networks.

#### 5.1.2 Health and Care Institute & Innovation Hub

- We will progress the work to establish a Health and Care Institute and Innovation Hub to support the transformation themes: workforce, unwarranted clinical variation and innovation.
- We will engage with both NHS and non-NHS partners, such as local universities and industry, to develop the detail of the model.
- We will also consider funding implications and any interdependencies or overlap with other ICS workstreams.
- We will work with Health Education England to develop the workforce function of the Health and Care Institute. The approach to developing the Health and Care Institute and Innovation Hub should also include social care and the third sector to enable the appropriate innovation in care pathways.
- The Institute and Hub are likely to be one organisation, rather than two separate structures, but this will be agreed in work going forward

### 5.2 SERVICE TRANSFORMATION

We will ensure that services are working together as well as possible.

In order to do this, we will ensure that care takes place in the right place, and that only care which needs to happen in acute hospitals is provided there.

We will also look at ways in which we can use our existing workforce better, through different workforce models.

#### 5.2.1 Moving care out of hospital into primary care and community care

The NHS England Five Year Forward View, and subsequently the Sustainability and Transformation Plans of both SYB and North Derbyshire (SYBND), have focused on the importance of ensuring that care is delivered in the right place. In many cases, patients are currently receiving care in acute hospitals where this could be better and more efficiently provided in primary or community care, or in their own homes.

The individual Places within SYBND are developing their own strategies for reducing admissions to hospital, and making sure that patients receive care outside hospital wherever possible. The six CCGs have agreed to develop this into a single strategy.

In order to support this, we will ask the Clinical Working Groups to look at care pathways, and identify from the services under review which would be better delivered in settings other than the acute settings. The CWGs will work with colleagues in primary care and community care to understand what workforce and investment in primary care and community care would be necessary to make this happen. The Clinical Working Groups have already had some discussions of this, and this will build on this work.

### 5.2.2 Transformation of clinical models and workforce roles

The HSR describes the need to develop new workforce roles, in particular the roles of the alternative professions, such as Physicians' Associates and Advanced Nurse Practitioners. The HSR envisages that developing the approach to these would be part of the role of the Hosted Networks.

Providers and commissioners, in responding to the HSR recommendations, have highlighted the importance of ensuring that we do not simply base reconfiguration options on current workforce models. Therefore, before we model the impact of reconfiguration on our workforce, we will ask the Clinical Working Groups to develop new workforce models and new clinical models to ensure that we are making the best use of our staff.

The reconfiguration modelling will take account of these transformed approaches to the workforce, to ensure that the reconfiguration options are based on the new approach rather than simply replicating the status quo.

## 5.3 RECONFIGURATION

The HSR proposed that, where transformation options do not go far enough, we should consider reconfiguring services.

Leaders in the healthcare organisations have agreed with the majority of the HSR proposals for further work. The exception is maternity, where a number of responses raised concerns about the sustainability of Standalone Midwifery Led Units. As a result, the work going forward will include SMLUs but will also investigate other ways to address the interdependencies with paediatrics.

South Yorkshire and Bassetlaw, with North Derbyshire (SYBND) [1], have agreed to model the following options:

### 5.3.1 Urgent and Emergency Care

One member of the public asked for confirmation that the system intends to retain all 6 Accident and Emergency departments, plus the paediatric A&E at Sheffield. We confirm that we will do this.

The South Yorkshire and Bassetlaw Integrated Care System, with North Derbyshire, agrees:

- We will retain all 6 accident and emergency (A&E) departments plus the paediatric emergency department at Sheffield Children's Hospital. This includes emergency departments staying open 24/7, with consultant coverage appropriate to the size of the unit, guided by Royal College of Emergency Medicine guidelines.
- We will consider what staff presence is appropriate in A&Es at different times of the day and explore how we can use staff in different ways. Alternative staff roles, such as advanced nurse or medical practitioners, or support from GPs, could help to address workforce challenges in our A&E departments.

[1] Note, Mid-Yorkshire has recent undergone reconfiguration with other trusts in its STP, as such is not a part of the reconfiguration proposals. Chesterfield is included within the scope of the reconfiguration proposals, but we will need to engage closely with Derbyshire commissioners to ensure consistency with the development of the Derbyshire Sustainability Plan, since Chesterfield sits within Derbyshire STP as well as having patient flows to SYB.

### 5.3.2 Care of the Acutely Ill Child

Some concerns were raised around whether Short Stay Paediatric Assessment Units (SSPAU) were an appropriate way forward for system partners.

This concern is noted, and it is important to reiterate that any proposals for reconfiguration will be developed in close collaboration with clinicians to ensure they meet safety and quality requirements.

However, clinical evidence supports the safety of SSPAUs as an alternative to full-time inpatient units, particularly when there is not enough activity or resource to sustain a full paediatric inpatient unit, assuming appropriate transfer protocols are in place for those patients requiring overnight care. The Royal College of Paediatrics and Child Health support such a care model, stating that for many patients they are a more appropriate care setting than an inpatient unit, and are being increasingly used to deliver high quality paediatric care[2].

The South Yorkshire and Bassetlaw Integrated Care System, with North Derbyshire, agrees:

- We will model the impact of changing one or two inpatient paediatric units (from the existing units in South Yorkshire and Bassetlaw and North Derbyshire) into SSPAUs.
- Where an SSPAU is proposed, we will ensure that it is supported by robust referral and patient transfer protocols to ensure children are able to access the care they need out-of-hours.
- If changes are being proposed to paediatrics services, this will be mirrored by appropriate changes to maternity and neonatology services on the site. We will continue to test out a range of models that meet the required interdependencies between obstetrics and paediatrics, and will assure the safety of any such models with the Clinical Senate.
- We will continue to model transformation options, such as using mid-grade staff, and advance nurse and medical practitioners in different ways, and changing job roles, to address workforce challenges.

### 5.3.3 Maternity

The HSR focused on being able to expand the choice of services available to women, and being able to deliver high quality care at each of these care settings, given the current and projected constraints on consultant and midwife numbers in the system.

The SYB system is working to deliver the recommendations of the Better Births report. This includes providing women with greater access to choice of where to have their babies, including home births and Midwifery Led Units.

The HSR recommended that the system should provide a MLU on every acute site, and that one or two sites should look at having Standalone Midwifery Led Units, supporting a a part-time Paediatric Assessment Unit, with obstetric, neonatology and specialist paediatric services being provided at another linked site. This is a model that is used in a number of places in the NHS.

Some respondents raised concerns about the safety and in particular the sustainability of Standalone Midwifery-Led Units (SMLUs). The hospital services programme will continue to work with local obstetricians, midwives, nurses, sonographers, neonatologists and other healthcare professionals in the development of any specific proposals in the next phase of work, and this will involve a thorough assessment of the clinical evidence on SMLUs.

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[2] Royal College of Paediatrics and Child Health, Standards for Short-Stay Paediatric Assessment Units, March 2017.
Available at: https://www.rcpch.ac.uk/sites/default/files/SSPAU_College_Standards_21.03.2017_final.pdf

In addition, the maternity workstrand will be asked to explore alternative clinical models, both locally and internationally, which allow of greater flexibility around the co-location of maternity and paediatric services, recognising the clinical interdependency that exists between these and neonatology services. We will test out other models that might allow for obstetric-led services remaining on a site without 24/7 paediatrics being present, and vice versa.

