HEALTH SELECT COMMISSION

Date and Time :- **Thursday, 10 October 2019 at 2.00 p.m.**

Venue:- **Town Hall, Moorgate Street, Rotherham.**

Membership:- **Councillors Albiston, Andrews, Bird, Brookes, Cooksey, R. Elliott, Ellis, Evans, Jarvis, Keenan (Chair), John Turner, Vjestica, Walsh, Williams, Wilson and Yasseen)**

Co-opted Members –Robert Parkin (Rotherham Speak Up),

This meeting will be webcast live and will be available to view via the Council's website. The items which will be discussed are described on the agenda below and there are reports attached which give more details**.**

Rotherham Council advocates openness and transparency as part of its democratic processes. Anyone wishing to record (film or audio) the public parts of the meeting should inform the Chair or Governance Advisor of their intentions prior to the meeting.

AGENDA

1. Apologies for Absence

To receive the apologies of any Member who is unable to attend the meeting.

2. Declarations of Interest

To receive declarations of interest from Members in respect of items listed on the agenda.

3. Exclusion of the Press and Public

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

4. Questions from members of the public and the press

To receive questions relating to items of business on the agenda from members of the public or press who are present at the meeting.

5. Communications

6. Minutes of the previous meeting held on 5th September 2019 (Pages 1 - 23)

To consider and approve the minutes of the previous meeting held on 5th

September 2019 as a true and correct record of the proceedings.

For Discussion/Decision

7. Social and Emotional Mental Health Strategy (Pages 24 - 43)
Jenny Lingrell, Assistant Director Commissioning, Performance and Inclusion to present.

8. Mental Health Trailblazer (Pages 44 - 53)
Jenny Lingrell, Assistant Director Commissioning, Performance and Inclusion to present.

9. Rotherham Foundation Trust - Achieve an Improved CQC Rating (Pages 54 - 57)
Angela Wood, Chief Nurse to present.

10. Trainee Nursing Associate (Pages 58 - 66)
Angela Wood, Chief Nurse to present.

For information

11. South Yorkshire, Derbyshire, Nottinghamshire and Wakefield Joint Health Overview and Scrutiny Committee - Update

12. Rotherham Healthwatch

13. Urgent Business

To consider any item(s) which the Chair is of the opinion should be considered as a matter of urgency.

14. Date and time of next meeting

The next meeting of the Health Select Commission will be held on 28th November, 2019 commencing at 14:00p.m. in Rotherham Town Hall.

Sharon Kemp.

SHARON KEMP,
Chief Executive.

HEALTH SELECT COMMISSION
Thursday, 5th September, 2019

Present:- Councillor Keenan (in the Chair); Councillors Albiston, John Turner, Bird, Cooksey, R. Elliott, Ellis, Jarvis, Williams, Evans, Vjestica and Walsh.

Apologies for absence:- Apologies were received from The Mayor (Councillor Jenny Andrews) and Brookes.

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

24. DECLARATIONS OF INTEREST

There were no Declarations of Interest made at the meeting.

25. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

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

26. ENHANCING THE RESPIRATORY PATHWAY - JACQUI TUFFNELL, HEAD OF COMMISSIONING NHS ROTHERHAM CCG, TO PRESENT

Jacqui Tuffnell, Head of Commissioning at NHS Rotherham Clinical Commissioning Group (CCG) gave the following short presentation outlining the rationale for change to the respiratory pathway, what was being proposed and the plans for engagement.

Why do we need to make changes?

- Poorer outcomes for our patients than our counterparts across the integrated care system (NHS Right Care data)
- Fragmentation across the respiratory pathway
- Fragmentation of the home oxygen service
- Improve diagnosis across Rotherham – accreditation needed for spirometry testing
- Improvement the management of respiratory patients
- High numbers of patients going into hospital – for example other areas support patients with low level pneumonia at home
- Longer stays for patients when they are in hospital
- Long term plan states care should be provided closer to home

What changes are proposed?

The development of the enhanced respiratory pathway has been a clinically led process, developed in line with best practice and the clinical benefit for patients has been at the forefront of discussions

The enhanced model for respiratory includes:

- Standardising the care across primary care for diagnosis and management – engagement on what this should look like.
- Improving patient education and access to support patients to self-manage – including digital options/apps
- Delivering care closer to home, with a specialist community respiratory team, reducing the requirement for inpatient care
- Delivering care during the day, at evenings and weekends to fit in with patients' lives
- For those who do require inpatient support a dedicated respiratory unit at TRFT
- Increased support for high intensity users to help stabilise their conditions

Service user, carer and stakeholder engagement

Patient and public and stakeholder engagement on the proposed changes is scheduled throughout September and will be via the following forms:

- Surveys, online and paper
- Face to face drop in sessions across Rotherham, including breathing space – different days and times so working population also have opportunity to be involved
- Mjog (Memory Jogger) text messages to patients, aimed at those with a specific respiratory condition
- Media messages
- Animation – to follow

The intention is to try and involve the wider population of respiratory patients, not just the 20% who particularly use Breathing Space.

Next Steps

- Incorporate engagement responses into the business proposal
- Governing body 2 October 2019/ Trust Board
- Commence recruitment to the new structure

The following issues were raised and discussed:-

- Mjog
  – Mjog or Memory Jogger was a well-used texting system from GPs for sending reminders and messages, for example to alert people about flu jabs. It would be used to inform a large number of people about the engagement sessions.

- Current relatively poor outcomes - to what extent was there still a legacy from the old mining industry?
  - Not so much now and there had been changes in smoking habits associated with that, but respiratory conditions were still growing. It appeared to be linked more with how the pathway actually worked.

- What was the scale of the poor outcomes for our patients and

being worse than counterparts?
- It was significant enough to need to do something because as well as poor outcomes Rotherham had the highest spend in relation to respiratory across South Yorkshire. The main areas were in relation to pneumonia care but also COPD management. It was around 10% difference with spend about 30% more. A slide pack with all the information could be circulated to Members.

- Improving patient education and access – would this include prevention as well as self-management?
  - Regarding prevention, other work had taken place in relation to smoking cessation, in particular through the QUIT programme which secondary care were on board with, including in the hospital. Smoking cessation was within the Public Health team as well and would be looked to see how it could be enhanced as part of this programme. My COPD on the app would support patients in terms of whether they were doing things that were unhelpful. Having more dedicated support from the respiratory specialist community nurses and physiotherapists within the communities would definitely support them to remain in the community as well.

- Face-to-face drop-in sessions – would these be in any particular locations or would they be borough-wide?
  - These had all been planned to take place at Breathing Space but Members were invited to suggest other locations.

- Rotherham Show – would the NHS have a presence at this?
  - The materials were not quite ready.

- Timeline and length of the engagement, as once live it would only really be two weeks.
  - During September the surveys would go online with messages through Mjog to people on how to access them. Sessions were planned during the whole of September to inform the pathway. Something was needed in preparation for winter in relation to respiratory care, hence it was important to engage but also to get on with implementing a model as described. The clinical model needed to be right, so the timeline included the winter period. Ideally there would be more engagement and the comments would be taken on board and if it was felt that the CCG had had insufficient input during that time they would be prepared to extend the process.

- When would success measures be seen for whether the changes were of benefit, as presumably one of those would be to save at least the 30% of current spending?
  - The pathway focused on improving outcomes, which was the reason for the changes proposed, whilst anticipating that those efficiencies would be made. The slide pack to follow would say that 12 months after implementation significant improvement was

expected in order to achieve the same level as our peers.

- Clear information was requested to show what the CCG expected that significant improvement to look like.

- Would Rotherham Hospital and other health premises such as doctors' surgeries have a presence or information?
  - Literature would go out to GP practices as well as using Mjog but as Public Health TV was quite difficult to change information would not be on there.

- Would this link in with the Rotherham Health App in terms of people being able to access the services through that mechanism?
  - Absolutely.

- What changes had resulted from the relocation of inpatients from Breathing Space to the hospital for their care?
  - Patients were relocated to the main hospital site a number of months ago due to some patient safety measures that needed to be put in place. The Trust had issues with sickness within Breathing Space and within the acute hospital and had to rationalise the nursing team to ensure safe patient care was provided. This was separate to the pathway review and until the review had been completed had not been identified as a permanent position.

- The Chair requested that the consultation materials be shared with the committee.

Resolved:-

1) That the Health Select Commission note the information provided regarding the proposed changes to the respiratory pathway.

2) That the following be provided for the Commission:
   - the slide pack;
   - consultation materials;
   - animation;
   - success measures for the pathway.

27. HOME FIRST - INTERMEDIATE CARE AND REABLEMENT - NHS ROTHERHAM, CCG AND ADULT SOCIAL CARE, RMBC TO PRESENT

Anne Marie Lubanski, Strategic Director for Adult Care, Housing and Public Health gave the following powerpoint presentation, recapping the information provided previously and focusing on how the work would be taken forward. This included how it would link in with the service redesign in Adult Social Care, which would see a 30% reduction in its workforce, maximising the front door, reablement and the preventative offer.

The pathways would be joint integrated working pathways with health rather than structural changes, although these could follow at a later stage. This was a significant piece of work and a testimony to partnership working and the maturity of it in Rotherham, as health and social care were two very different systems, especially regarding contributions and charging. The pathways were based on best practice, on the 12-week recovery model seen in mental health principles and two proof of concept initiatives would run with the reablement team to test things. The trusted assessment role would also be looked at so that people would not have to wait to see someone else to get something they might need.