Any such options will be developed in close collaboration with expert Clinical Working Groups and submitted to the Clinical Senate for scrutiny, to ensure that they are safe and appropriate.

The system partners will also seek to engage with mothers and women of child bearing age to understand their thoughts and concerns on how and where they would like to give birth.

The need to fully consider the interdependencies between maternity, neonatal and paediatric services was also flagged in responses from Boards and Governing Bodies. The system has agreed to add neonatologists to the Clinical Working Group on Care of the Acutely Ill Child, and to include neonatology in any reconfiguration modelling in order to address this.

The South Yorkshire and Bassetlaw Integrated Care System, with North Derbyshire, agrees:

- We will model the impact of a reduction in the number of obstetrics units by one or two units, from the existing units in South Yorkshire and Bassetlaw and North Derbyshire.
- We will engage with the public on their preferences for midwifery-led care and we will continue to work with clinicians to understand if SMLUs can be delivered safely and efficiently.
- For those Places which potentially would not have an obstetric unit, we will model the implications of offering choice through standalone midwifery-led units, supported by robust referral and patient transfer protocols if needed.
- We will also explore alternative clinical models. Traditionally, if changes to the maternity services are being proposed on a site, this would be mirrored by changes in paediatric services. However we will also continue to explore alternative models that might allow the interdependency between maternity and paediatrics to be satisfied in other ways, and will assure the safety of any such models with the Clinical Senate. We will also engage with the public around these to ensure that the implications of any proposals are clear and to hear and consider their feedback.
- We will include neonatology in the modelling moving forward and involve neonatologists fully in the acute sustainability programme through the Care of the Acutely Ill Child Clinical Working Group.
- We will continue to model transformation options, such as using mid-grade staff, and advance nurse and medical practitioners in different ways, and changing job roles, to address workforce challenges.

#### 5.3.4 Gastroenterology

Maintaining the quality, safety and sustainability of services are all key criteria taken into consideration throughout the development of any options and their evaluation, and in depth site-specific modelling of options will be done to assess and evaluate future options before any are considered and taken further.

One respondent raised concerns about the safety implications of moving to full out of hours services on three or four sites; however, we note that the system does not currently provide out of hours services on all of these sites.

One respondent suggested that staff should move to the patient rather than vice versa. However, this was discussed in the Clinical Working Group and was thought to be a less safe option, given the

risk that a consultant called to an emergency on one site could not then support an emergency at another site.

The South Yorkshire and Bassetlaw Integrated Care System, with North Derbyshire, agrees:

- At present we do not have five full out-of-hours areas, therefore, going forward as a system we will model moving to three or four rotas, and engage with our clinicians to ensure the concerns raised above are covered.

#### 5.3.5 Stroke

The HSR did not propose any reconfiguration proposals for stroke services, as changes were already underway through the work on hyper-acute stroke units. The South Yorkshire and Bassetlaw Integrated Care System, with North Derbyshire, agrees:

- We will further develop proposals for the collaborative working of stroke services through paired sites, between sites with a HASU and an ASU. Such a collaborative way of working could be supported through the stroke Hosted Network.
- We will develop standardised commissioning specifications for early supported discharge, inpatient rehabilitation, and transient ischaemic attack services.

### 5.4 Considerations in Relation to Reconfiguration

#### 5.4.1 Sites in Scope

The HSR's reconfiguration recommendations were site agnostic, based on the collective availability of workforce and capacity across the South Yorkshire and Bassetlaw, and North Derbyshire (SDYBND) region relative to forecast activity levels and care quality requirements. Some organisations have wished to outline concerns about service change at an early stage.

At this point, the principles around potential reconfiguration require that all the possible options must be considered equally. As an immediate next step, we will lay out the approach that the system will take to defining the sites and options which will be modelled, in line with national guidance and statutory requirements around options development and options appraisal.

We confirm that the hospital sites included in the baseline for the reconfiguration modelling (i.e. sites where services might change) are:

- Barnsley Hospital
- Bassetlaw District General Hospital
- Chesterfield Royal Hospital
- Doncaster Royal Infirmary
- Northern General Hospital
- Royal Hallamshire Hospital
- Sheffield Children's Hospital
- Rotherham General Hospital.

The South Yorkshire and Bassetlaw Integrated Care System, with North Derbyshire, agrees:

- As a priority, the acute sustainability programme will work with CCGs, Trusts and Clinical Working Groups to develop site-specific reconfiguration options to be taken forward for more detailed modelling and analysis.

- As we take the work forward, all Trusts will be considered in the context of the site-specific modelling; and we have an open mind in relation to how they are included. The system may wish to designate some fixed points, based on permissible criteria and in line with guidance and precedent. There would be an agreed approach to determining any fixed points, with full engagement from system leaders, patients and the public.
- Refreshed hurdle and evaluation criteria will be used to assess these options to ensure that any proposals that are taken further meet robust quality and safety requirements, and provide equal access to care for patients across the region. We will engage with system leaders, patients and the public in refreshing and agreeing weightings for the evaluation criteria.
- We recognise the need to work closely with Derbyshire CCGs around the impact of any proposals affecting Chesterfield on the Derbyshire STP.

The options modelled will be in line with the approaches agreed above.

#### 5.4.2 Trusts outside the ICS

It is possible that under some reconfiguration scenarios the nearest service for some of our patients will be outside of the SYBND footprint.

Sites that could potentially receive additional patients from the SYBND region include, but are not limited to:

- Calderdale Royal Hospital
- Dewsbury and District Hospital
- Huddersfield Royal Infirmary
- King's Mill Hospital
- Leeds General Infirmary
- Lincoln County Hospital
- Pinderfields Hospital
- Pontefract Hospital
- Scunthorpe General Hospital

In addition, some STPs outside SYBND are undertaking reconfigurations or service changes of their own, so some of the hospitals on our borders may be making changes which could themselves impact on the SYBND sites.

The system agrees the following:

*Patients moving outside SYBND:*

- We will model all the appropriate options, including those where patients might move to trusts outside SYBND.
- However, as we do this we will undertake due diligence around understanding any quality, safety and capacity issues at the potential receiving sites.
- In evaluating the options, one of the existing evaluation criteria is quality, and we will consider any implications of quality for patients receiving care from trusts outside SYBND. In the assessment of equalities, we will also consider the potential equality implications of

some patients receiving care at sites which are not signed up to the principles of the SYB Hosted Networks.

*Proposed changes in neighbouring STPs*

- The Review team is already in contact with the leads on reconfiguration in neighbouring STPs, and contacts with these leads will continue.
- As we develop the modelling for the SYBND reconfiguration options, we will include the implications of potential patient flows into SYBND caused by potential reconfigurations in our neighbouring health economies, where these are known.

### 5.4.3 Transport

Feedback from members of the public raised concerns around transport, and asked in particular that we ensure that we link to strategic planning around travel and transport across the footprint. We will invite the leads on transport issues in the key organisations responsible for designing transport across the region to our travel and transport group, so the transport strategy will be a focus going forward.