From a commissioning perspective across the CCG and RMBC the view was that this would become a more cost-effective model, not immediately as some of it would be iterative going through the process. In Year 2 it would be a question of looking at where things could be done differently and whether it was about efficiencies or reinvestment would be considered later on.

Heading into winter was part of the challenge of how to double run and test things, at a time when it was also critical for the Trust not to impact on flows in and out of the hospital.

Communication and engagement were key areas to get staff on board and to understand the cultural changes and potential professional changes necessary. Work would also be needed with the GP Federation following the introduction of Primary Care Networks (PCNs).

Why Change?

- People have told us

They would like to be at home wherever possible
They would like to regain their independence
Current services were disjointed and could be hard to navigate

- Care Quality

Evidence shows people did better at home
We know that a large number of people received care in a community bed when they could have gone home with the right support
Rotherham had significantly more community beds than other similar areas
Current services were focussed on older people and their physical needs
Through changing the way we worked, more people were going home and our community beds were not fully utilised

Current Services

- Community-based Services

Integrated Rapid Response (TRFT)
Community Locality Therapy – urgent (TRFT)
Independent and Active at Home Team (TRFT and RMBC)
Reablement (RMBC)

- Bed-based Services

Intermediate care at Davies Court and Lordy Hardy Court (RMBC and TRFT)
Oakwood Community Unit (TRFT)
Waterside Grange (Independent Sector)

- Services currently provided by a range of teams and bed-based sites
- In addition, several teams of Social Workers and therapists working into the bed-based provision
- People moved through multiple services rather than an integrated pathway
- Significant duplication and some capacity issues in a number of services

Project Aim

Referrals
↓
Co-ordination
↓
Integrated Intermediate Care and Reablement Service
→Pathway 1: Integrated Urgent Response
→Pathway 2: Integrated Home-based Rehab/Reablement
→Pathway 3: Integrated Bed-based Rehab/Reablement

- To simplify current provision to provide an integrated, multi-disciplinary approach to support individual needs across Health and Social Care
- To re-align resource to increase support at home, reducing reliance on bed-based care

Future Services

- 3 core integrated pathways
- Services aligned to work as a single team to provide the 3 pathways
- Increase in community capacity to meet the demand to support people at home (urgent response or rehabilitation/reablement)
- Reduction in community bed-base (phased and double-running for a period with increased community capacity)
- Integrating processes for triage and co-ordination to ensure people get the right support
- Reduction in duplication

Community-based Pathways	Bed-based Pathway
1. Urgent response (integrated team)	3. Community bed-base – rehabilitation and reablement without nursing (integrated team)
2. Home-based reablement and rehabilitation (integrated team)	3. Community bed-base rehabilitation and reablement with nursing (integrated team)

Benefits

Patients and Carers	Commissioners (CCG and RMBC)	RMBC (Service delivery)	TRFT
Improved experience of services Telling story once Reduced duplication and hand-offs Improved outcomes More people able to be supported at home	Supports Rotherham Plan for 'Home First' and integration of Service delivery Reduces over reliance on bed base where Rotherham was an outlier More cost effective model	Supports delivery of the Council's target operating model and future sustainability Improving flow through the Social Care system	Supports the Trust's wider plans for bed configuration/estate moves Improving flow through the Hospital and Community Services

Taking the work forward

Pathway Redesign & Implementation

Off-site Community Unit Implementation

→Workforce: HR and OD
→IT, IG and Analytics – system inter-operability and sharing information
→Accommodation
→Communications and engagement
→Finance, contracting & commissioning (including winter beds and flows)

Proposed Timeline/Phasing

Integrated Model

Home-based pathways 1&2 — From 1 April 2020
Reduced intermediate Care Bed Base — From June 2020

Therapy Led Community Unit with Nursing

Phase 1 off-site - Open off-site Unit — November 2019
Phase 2 on-site — November 2020

Discussion ensued with the following issues raised and clarified:-

- The staffing side was of interest because of the known recruitment difficulties in the Health Service and it would be helpful to see a profile as this evolved and if any patterns emerged on difficulties.
  - It was agreed to come back and keep Members informed.

- With the intention to reduce the number of points at which patients were triaged and having the three pathways, how would it work with GPs? Would there be a GP allocated to a pathway or would people still have their own GP, as not all GPs held the same view

on things?
- People would have their own GPs. PCNs had only started in July 2019 and conversations would start to happen at the end of the year, including how they would work with Adult Care and the Trust as it was such an early stage. RMBC had six localities which would never match the PCN breakdown because a GP might have a practice in one part of the borough but a satellite in other localities as well. The key was to ensure everybody understood the benefits of the pathway, including primary care. Dr Muthoo, leader of the Federation, was a member of the group co-chaired by the Strategic Director and Chris Preston, The Rotherham Foundation Trust (TRFT) and was very engaged and supportive of this way forward.