The South Yorkshire and Bassetlaw Integrated Care System, with Mid Yorkshire and North Derbyshire, agrees:

- We will model the potential impact on travel times due to reconfiguration. Within the travel time modelling we will look at blue-light emergency transport, and journeys through both private transport and public transport means.
- We will also conduct a postcode-level analysis to look at the impact on different socio-economic groups based on indices of deprivation data, to ensure that no groups are disproportionately affected by change.
- We will engage local partners to set up a strategic travel group as a priority. This group will comprise representation from local acute trusts, commissioning bodies, ambulance services (both Yorkshire and East Midlands Ambulance services), local authorities, patients and the public, and other relevant local travel and transport stakeholders (such as local public transport providers). The programme will engage this group regularly as options are developed and assessed. Clinical Working Groups will be engaged in a similar capacity to understand the safety implications of increased travel times in emergencies. In such a way the acute sustainability programme will ensure that options taken forward seek to minimise and mitigate any increase in travel. It will consider the issues around public transport, in both urban and rural areas.

### 5.4.4 Equalities and the Equalities Impact Assessment

Ensuring equitable access to high quality care has been raised as an issue by patients and the public, and is a priority for the programme. A core aim of the Review was to address health inequalities, and this will be at the heart of modelling, and assessing our options, going forward.

The South Yorkshire and Bassetlaw Integrated Care System, with Mid Yorkshire and North Derbyshire, agrees:

- We will ensure the completion of an equalities impact assessment to inform any future proposals.
- This will be supported by quantitative modelling that seeks to identify any potential impact on patients, broken down into demographic groups, to understand and assess the impact on different groups in society. We will look at the impact on the protected groups (as identified

in the Equalities Act), as well as issues around socioeconomic inequalities which we will identify through postcode analysis.

- The programme will continue to engage with a wide range of stakeholders, including a particular focus on seldom heard groups, to hear and understand their views and concerns to ensure that their feedback is taken into consideration.
- The evaluation of options against evaluation criteria will include an assessment of impact on equalities, through the access criterion, as well as the separate Equalities Impact Assessment.

### 5.4.5 Affordability

Financial analysis was undertaken to understand the cost-benefit and affordability of any of the high-level reconfiguration options. Consideration was made of both any impact on trust operating expenditure and any capital cost requirements. Transition costs were also taken into account. The financial impact of each option was considered as one of the evaluation criteria in the HSR, and will continue to be so in any future appraisal of site-specific options.

More detailed modelling to fully understand financial impacts on providers and commissioners of site-specific reconfiguration options will be conducted in the next phase of work.

One response from the public raised concern about the level of modelling done to date querying whether data from all trusts had been used in the modelling, and cited the 'limitations' section in the financial annex of the report. We confirm that data from all trusts (reference costs and STP forecasts) was used to inform the analysis that underpins the HSR. The 'limitations' point relates specifically to the fact that at the time of writing only Barnsley had contributed service line reporting (SLR) data; not all trusts collect SLR data. A detailed response to the concerns raised by the member of the public is provided in **Annex A – Responses to HSR Feedback**.

The financial analysis published alongside the HSR used the data available at the time that the modelling was developed. Several trusts made more detailed data on activity available shortly before publication, and this was used to update workforce projections. However the updated data was made available too late to be included in the capacity and financial data, so an updated analysis is attached as an Annex to this Strategic Outline Case in **Annex E – Addendum to HSR Financial Modelling**. The changes are marginal (the greatest change to cost implications in any scenario is £1.3m, with most changes being £0 to £300,000) so the updated data made no impact on the final recommendations.

#### *5.4.5.1 Operating costs analysis*

Baseline trust provider costs for 2021/22, before any configuration changes, were taken from STP (now ICS) plans, which included assumptions around the impact of cost improvement programmes (CIPs), out-of-hospital schemes, and other service changes.

Various financial impacts were analysed:

Workforce efficiencies were quantified, whereby savings could be realised from the reduction in locum usage, given the decreased requirement for certain groups of staff following consolidation. Another key source of workforce efficiencies was that it might be possible to increase service coverage with fewer additional full time equivalents, relative to the current configuration. Changes to service models might also result in financial impacts: for example, new delivery models such as urgent treatment centres could be used to take activity out of A&E. Shifting additional care out-of-hospital, where appropriate, was another driver of cost impact.

Fixed cost savings were quantified to recognise a partial offset for new build costs. This was linked to changes in bed capacity when any activity shift led to new build costs.

These reductions in operating expenditure were balanced against any increased capital expenditure, with the revenue cost of any required capex phased equally over a 10-year period. More detail on the approach to quantifying capital costs is set out below.

Future stages of modelling will use more accurate trust costing data and work with commissioners and providers to quantify any associated impact on operating income.

#### *5.4.5.2 Capital costs analysis*

Capital costs were quantified on the basis of requirements for additional bed build at sites receiving additional activity. If the receiving site has no spare space, the incoming bed would be by necessity a new build. If the receiving site has spare space but not in the same department, the spare bed would need to be refurbished, for c. 50% of new build cost. If the receiving site has spare space in the same department, the incoming bed could be accommodated for no cost.

# 6 CAPITAL FUNDING

As part of the national process for prioritising STP/ICS capital, the ICS has completed a draft Estate Strategy and associated capital bids which include a range of schemes designed to deliver clinical, estate, patient quality and experience and workforce benefits across the system as a whole; including identifying an estimated future capital requirement associated with the final report of the HSR published on 9 May 2018.

HSR modelling on capital costs focused on the cost of moving activity and associated bed build. However, more detailed modelling in the next phase of work may draw out more granular capital needs, such as for technology and digital infrastructure, costs of which were accounted for in the capital bid.

At the point at which the system was required to submit bids for the next five years, HSR had not yet been fully considered by the system, and this Strategic Outline Case was still in development. On the advice of NHS England, therefore, South Yorkshire and Bassetlaw included a placeholder bid for capital related to the HSR, using a mid-range scenario from the modelling undertaken from the HSR. This bid will, obviously, only be pursued in the event that the system agrees to take forward reconfiguration, following public involvement and, if needed, consultation, and therefore the capital is required.

The ICS's total capital bid is comprised of five component workstreams as follows. The HSR reconfiguration element is 1e below. Note that, rather than including either the highest or the lowest level of costs identified in the HSR modelling, the scenario used here is a middle range which involves changes to one large and one small site for maternity and paediatrics.

| ICS Initiative/ Clinical Workstream | Physical assets obtained: | Phasing of workstreams: | Capital Required: |
|---|---|---|---|
| 1a System Sustainability – Primary and Community investment | Creation of additional capacity for delivering primary and community care services, training and development | Phase 1: Primary Care, Community, Mental Health, Digital and Linked Acute schemes can be delivered ahead of the HSR Strategic investment. As schemes are worked up and where change is considered significant, the ICS would be subject to NHS assurance processes, including potential public consultation and we would carry out our statutory duties. | £57m |
| 1b – System Sustainability – Mental Health Investment | Creation of community crisis centre and reprovision of co-located services into new community hubs | | £43m |
| 1c – System Sustainability – Digital Investment | Introduction of a single, SYB-wide shared digital platform across a number of key services | | £35m |
| 1d System Sustainability – Linked Acute Schemes | Range of updated and improved clinical facilities across all acute providers (including removal of Nightingale wards, co-location of emergency services and the expansion of critical diagnostic services and key acute services) | | £71m |

| ICS Initiative/ Clinical Workstream | Physical assets obtained: | Phasing of workstreams: | Capital Required: |
|---|---|---|---|
| 1e System Sustainability – Strategic elements of HSR | Reprovision of 208 new beds across existing sites, to support the reconfiguration of key acute services across the ICS (subject to consultation).<br><br>The scenario of 208 beds was identified as a mid-point between the maximum and minimum scenarios identified within the Hospital Services Review. It is an indicative figure at this point. | Phase 2: the HSR implementation could be completed alongside the Phase 1 workstreams. As the scheme is subject to NHS assurance processes, including potential public consultation, it is anticipated that a number of the Phase 1 schemes would already be completed if the scheme went ahead. | £99m |

In addition, two further capital bids have been submitted around ensuring the sustainability of facilities that support acute services at Doncaster and Bassetlaw Hospitals and an ICS-wide Cancer Strategy.

The Doncaster and Bassetlaw work predominantly looks at improvement of emergency care services and improvement of services at Doncaster Royal Infirmary. We will work with the Trust on any areas that might impact or be impacted by the hospital services workstream.

In relation to the ICS-wide Cancer Strategy, the capital bid would cover potential improvements to sites and facilities across South Yorkshire and Bassetlaw. As with the HSR, any changes would be subject to engagement and, if necessary consultation with the public.

# 7 NEXT STEPS

This Chapter outlines the next steps being undertaken by the system to deliver the recommendations of the HSR, as per the agreed way forward detailed earlier in this Strategic Outline Case.

## 7.1 SERVICE LEVEL COLLABORATION

**Developing Hosted Networks:**

- Agree a framework for all the Hosted Networks, at a system-wide level;
- Establish criteria as to what responsibilities a trust must be able to meet in order to be a host;
- Define the responsibilities of the Hosts and Members;
- Agree how this links to the ICS structures;
- Agree which trusts will lead on each of the Networks; and
- Establish the Hosted Networks

## 7.2 SYSTEM LEVEL COLLABORATIVE WORKING

**Develop Institute of Health and Care: covering Workforce**

- Agree the objectives, structures, funding and governance of the Institute; and
- Agree how it will relate to the trusts and how it will support the work of the Hosted Networks
- Establish the Institute of Health and Care

**Develop Innovation Hub: covering Innovation**

- Agree the geographical footprint of the innovation hub, who are its members, and how it relates to the Institute of Health and Care (whether it is part of the same organisation or a separate one);
- Agree the objectives, structures, funding and governance of the Institute; and
- Agree how it will relate to the trusts and how it will support the work of the Hosted Networks
- Establish the Innovation Hub

## 7.3 SERVICE TRANSFORMATION

**Transformation of clinical models and workforce roles:**

- Engage Clinical Working Groups and Health Education England, and other workforce committees, to develop new clinical models and new workforce models to ensure that we are making the best use of our staff; and
- Ensure that any reconfiguration modelling takes account of these new clinical models.

**Supporting the out-of-hospital strategy:**

- The strategy for Out of Hospital care is being developed in the ICS in partnership with its five places identifying pathways in the core acute areas which would shift into primary or

community care, and the workforce / capital / financial implications of this shift of activity whilst the acute sustainability work develops.

## 7.4 RECONFIGURATION

**Develop specification for modelling:**

- Develop the specification of what the modelling needs to be able to model for financial, activity, workforce and access data;
- Agree what data sources, at what levels, are required for this; and
- Agree how the modelling will relate to the requirements of the Equalities Impact Assessment.

**Agree evaluation criteria:**

- Refresh the existing evaluation criteria to ensure that they are still fit for purpose and to address any gaps; and
- Engage the public and stakeholders on the weighting of evaluation criteria

**Agree shortlist of options to be modelled:**

- Develop the shortlist of options around the modelling, including identifying any 'fixed points' i.e. sites or services which would self-evidently not change, and all the possible combinations of the remaining sites.
- Engage clinicians on the proposed shortlist of options for modelling; and
- Engage patients and the public on the proposed shortlist of options for modelling

**Model shortlisted options:**

- Collect the relevant data, build the model using information around the transformed workforce developed by the Clinical Working Groups, and run the agreed options through the model. This will be iterated multiple times to ensure that the data is genuinely robust and reliable.

**Agree preferred option(s) to be considered for consultation:**

- Evaluate the outcomes of the modelling against the evaluation criteria: this will need to involve patients and the public as well as stakeholders across the system; and
- Identify a shortlist of preferred option(s) which are likely to be included within the Pre-Consultation Business Case, based on the outcomes of the evaluation process

**Produce Pre Consultation Business Case:**

- Engage with the Joint Health Overview and Scrutiny Committee to confirm if any elements of the proposed changes require formal public consultation (see below);
- Draft Pre-Consultation Business Case;
- Submit to NHS England for assurance (see below)

## 7.5 PUBLIC CONSULTATION AND ENGAGEMENT

The development of the HSR has included a significant level of public and clinical engagement. Going forward, we will build on this to ensure that clinicians, members of staff, patients and the public have as many opportunities as possible to be involved.

Respondents acknowledged the engagement that had been done to date, with clinicians, nurses, midwives, other healthcare professionals, the public and patients. However, several respondents felt more should have been done. Some respondents felt that the HSR had not yet engaged sufficiently with local authorities, and specifically their elected members.

Engagement with seldom heard groups was acknowledged as positive of the work to date and the acute sustainability programme will continue to do so in any future phases of work.

Future next steps include:

- **A detailed Engagement Plan**, to include the approach to involvement, will be developed by the ICS Communications team, in collaboration with the PMO for the acute sustainability work. It will be shared with the SYB ICS Citizens' Panel and Joint Health Overview Scrutiny Committee for comment and signed off by the Sustainable Acute Services Steering Group, and by the Collaborative Partnership Board. This will ensure that patients and the public have their say on proposals at all stages of development and will seek to engage people from all areas of the region.

- **Clinicians**, other healthcare professionals and other staff groups within services will continue to be engaged through the reconstitution of the Clinical Working Groups (see below). These will meet on a regular, scheduled basis and will be a key forum in which the programme will shape and develop any options for modelling and evaluation, actively seeking their expertise in the subject and knowledge of SYBMYND and its population.

- **Engagement with patients and the public**: The approach will be outlined in the engagement strategy. In summary, the acute sustainability programme will continue to engage regularly through the ICS Citizen's Panel, CCG Engagement Groups (including Patient and Partnership Groups), provider Trust Engagement groups and other relevant forums, such as Healthwatch, voluntary sector groups, local Maternity Voices Partnerships.

  Several large engagement events will also be held throughout this next phase of the Review, which will be specific to this programme of work. As respondents have pointed out, as proposed modelling work progresses, the nature of engagement will become more specifically related to changes to individual sites and services, whereas it has tended thus far to relate to broader discussion of concepts. Involvement will be frequent and regular to ensure clarity and transparency around proposals as they develop. We will also build upon the learning from previous consultations undertaken by our and other systems, to ensure relevant experience informs our work.