- Although the overall head count seemed ok, was there a possibility that when people were asked to move or to take on new skills and to adopt new ways of working that some might decide they wanted to work for someone else?
  - There was always that risk but as seen with the Occupational Therapists (OTs) moving into the Single Point of Access, after initial resistance in the restructure. They could see the benefits of being in the same building and talking to one another. This was effective partnership working and was always different at the front line with a lot of work to do there, but both TRFT and RMBC had taken it down multiple layers into both organisations and could see the advantages of joint working.

- Two information management systems were used in Liquid logic and SYSTM1, with people likely to have records in both databases and fields in both with effectively the same information. If the information was not in fact identical, was there a risk things could go awry? Were protocols in place to ensure that when people copied or cut and pasted information that it was identical?
  - RMBC was contracted to have Liquid Logic for a number of years but much of the database was already shared across the Cloud. People at the hospital could see SYSTM1 and the other systems used at the hospital and the Integrated Discharge Team could see Liquid Logic at a certain level.

  This had been discussed within the steering group as part of the pathway work and the key was the same decision points to sit in both systems, consistent and agreed, to remove any confusion. Mental health had manual input as they used two systems, which was time consuming and there were other issues in addition, thus it was a case of being pragmatic.

  Information Governance was important in terms of people only seeing the information they wanted or needed to see but the main issue was correct sign offs and staff not being stuck by the system.

- The worst possibility would be with some text that was supposed to

be identical in both systems and in one system it included the word not and in the other it did not.
- In a project of this size it would be disingenuous to say all human error could be eliminated. People had different styles of writing and there was a need for coherence in how people recorded what they did, which was about professional judgement. In RMBC, people talked all the time about positive recording and being aware of third party information and data access requests in the context of having to return and remember something six years after writing it. The pathways would be very clear in terms of what should be recorded, for intermediate care and reablement and when. TRFT concurred that they too held similar conversations with their staff.

- What would the future measures of success be in terms of introducing this particular extensive change, other than the financial ones already included?
  - A very easy one would be hospital admissions went down absolutely.
  - Another was not having the revolving door of some people in the community who fell back from where they were, had to go back into hospital and deteriorated each time, because it was quite traumatic every time someone had to go into hospital.
  - The other measure of success was that Adult Care needed this to work, i.e. self-management for longer so people did not come in to long term care and support needs, including looking from a budgetary viewpoint, so that people were staying at home and maximising their independence.
  - Drawing parallels with mental capacity, where under the law people were assumed to have capacity, the assumption should be that someone would recover. Intervention at the right time and in the right way was needed and would include digital and equipment so people would not need ongoing health and social care support, or if they did, at an absolute minimum. The service would look to build confidence in terms of assistive technology as much of the direct support provided could be replaced by a technological offer.
  - An old KPI in social care that would still be used was whether someone was still at home 91 days after a reablement intervention as an indicative measure that people were not going into hospital or elsewhere. It allowed you to see where people were at that point in either system. The best outcome would be a healthier resident population.

- Were we at the vanguard of this particular approach or were there other areas where this had taken place?
  - Different approaches had been taken, for example some areas had set up Care Trusts with all the staff together, going for structure rather than pathways. Visits to other areas such as Northumberland had been undertaken and people tended to default to thinking new structures were needed but Rotherham had chosen integrated working rather than integration. We were not a

trailblazer but in terms of the maturity of our approach many places would not have this.

- Would the decrease in community beds impact on any of the providers in a serious way?
  - The context in Rotherham was too many residential care homes, coupled with the national shortage of nursing homes due to nursing recruitment challenges, plus too many care homes which created issues with regard to safeguarding.

  In terms of the bed base in intermediate care, people sometimes ended up in a bed base rather than being helped to stay at home longer. People being helped to live at home was not new as it came in from 2000 as part of the direct payments statutes and social care had overly relied on bed-based activity for far too long. It might have an impact on how the market changed but was still too early to say how that would come through. The best quality providers were wanted for remaining placements and part of the Strategic Director's statutory role was to market shape, building quality and making no aspersions in terms of any providers. A tender process for the new care and support contract jointly with the CCG was under way because we wanted that to be the best it possibly could be and it sat alongside this piece of work.

- Services were encouraged to undertake market shaping in a proactive way rather than a reactive way when a problem arose.

- Clarification was sought on the monetary split between TRFT, RMBC and RCCG and whether any large transfers of money from one partner to another had taken place with the shift from a bed base to a community base? Where were savings accrued?
  - For both RMBC and the Trust the offer was staffing, with no money moving across because it was integrated pathways, not structures, although changes to roles and what people did were being worked on. As a system across health and social care, the Better Care Fund and winter pressures money would continue to be used, together with the additional monies from the Improved Better Care Fund, which had helped fund the parallel running that had been agreed. No virement of funds took place other than in an agreed way to deliver the projects and that was part of the bridge to reach the next stage being implemented in October 2020.