- **On travel and transport**: a specific patient and public group will be convened to focus on the transport and travel implications of any service change proposals. This will support a clinical and operational group on transport and travel.

- **Engagement with Local Authorities**: Whilst the HSR engaged with the Joint Health Overview and Scrutiny Committee, and will continue to do so, the programme will seek to strengthen moving forward. The Review team will engage with Directors of Public Health and Health and Wellbeing Boards on the hospital services workstreams, such as working with them as the modelling is developed to ensure that population data is accurate. More generally, the system partners will engage with Local Authorities, including Leaders, around the development of shared working across the system.

- **Formal Public Consultation**: If required, a formal public consultation plan will be developed and published alongside any pre-consultation business case, detailing plans to consult with all of the stakeholders in the SYBMYND health economy. We will actively seek comment on proposals from commissioners, trusts, healthcare staff, patients and the public, local authorities and others in order to inform any service change decision.

## 7.6 ASSURANCE OF THE PROPOSALS

As well as significant engagement with system stakeholders, patients and the public, proposals will undergo regulatory assurance processes with national NHS bodies:

**Clinical Senate sign-off of proposals:**

- The North West Clinical Senate will be asked to formally review options which require clinical changes to ensure that they are robust

**NHS England assurance of proposals:**

- The system will submit all proposals to NHS England for formal assurance as required

## 7.7 GOVERNANCE

The HSR was an independent review. Therefore, while its governance aimed to ensure that all the member organisations were closely involved in and sighted on the work, its governance reflected its Terms of Reference.

Going forward, the HSR ceases to be an independent review, and will become one of the workstreams of the ICS. The name of the programme, and its governance, need to reflect this.

Going forward, the health and care economy as a whole is going to need to develop appropriate governance to support the ICS and its partners. This will need to respect the existing statutory framework, while allowing for streamlined decision making in the integrated structure.

The HSR made a recommendation around ensuring that the governance is appropriately streamlined going forward, within the current statutory framework:

*"The current arrangements between providers are unlikely to be fit for purpose when considering the scale of change that is included in this report. SYBMYND should review current governance arrangements and ensure these enable rapid decision making at pace to support the successful implementation of the recommendations in this report"*

One member of the public raised a question around whether the governance was appropriate, and cited the point made in the review about the current arrangements between providers. They also expressed a query about the maintenance of statutory duties and lines of accountability in the any arrangements. It should be clarified that all commissioners will retain and perform their statutory duties, with providers and associated bodies held to account through any contracts held with the CCG(s).

Going forward, the workstream taking forward the recommendations of the HSR will be known as the Hospital Services programme (subject to agreement from our Citizen's Panel and other public stakeholders that this phrase is easily understood).

The governance will continue to recognise the need to involve all trusts and CCGs, and other core stakeholders, and the need for strong leadership. All relevant organisations should continue to be equitably and appropriately represented in the governance of the programme.

The governance will be formally laid out in, and signed off as a part of the Terms of Reference for the sustainability of acute services work going forward. However in summary we propose the following arrangements.

**Programme Governance:**

- **A Hospital Services Steering Group.** Stakeholder organisations agreed (in the Joint Committee of Clinical Commissioning Groups (JCCCG) and Collaborative Partnership Board) that we should maintain and expand the HSR Steering Group. The Steering Group will be a dedicated clinical and operational group at executive level, which will oversee the

development of the hospital services work and be accountable for delivery of the work programme within organisations. It will play a key role in the evolution of Review process, including the development of reconfiguration options and robust evaluation and appraisal frameworks.

The Steering Group (SG) is likely to bring together Medical Directors and operations executives from acute trusts, CCG Accountable Officers, senior leads from the community and mental health trusts and the Yorkshire Ambulance Service, and NHS England.

Moving forward, it is proposed that there should be designated sub-committees under the SG, such as a strategic travel group and a data and modelling group. Respondents were keen to ensure that they were represented on these groups and the membership of these groups will be confirmed in the Terms of Reference.

- **Clinical Working Groups** (CWGs) will bring together clinicians, nurses, and operations directors, and other healthcare professionals from the acute trusts, to advise on the development and evaluation of any proposals. Community and mental health services, primary care and commissioning representatives will also sit on CWGs to ensure the perspectives of the different clinical sectors are heard.
- **The Collaborative Partnership Board** (CPB) will have formal oversight of the programme for the ICS.

**Statutory and Delegated powers:**

- **The Boards and Governing Bodies of the trusts and CCGs** will be responsible for formal sign-off of proposals, since at this point they are the organisations which are statutorily accountable. These groups include Non-Executive Directors.

  Ultimately, statutory powers around decision making on service change rest with the CCGs, who will sign off and lead any consultation on service change.

- **The Joint Committee of Clinical Commissioning Groups (JCCCG), Committees in Common (CIC) for the acute trusts, and the ICS Executive Steering Group** do not currently have any formal delegated powers around this workstream but will continue to oversee and advise on direction.

  However, as part of work to develop the Integrated Care System, we are seeking to develop the governance of the system, within the existing statutory framework. The arrangements above may therefore evolve during the course of the programme if any changes are agreed to the delegated powers of the JCCCG and CIC.

**External scrutiny:**

- **The Joint Health Oversight and Scrutiny Committee** (JHOSC) will continue to exercise its formal powers of scrutiny. Further governance arrangements involving Local Authorities may evolve.
- **NHS England**: The programme is committed to adhering to formal NHS England Gateway processes, and will undertake these in a managed and scheduled way. There will continue to be NHS England representation at SG. The ICS will also submit developing proposals to the Northern England Clinical Senate for feedback on emerging proposals at the appropriate time.

# 8 TIMELINE FOR DELIVERY

The following section lays out the timeline for delivery of the work programme above, as well as the proposed arrangements for public engagement and governance.

## 8.1 HIGH LEVEL TIMELINE

The next phase of work, including the development and evaluation of site-specific options, will commence in earnest in October. Engagement with staff, patients and the public will be ongoing throughout the timeframe of the review, with plans aiming to launch a formal consultation on detailed, developed options in the early autumn of 2019 (if required).

Both Trust Boards and CCG Governing Bodies flagged the timeline of the next stage of work as something on which they would like further assurance. Organisations emphasised that decisions on change need to be made and delivered with enough pace to not prolong uncertainty for staff, while allowing sufficient time to fully consider the implications for staff, patients, and the public.

### 8.1.1 Agreed way forward

The timeline for delivery will be partly dependent on external factors, over which the health system has limited control. However, the intention is that we should follow the following timeline for reconfiguration work:

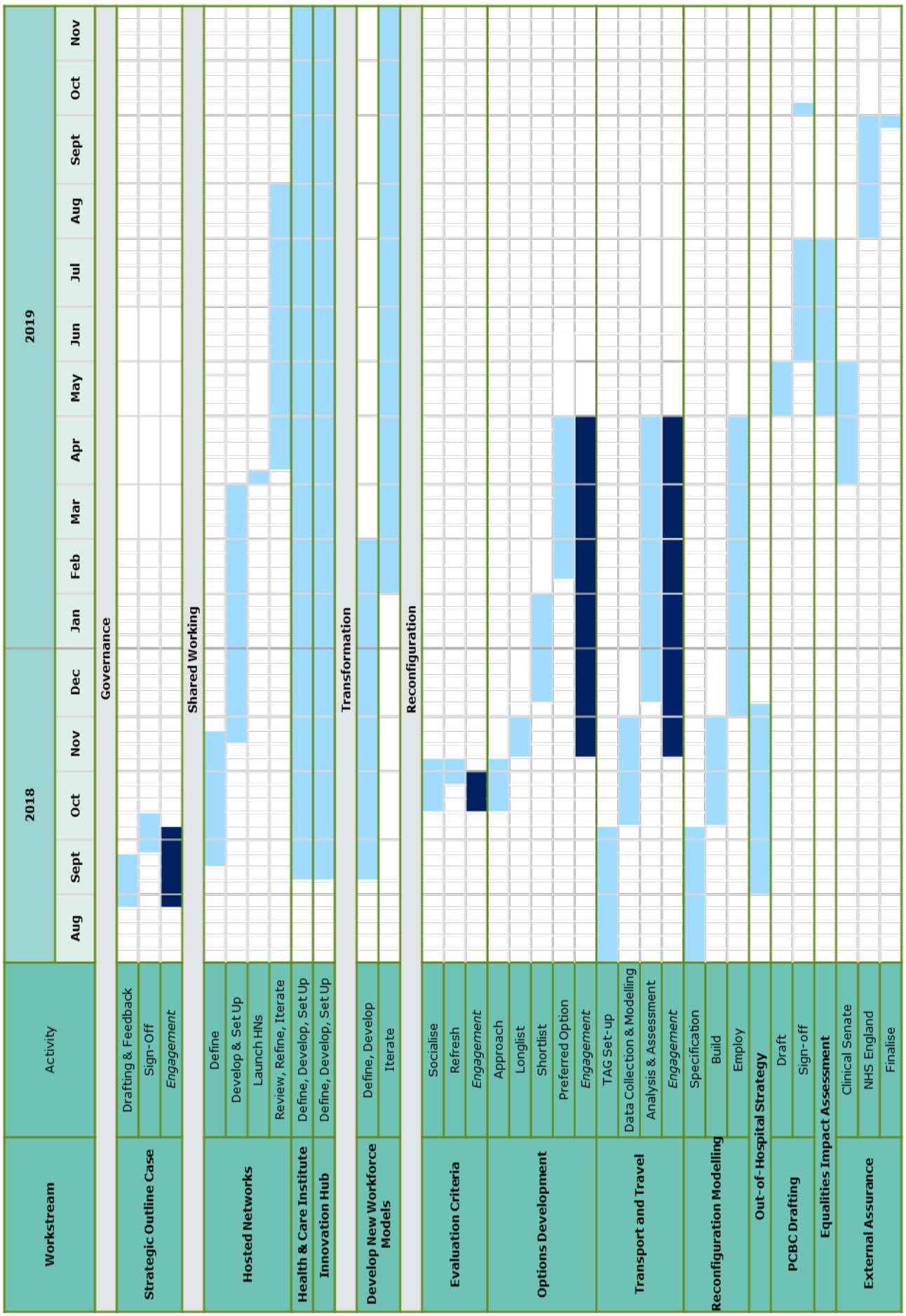
- September 2018: SOC discussed in public session at Trust Boards and CCG Governing Bodies. Governing Bodies sign off SOC under their statutory responsibilities for service change
- October 2018: Sign-off SOC at the Collaborative Partnership Board
- October – February 2018: prepare and model site-specific options; engagement with Clinical Senate and JHOSC, and ongoing public engagement
- February – October 2019: agree preferred option(s) for the pre consultation business case, if required, with public engagement; NHSE assurance process; engagement with JHOSC; draft PCBC;
- October 2019 –January 2020: public consultation on options, if required
- December 2020 onwards: Develop a Decision Making Business Case if required

Shared working plans for the establishment of Hosted Networks will be advanced alongside reconfiguration works, with a proposed timetable as follows:

- September – October 2018: Set up a programme to design and oversee implementation; agree the framework for a Level 1 network, its priorities and scope
- November – December 2018: Agree principles of engagement; appoint leads / hosts for the networks
- December 2018 – January 2019: Agree detailed requirements (including SLAs) of the leads / host
- February – March 2019: Design accountability framework; design governance and contractual arrangements
- 1st April 2019: Launch Hosted Networks

Alongside these streams of work there will be a parallel stream on transformation to develop new ways of working across the system, in conjunction with Health Education England, various groups of healthcare professionals, patients and the public.

An indicative timetable laying out the key milestones for the programme is detailed below.


Workstream
Activity
2018
2019
Aug
Sept
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sept
Oct
Nov
Governance
Shared Working
Transformation
Reconfiguration
Strategic Outline Case
Drafting & Feedback
Sign-Off
Engagement
Hosted Networks
Define
Develop & Set Up
Launch HNs
Review, Refine, Iterate
Health & Care Institute
Define, Develop, Set Up
Innovation Hub
Define, Develop, Set Up
Develop New Workforce Models
Define, Develop
Iterate
Evaluation Criteria
Socialise
Refresh
Engagement
Options Development
Approach
Longlist
Shortlist
Preferred Option
Engagement
Transport and Travel
TAG Set-up
Data Collection & Modelling
Analysis & Assessment
Engagement
Reconfiguration Modelling
Specification
Build
Employ
Out-of-Hospital Strategy
PCBC Drafting
Draft
Sign-off
Equalities Impact Assessment
External Assurance
Clinical Senate
NHS England
Finalise

# 9 GLOSSARY

| Term | Definition |
|---|---|
| **A** | |
| A&E | An accident and emergency department provides acute care for patients who arrive without prior appointment either by their own means or by ambulance and who have medical or surgical conditions that are likely to need hospital admission. They are typically open 24 hours a day, seven days a week. |
| Acute Care | Urgent short-term treatment - usually in a hospital - for patients with a new injury or illness or for patients with an existing condition that is worsening. |
| Acute Stroke Unit (ASU) | An acute neurological ward providing specialist services for people who have had a stroke. Patients are cared for in an intensive model of care with continuous monitoring and high nurse staffing levels. Typical length of stay may be up to 7 days. Patients are typically admitted to a Hyper-Acute Stroke Unit (HASU) for immediate emergency treatment before transfer for an ASU for ongoing care. |
| Acute Trust | NHS acute trusts manage hospitals. Some are regional or national centres for specialisms. Others are attached to universities and help to train clinicians. Some may also provide community services. |
| Advanced clinical practitioner (ACP) | An experienced, registered health and care practitioner with a Master's level award or equivalent that encompasses the four pillars of clinical practice, leadership and management, education and research, with demonstration of core capabilities and area specific clinical competence. ACPs undertake a level of practice characterised by a high degree of autonomy and complex decision making. Specific roles include Advanced Nurse Practitioner (ANP) and Advanced Therapy Practitioner (ATP). Delegating responsibilities to these roles reduces the burden on other clinicians. |
| Alternative workforce | This general term refers to roles for healthcare professionals that are 'non-traditional' and generally support or augment the work done by clinicians such as doctors and nurses. It encompasses Physician Associates, advanced clinical practitioners and support roles. |
| Antenatal Care | Care of women during pregnancy up to their going into labour by various healthcare professionals to ensure that mother and baby are as healthy as possible during pregnancy. This care also includes education, advice and support to make sure the mother is ready for labour. |
| **C** | |
| Care outside hospital | Care that takes place in a community setting. This could be a patient's home or community health centre. |
| Clinical Commissioning Groups (CCGs) | These are the health commissioning organisations that replaced primary care trusts (PCTs) in April 2013. CCGs are led by GPs and represent a group of GP practices in a certain area. They are responsible for purchasing healthcare services in both |