- Were staff flowing either way?
  - RMBC have said to staff that if for example health or a GP practice had a building in Maltby and space it might make sense practically given the work was on a locality basis, but it would be a considered rather than a reactive view. Going back to trusted assessors, if an OT was going to see someone needing ongoing support an hour-a-week to do something, on that part of the pathway would be those decision points on what could be agreed

and tolerances. Financially this had to work based around people coming into the system and the type of intervention because the money had to last for people who needed ongoing care and support. In 12 to 18 months those discussions would happen but at that time the offer in terms of front line enablement officers had not reduced. Based on the information around activity it could have done but we wanted to make sure this had the best opportunity to happen and with the right workforce. OTs based in the Single Point of Access team were not RMBC employees but sat with us and worked with us, which was the whole principle.

- Reassurance was sought that although short term money was used for some aspects this would not be reliant in the long term on short term money?
  - Things were not reliant on the short term money; this was about building our workforce in a different way, in RMBC and the Trust.

- No-one doubted that most people would rather be treated at home or to recover at home, but could you assure me given that there would be a reduction in beds that people would not be pushed out too early? What checks would be put in place to make sure that people were ready to go home and would receive the care and support they needed?
  - This was not only people coming out of hospital; it might be someone who had been bereaved or lost their partner and their skills were not where they should be. Work was happening in the community.

  Creation of the Integrated Discharge Team brought hospital and social work teams together in one room and was a positive case of partnership work between RMBC and TRFT. A single referral funnelled through the team who would say whether a person needed an intermediate care bed, or if they needed a bit more time but were medically fit for discharge, if they could possibly go back home to reablement and another intermediate care offer. The three pathways included the hospital discharge pathway but that was not the only pathway, so people would come in and out at different times. Everything was about making sure of people's safety with best outcomes at the heart of any changes made.

  The Chief Nurse concurred that the two organisations had worked very closely to ensure that the Integrated Discharge Team worked really well for the hospital, for the community, for the patients and would not push people out there. They were referred and had a full assessment before leaving hospital. The team won a national award a few months ago at the HSJ Awards.

- If this is done right the Trust would save money but where would the Council save money with pressure on Adult Care because people's stay in hospital would be much shorter and the number of

people supported in the community theoretically would grow? Rotherham had an unhealthy and ageing population and there would be an age where people would be unable to be looked after at home, for example because their carer or partner had died. How in the longer term would we be able to reduce care home spaces because people would not be available to help us to be independent, whether due to age or disability?
- From a social care perspective it was known from analysis over the last three years that many people came into services because they were unaware of what was out there. This was illustrated by the abandoned contacts in the single point of access, as only around 20% went through into the next stage, because many people phoned the Council to ask for something it was not within their role to do and similarly with health. For triage under the new model the service wanted really good qualified social workers at the front door, along with the other call advisers, to be giving the right information or signposting people appropriately, with OTs as mentioned giving resolution at that point. If a grab rail was not fitted quickly for someone at risk of falls they could fall, need hospital admission and go back in that loop.

In relation to making savings, everything done at the moment was about cost avoidance for the Local Authority at that end because by not taking that kind of preventative, interventionist approach the money started to increase against every individual.

Project Alcove was a pilot with about 40 people testing Alexa and some of the case studies were amazing. Dementia was an issue, as was a growing SEN children's issue that from an Adult Care point of view was being watched. If the number of people who did not really need ongoing care and support was not minimised, the money for those people that did would not be there. Residential care would always be needed but the issues were how it would be done and how to become more innovative. Reablement was a means of providing what people needed at the right time, in the right way and was why the recovery model was the way forward. From research and experience, after six weeks intervention, aside from their health, people's confidence might not be there but as soon as they went into localities they were in and it was forever ever money. Building the six weeks recovery to give them the confidence to be as independent as possible formed part of the interventionist approach because if not the money in Adult Care would increase exponentially.

- There might be carers who were unwilling to be carers, and older women especially could have other caring responsibilities and thus pressures. Carer assessments were undertaken for people in long term provision, but had there been consideration of and support for the carers of people in short-term interventions?
  - Under the Care Act carers had parity of esteem and regardless of

whether the person they were caring for wanted an assessment or not, carers had the right and entitlement to an assessment. As part of the Adult Care restructure and new adult care pathway two roles had been identified specifically for carers, one operational and another for a strategic lead, which had been a gap and the caring role needed to be looked at. From the 2011 census many people identified themselves as significant carers but probably only a couple of thousand came through the social care doorway. Carers identified themselves in different ways and might not see themselves as a carer but rather as the patient's partner.