| | |
|---|---|
| | community and hospital settings. |
| Clinical governance | A framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. |
| Clinical interdependencies | Where some clinical services need other clinical services to be based on the same site for particular types of care to be successfully and safely delivered. |
| Clinical pathway | A clinical pathway is a template or blueprint for a plan of care for a specific speciality or condition. It is a guide to best practice treatment patterns, but does not replace the need for clinical judgement in meeting an individual's needs. |
| Clinical protocol | The detailed outline of the steps to be followed in the treatment of a patient with a particular condition. |
| Clinical Reference Group (CRG) | A group of clinicians and healthcare professionals convened to agree on and develop a specific clinical process, protocol or standard. The group is typically governed by a Terms of Reference and is part of a wider framework such as a Hosted Network. |
| Clinical Working Group (CWG) | A group comprised of clinicians, nurses, allied health professionals and other healthcare professionals from a specific service in the scope of the HSR. The primary purpose of the CWGs was to bring together members of staff from across SYB(MYND) to discuss service challenges, best practice and potential solutions, as well as to provide input and feedback into the review process. |
| Committees in Common (CiC) | A sub-committee of multiple committees with an agreed level of delegated decision-making rights on behalf of each committee. There must be clear terms of reference and reporting lines back to each committee. |
| Community Midwifery-led Unit / Birth Centre | A form of standalone midwifery-led unit providing prenatal, midwifery and postnatal services to predominantly low-risk mothers (see SMLU). |
| Community services | A wide range of non-emergency services provided closer to home at community facilities including local health centres and GP practices. Some may be provided by social care services. |
| Consultant-led obstetrics units | An obstetric unit with consultant presence, providing maternity and obstetric care to mothers, with the capacity to deal with a broader range of complications and conditions than a midwifery-led unit. |
| **D** | |
| District General Hospital (DGH) | Typically, the major healthcare facility in its locality with services that may include maternity, ED, acute medicine, surgery and a range of outpatient care. It may also provide some specialist facilities for care such as specialist surgery but does not cover all specialist services. |
| **E** | |
| Early supported discharge (ESD) | An intervention for adults after a stroke that allows their care to be transferred from an inpatient environment to a community setting. It enables people to continue their rehabilitation therapy at home, with the same intensity and expertise that they would |

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| | receive in hospital. |
| Elective care | Treatment that is planned in advance because it does not involve a medical emergency. |
| Emergency care | Treatment for acute medical and surgical emergencies that may need admission to hospital. This includes severe pneumonia, diabetic coma, bleeding from the gut, complicated fractures that need surgery, and other serious illnesses. |
| Emergency Department | An acute hospital department responsible for the delivery of emergency medicine and care, providing treatment to patients arriving at hospital with an immediate care requirement. Accident and Emergency is a form of ED. |
| Engagement | The measurable degree of a stakeholder or patient's positive or negative involvement with the NHS, which influences their willingness to take part in NHS issues. In the context of the HSR, it refers to the involvement of different stakeholders to gather views, feedback and recommendations. |
| Evaluation criteria | A series of questions and factors to test options against to determine whether they are suitable and optimal for their intended purpose. Evaluation criteria have been agreed and used in the HSR to test service reconfiguration options. |
| **F** | |
| Facing the Future | *Facing the Future: Standards for children with ongoing health needs*[3] are a set of standards that focus on ensuring prompt and correct diagnosis, improving the long-term care and management of children in healthcare services. These standards were developed jointly by the Royal Colleges for Paediatrics and Child Health, General Practitioners, Nursing, Physicians and Psychiatrists. |
| Flexible working | The ability for clinicians and other healthcare professionals to work across multiple sites in networked system of care. |
| Foundation Trusts | NHS foundation trusts (FTs) are NHS organisations that run acute, community or mental health hospitals. They differ from non-foundation trusts in that they have greater financial autonomy and therefore more freedom to decide their own plans and the way local services are run. Foundation trusts have members and a council of governors. |
| Function | In the context of the HSR, 'function' refers to specific operational and management processes and is used as a generic term. It does not refer to statutory functions of NHS bodies (such as commissioners) unless explicitly stated. |
| **H** | |
| Hospital Services Review (HSR) | The programme to review the shape and nature of acute hospital services across SYB(MYND), culminating in this report. The HSR was commissioned by SYB commissioners on behalf of the partners in the SYB STP. |
| Hosted Network | A clinical network between acute trusts where a host trust provides leadership and coordination to support a system-wide approach to: workforce deployment and development; the adoption of standardised clinical guidelines; and the spread and |

[3] Facing the Future, Royal College of Paediatric and Child Health, available online at https://www.rcpch.ac.uk/sites/default/files/page/Facing%20the%20Future%20Together%20for%20Child%20Health%20final%20web%20version.pdf

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| | adoption of innovation and best practice. |
| Hub | A setting for care outside hospital where patients are brought together for treatment also serving as a base for local healthcare teams. The services offered will vary depending on local needs and will range from bases for multidisciplinary teams to 'one-stop' centres for GP services, diagnostic and outpatient appointments. |
| Hyper Acute Stroke Unit (HASU) | Hospital wards that specialise in treating people who have had a stroke. A dedicated unit that gives all stroke patients access to the most up-to-date treatments and latest research breakthroughs during the first 72 hours after a stroke: swift action can reduce levels of disability and, in some cases, may even eradicate symptoms completely. Patients will typically be transported to a Hyper Acute Stoke Unit for initial emergency treatment before later being transferred to an ASU for ongoing care and therapy. |
| **I** | |
| Integrated Care System (ICS) | A partnership of NHS organisations, including providers and commissioners that collaborate to provide healthcare in a region in a close and coordinated manner. Member organisations take collective responsibility for managing resources, delivering NHS standards and improving the health of the population they serve. |
| **J** | |
| Joint Committee of Clinical Commissioning Groups (JCCCG) | A collective committee made up of representation from clinical commissioning groups (CCGs) in SYB. |
| **L** | |
| Lead / prime provider | A trust within a Hosted Network from which services are commissioned, which then sub-contracts service delivery to other trusts within the network. The lead / prime provider holds other providers to account for outcomes and for adoption of clinical protocols and pathways. |
| **M** | |
| Midwifery | The profession which leads on normal pregnancy and birth and provides expert care to mother and baby during pregnancy, childbirth and the postnatal period within a family centred environment. |
| Midwifery Led Units | Units run by midwives that can either be run alongside a main hospital maternity unit (AMLU) or completely standalone from hospital (SMLU). MLUs are ideal for handling births with no complications. Women facing complications may be advised to give birth at a consultant-led maternity unit. |
| **N** | |
| Neonatal Unit | A unit of a hospital that provides care and treatment of new-born babies who are too sick to be cared for by their mothers. |
| Networked services | The coordinated provision of care within a particular specialty across a number of providers or sites in a region. Different elements of care may be provided at different |

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| | sites, requiring patient transfer to the appropriate care location. |
| Nurse Practitioner | An Advanced Practice Registered Nurse who has completed graduate-level education (either a Master of Nursing or Doctor of Nursing Practice degree). Nurse Practitioners treat both physical and mental conditions independently including prescription of select medications. |
| **O** | |
| Obstetrics | The medical speciality dealing with the care of pregnant women and their babies during pregnancy, childbirth and the postnatal period. |
| **P** | |
| Pairing | Two trusts working closely together to deliver an agreed set of joint functions. This may include coordination of staff and resources across the two sites, supported by appropriate contractual arrangements. |
| Physician Associate (PA) | Physician associates are medically trained, generalist healthcare professionals, who work alongside doctors and provide medical care as an integral part of the multidisciplinary team. Physician Associates work with a dedicated medical supervisor, but are able to work autonomously with appropriate support. |
| Place | The term used in the SYB STP plan for the main areas and their healthcare organisations that make up the SYB footprint. These are Barnsley, Bassetlaw, Doncaster, Rotherham and Sheffield. They encompass health and social care providers, in acute and community settings, as well as commissioners, local authorities and other key stakeholders in an area based around key population centres. |
| Place Plans | Statements that set out the vision, ambitions and proposed direction of travel for the design and delivery of health and care services in a Place. These plans are generally produced by commissioners of health and care services, usually in cooperation with service providers. |
| Primary care | Primary care services provide a first point of contact in the healthcare system for many patients, acting as the 'front door' of the NHS. Primary care includes general practice, community pharmacy, dental, and optometry (eye health) services. Patients may be treated in this setting or referred for onward treatment in a different setting (such as secondary or tertiary care). |
| **R** | |
| Reconfiguration | The rearrangement of the location and type of clinical service provided across a given area. It may include transferring the provision of different service components between acute providers, as well as transfer of some care to alternate settings such as the community. |
| Referral | The process whereby a patient is transferred from one professional to another, usually for specialist advice and/or treatment. |
| Rotations | The formalised process of organising for staff to work across multiple sites or services in a routine way. It may be used to facilitate provision of services in multiple locations or to support staff development and training. |

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| Royal Colleges | The Royal Colleges are professional organisations for doctors, nurses and allied health professionals. In general, they have a vision of improving, maintaining and promoting standards of care within the specialist area which they cover. They work jointly to develop policy on some issues and work closely with other organisations and associations that have similar objectives. They promote education and research in their respective fields. |
| **S** | |
| Secondary care | Specialist healthcare usually provided in hospital after a referral from a GP or other health professional. |
| Seldom heard groups | 'Seldom heard' is a term used to describe groups who may experience barriers to accessing services or are under-represented in healthcare decision making. Traditionally, some of the groups identified in engagement activities include rural communities, black and minority ethnic (BME) groups, gypsies and travellers, lesbian, gay, bisexual and transgender, asylum seekers and refugees and young carers. However, teenagers, employees, people with mental health issues and many others may also be considered as seldom heard, since they may not find it easy to engage with traditional methods of public engagement. |
| Sentinel Stroke National Audit Programme (SSNAP) | The Sentinel Stroke National Audit Programme (SSNAP) aims to improve the quality of stroke care by measuring both the structure and processes of stroke care against evidence based standards. These standards are informed by the National Clinical Guideline for Stroke, and national and local benchmarks. |
| Short Stay Paediatric Assessment Unit (SSPAU) | A facility within which children with acute illnesses, injuries or other urgent referrals (from GPs, community nursing teams, walk-in centres, NHS Direct and emergency departments) can be assessed, investigated, observed for a short period of time and treated without recourse to in-patient areas. May be co-located with ED. |
| Single service model | A network where care is delivered directly by the lead trusts and responsibility for patient care and clinical governance rests with that lead trust. Staff and resources are paid for and managed directly by the lead trust and activity is commissioned directly from the lead trust. |
| South Yorkshire and Bassetlaw (SYB) | SYB refers to the more specific region within SYB(MYND) that covers acute trusts which will be members of the SYB shadow Integrated Care System, as well as the footprint of SYB Sustainability and Transformation Plan. |
| South Yorkshire and Bassetlaw and North Derbyshire (SYB(ND)) | SYB(ND) refers to the area within scope of this review (see SYB(MYND)), excluding Mid Yorkshire. It may be used to refer to recommendations on reconfiguration of services, in which Mid Yorkshire Hospitals NHS Trust is not included. |
| South Yorkshire and Bassetlaw Integrated Care System (SYB ICS) | SYB is one of the first and largest Integrated Care Systems. An ICS brings partner organisations closer together, taking further responsibility for finances in return for greater flexibility in delivering NHS services. ICSs are in shadow form and due to go into operation at the beginning of 2018/19 financial year. The shadow period refers to the period before the full operation of the ICS, during which the system will develop and gradually implement the governance, structural and financial arrangements required to 'go live' as an integrated care system. |
| South Yorkshire and | SYB(MYND) refers to the area serviced by acute trusts within the scope of this review. |

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| Bassetlaw, Mid Yorkshire and North Derbyshire (SYB(MYND)) | There are seven acute trusts in SYB(MYND): Barnsley Hospital NHS Foundation Trust, Doncaster and Bassetlaw Hospitals NHS Foundation Trust, Rotherham NHS Foundation Trust, Sheffield Children's NHS Foundation Trust, Sheffield Teaching Hospitals NHS Foundation Trust, Chesterfield Royal Hospital NHS Foundation Trust, and Mid Yorkshire Hospitals NHS Trust. |
| Standalone Midwifery Led Units (SMLU) | Maternity units that are led and staffed by midwives without consultant presence, in a setting that is unattached to a hospital. They generally provide prenatal, midwifery and postnatal care to lower risk mothers. They may be in community settings and are sometimes called Community Birth Hubs or Centres. |
| Sustainability and Transformation Plan (STP) | Five-year plans covering all aspects of NHS spending within a given geographical footprint. STPs have a broad scope in planning healthcare, including: improving quality and developing new models of care; improving health and wellbeing; and improving efficiency of services. STPs are developed by Sustainability and Transformation Partnerships, made up of NHS organisations and local councils. The SYB STP has now become an Integrated Care System (see ICS). |
| **T** | |
| Tertiary care | Highly specialised treatment such as neurosurgery, transplants and secure forensic mental health services. |
| **U** | |
| Unwarranted clinical variation | Variation that cannot be explained by the condition or the preference of the patient; it is variation that can only be explained by differences in health system performance |
| Urgent Treatment Centre (UTC) | Urgent care centres designed as an alternative to ED departments for patients with less severe, non-emergency conditions. Often co-located with EDs with patients triaged and streamed at the front door, and equipped to diagnose and deal with many of the most common patient conditions. May also be standalone at sites without an ED. |
| **W** | |
| Whole-time equivalent (WTE) | Whole-time equivalent is a unit that indicates the workload of an employed person (or student) in a way that makes workloads or class loads comparable across various contexts. For medical staff, it generally refers to 10 programmable activities per week of resource. |