Aim 3 in the Health and Wellbeing Strategy focused on looking at the broader term carers to ensure that when talking about signposting that people were comfortable with that. Increased use of GPS watches would enable carers to use phones to check the GPS if the cared for person tended to roam. It was a case of looking at things in different ways with the new role to really start thinking of the narrative on what was done around carers.

The Strategic Director stated that she would like to come back in 12 months' time to update the Commission about work in this area, both across the system and in social care.

- How confident were you in having sufficient resources and skills to support people from a mental health or learning disability perspective within this particular area?
  - Traditionally talk about reablement defaulted to older people as there was a tendency not to think that people with learning disability or mental health needs required a reablement approach and to think of it as being about personal care.

  Through reablement, staff were able to get people up and dressed but if they had nothing to do or lacked the confidence to go anywhere then reablement failed. From an RMBC perspective the resource inputted i.e. staff was for people aged 18+ from one global pot. Cultural change regarding reablement was needed in both organisations for staff to feel comfortable, as it linked to perceptions around risk. Reablement was not necessarily about a physical change; it could be about confidence. It was about staff feeling empowered to walk to the shops with someone without worrying about exceeding their time slot. The present model was very much one of seeing people in defined time slots but as part of the proof of concept the reablement workers in the pilot were told these are the people you will be working with and you determine what to do. Time was not an issue as it was non-chargeable. The managers struggled but front-line workers were overwhelmingly positive because they were seeing and doing things they knew would make a difference for individuals, which might be outside the comfort zone of previous practice.

Two six week pilots, the first with some initial problems, had taken place in preparation for implementation from the end of October. Already good outcomes were resulting from one team operating differently. Such a cultural shift would take time to cross over into mental health and learning disability but this was the aspiration and would happen.

- Members were pleased to hear the focus would be on providing care and support to achieve outcomes rather than completion of time sheets.

- The importance of continuing professional development and supervision and also having reporting structures were issues that emerged from the evaluation of the health village pilot. How confident were you that we have learned from that model?
  - As Reablement was a Care Quality Commission (CQC) registered service the supporting structures needed to be robust and would be looked at. It was also a question of helping the CQC to understand what partners wanted to achieve. There was learning for health from the health village pilot, in a different vein to that for Adult Care.

Anne Marie was thanked for her detailed presentation by the Chair and would be invited to provide a future progress update.

Resolved:-

1) That the Health Select Commission note the information provided.

28. DEVELOPING ROTHERHAM COMMUNITY HEALTH CENTRE - JACQUI TUFFNELL, HEAD OF COMMISSIONING, NHS ROTHERHAM CCG TO PRESENT

Jacqui Tuffnell, Head of Commissioning at NHS Rotherham Clinical Commissioning Group (RCCG) gave the following short presentation recapping the context and proposals and showing the outcomes from the engagement with patients/families.

Rotherham Community Health Centre

- Rotherham Community Health Centre (RCHC) – purpose built to house the walk-in centre, GP practice, dental services and community /outpatient facilities, already includes quite a lot of therapy
- Services have changed resulting in 2/3 of the centre now being empty – clear feedback from our population that it needs to be better utilised

What will work best for the centre and our population?

- 5 options considered - CCG worked with our estates and advisers across our community and undertook a One Estate Review as well, including the Council, RDaSH and the hospital.

- Recommended option to relocate Ophthalmology outpatients enabling:
  - amalgamation of the service
  - to meet CQC requirements separating children from adults
  - ensuring the estate is fit for purpose to meet current and future capacity (double the floor space)
  - reducing the footfall substantially on the hospital site (by approximately 48000 visits per year), freeing up car parking and increasing the footfall into Rotherham's town centre, which should contribute to regeneration of the town centre
  - responding to the public's request to utilise this central, good quality facility

Slides 4-11
Responses to questions regarding:
- Being a patient/carer
- Age/Disability
- Environment in Ophthalmology Out-patients and seating sufficiency
- Travel mode to the hospital
- Parking/Drop off at the hospital
- Ease of getting to the RCHC compared with the hospital

Headlines from the engagement
107 surveys were completed over 2 days 13-14 August in ophthalmology outpatients and B6, covering a variety of clinics. People from a wide variety of ages and backgrounds took part. The clinics were not as busy as usual, due to the time of year, in particular a number of the paediatric appointments were DNA (Did Not Attend).

Generally, most people were very supportive of the proposal, with a substantial number who were extremely enthusiastic - 61 felt it would be easier, 22 felt it would be harder; 24 were neutral; either they felt it would be the same or were unsure.

Main points
- The majority of concerns were around parking
- A small number of people noted they live close to the hospital or on a bus route/road where they would pass the hospital, so it would be further for them
- Several people wanted assurance that the staff would be the same
- Even though the walk from car to unit would be shorter, some people will still need a wheelchair to be available
- From the patients attending B6 often on a monthly basis, there was more concern and apprehension about a change of location; often with no concrete reason (i.e. *'I like it here'*); this is felt to be due to the fact that these are likely to be the most dependent patients, who have become very familiar with the current location and process
- There were generally fairly low expectations around the

environment - *'it's OK as it is' ' it's a hospital isn't it'.*

- Other concerns raised were around traffic in the town centre, waiting for appointments and in clinic, not being called in
- Several people asked how much it would cost; so assurance that we are spending the Rotherham pound well
- It was also noted that patients are brought to ophthalmology from other areas of the hospital – those mentioned were neuro and the Urgent and Emergency Care Centre (UECC). It was queried how this would work if the department was to move, how often this is needed, and what the impact could be on appointments if staff are called to TRFT site, or the implications for moving patients round the site**.**

Supporting the change

- Parking – there is some on-site parking at RCHC and a drop off zone will be created, there are a number of car parks in a short walking distance
- Urgent patients from other areas – a small 'urgent' service will continue at TRFT connected to the staff who will be providing surgery
- Rotherham pound – the department is in need of an upgrade particularly to split paediatrics from adult services and insufficient space currently therefore investment is required whether this is at the hospital or RCHC
- Long term attenders – consideration of the impact of the change for this group – support and assurance

Next steps

- Incorporate the findings from the engagement into the business proposal
- Business proposal to Governing body and Hospital Trust Board in September or October
- If approved, building work to commence in the autumn and service to move by next April

Angela Wood, Chief Nurse at TRFT viewed the proposals as a positive opportunity for the Trust to make sure the ophthalmology services were the best they could possibly be and in the right environment. Staff had been heavily involved in looking at the site and ensuring it would be fit for purpose. She had visited with the Board, non-executive Directors and other colleagues and talked to the teams about the proposal and how that would impact on the extra outcomes they could give to the patients.

The following issues were raised and discussed:-

- Following on from the concerns raised above, will the proposals cover if patients had to go to ophthalmology from neuro or from the Urgent and Emergency Care Centre?
  - Urgent patients have been planned for and would not have to transfer down to the health centre. It was the day-to-day activity in

the unit with patients who were programmed and planned to have an appointment who would go to the Community Health Centre, not the urgent service.

- Had there been any progress on arrangements for pharmacy provision?
  - Nothing definite had been agreed but it formed part of the case for TRFT. Pharmacy was currently provided from up at the hospital and it was a question of whether or not an element of that service would transfer in situ. Patients would not be required to go to the hospital to collect their pharmacy products.

Members noted the information provided and were supportive of the proposals following the public engagement.

Jacqui was thanked by the Chair for her presentations.

Resolved:-

1) That a further report be provided in 2020 once the changes to the ophthalmology outpatient service had been implemented to evaluate the impact of the changes.

29. MATERNITY AND BETTER BIRTHS - JUNE LOVETT, THE ROTHERHAM FOUNDATION TRUST, TO PRESENT

June Lovett, Associate Chief Nurse and Head of Nursing, Midwifery and Professions at The Rotherham NHS Foundation Trust (TRFT) gave the following presentation to provide an overview of current activity and the course of direction for maternity services.

Work to improve the strategy for maternity services was particularly focused on the seven key lines of enquiry within the national "Better Births" strategy. These encompassed stillbirth and neonatal deaths; intrapartum brain injuries; personalised care plans; choice agenda; continuity of care; midwifery settings; and smoking.

What's working well

- Partnership working across the place e.g. one Personalised Care Plan
- Local Maternity System Board (LMS) and Hosted Network (HN) Collaborative approach, jointly chaired by Louise Barnett and Chris Edwards
- TRFT representation and attendance at the SY&B ICS Local Maternity System
- Local Maternity System Board and place working
- Rotherham Maternity Transformation Plan including new tracker development and Funding Plan – sets agenda for next 12 months
- Robust governance arrangements and reporting structures set up:
  - Better Births Group (in Rotherham) – Key external stakeholders including Maternity Voices Partnership (MVP), service user

representation
- Sub Groups in place for progression of the 7 Key Lines of Enquiry
- Action and Monitoring Logs created and maintained and reported to Better Births Group

* Reporting into the Maternity Governance Group
* Maternity Voices Partnership enhancing women and families engagement – robust and active group
* Leadership, dedicated, energised and enthusiastic Team to drive forward transformation – staff engagement, ownership and vision
* Place Partnership working to improve the health and wellbeing of mum and baby such as smoking cessation, and sub groups with appropriate representation
* LMS Achievement of Continuity of Carer LMS trajectory 20% and Use of a Personalised Care Plan 40%
* Commitment and support from CCG Communication Lead regarding a communication Strategy to help the service raise its profile and encourage women to use the service
* Involvement in the development of the Rotherham Health App – early stages

Smoking cessation was viewed as a golden thread across all the workstreams, ensuring the best health of the mother to then give the best chance in terms of health outcomes for the baby. A strong smoking reduction focus for women would make a huge difference in relation to the Public Health agenda, on which TRFT worked collaboratively and in parallel with Public Health colleagues.

What are we worried about?

* Achievement of all future key trajectories and sustainable support
* The Rotherham NHS Foundation Trust Estates provision that is required to progress the Place Plan – such as a Alongside Midwifery Led Unit, Hubs in communities Delivery Suite alterations including Bereavement Suite and Greenoaks relocation
* Achievement of 35% Continuity of Carer by 31 March 2020 and embedding a new service model
* Sustained funding and commitment in relation to workforce staffing for achievement of continuity of carer
* On call processes and business continuity at times of increased capacity on the delivery suite, especially as simultaneously changing the service model
* Improvement in relation to Maternity Data set information and Performance Dashboard information regarding Smoking Cessation Service – demonstrate outputs and difference made
* Marketing of Rotherham Maternity Services

Hubs at Aston, Maltby and Rawmarsh would not only be for maternity services but around the children's agenda as well to offer a one-stop service for some of these community services rather than coming into the hospital.

What needs to happen, by when?

- Continued strong and focused leadership and committed Team – clarity and driving forward
- Refresh Maternity Transformation Plan by 30 August 2019 and including the plans regarding the prevention, Public Health and digital agenda
- Continue with TRFT robust governance, monitoring and reporting arrangements
- Plans in place for estates requirements and Hub set up support – Greenoaks relocation imminent, look at triage area
- Continuity of Carer Sub Group actively progressing plans to achieve the trajectory – increase in staffing for the new model
- Maternity Escalation Plan in place since May and Maternity On call Rota for acute services - commenced on 19 August 2019 to ensure a safe service
- Set up of the new Maternity Hosted Network and Local Maternity System (LMS) Collaborative Group – 10 September 2019 and appointment of Maternity Clinical Lead
- New Smoking Cessation Service Performance Dashboard from August 2019
- New Maternity Digital Group established - commenced 14 August 2019
- Raise the profile of Rotherham Maternity Services – Communication Strategy and marketing - Maternity and Family Showcase commencing 4 September 2019 to learn about services

The first Maternity and Family Showcase, featured a number of market-type stalls from both maternity and children's services as well as external bodies such as Healthwatch and the Fire service. Intentions were to hold an event on the first Wednesday of every month and to keep building on it to raise the profile of maternity services.

Discussion ensued on the following points:-

- Details about the current breastfeeding service.
  - Breastfeeding was not a workstream within "Better Births" but the Trust was proactively looking at increasing breastfeeding, both at birth and sustained further down the line. The service was accredited for its birth and breastfeeding and would be seeking re-accreditation in December. The hospital was committed to ensuring women had the right support for breastfeeding, which also fitted in with the Public Health agenda. Workstreams were ongoing around the breastfeeding aspects and from a monitoring point of view breastfeeding statistics were overseen by Performance Data Boards and the local authority. At the showcase event a specific stand around breastfeeding had generated plenty of interest.

- Support for patients to access the complaints procedure.

- If anybody had concerns the service tried to address those immediately but if not there were a number of aspects. The birth afterthoughts service was initiated in 1998, not so much for complaints but rather because sometimes there were felt to be unanswered questions, as the service could seem a bit like a jigsaw where people could not always quite put all the pieces together. For example, in the delivery room if it had been necessary to get the baby out quickly without an opportunity to ask questions about what had happened. The service could meet the family, talk to them about their whole birth experience, use their records and hopefully answer any questions, although that was not really a complaint. The birth afterthought service was embedded and if unanswered questions were not addressed they could become a complaint if people felt they had not had that opportunity.

  Families would be supported to contact the complaints service and there was also Healthwatch but the service was very open in trying to go and speak with families to try to address issues. Although women might be in hospital for a period of time when they returned home they also still had continuing care.

  It was confirmed that information about the afterthoughts service and the complaints service were provided in the information given to women accessing the service.

- Statistics and information to come back on how successful the achievement of the future key trajectories, sustainable support and the 35% continuity of carer by 31st March 2020 had been.
  - Plans were in place to achieve these and a future update could be provided. It was clarified that the percentage target was a collective one across the sub-region, not an individual target for Rotherham. Services wanted to achieve a high percentage, making sure that when women were booked on a pathway they had a small team of midwives providing that continuity of care as it was about building trust and that relationship. It was a question of getting the model right and keeping a safe model and the future plans would increase the models of care for the different groups of patients.

- Use of the Mjog service as well as developments with the Rotherham Health App.
  - Although unfamiliar with Mjog, maternity services had been keen to get involved with the Rotherham Health App at an early stage to give women a choice about access to information. At the moment the personalised care plan was a paper version because it belonged to the woman but the service was looking to an electronic version as well and the app would be a great way to do that. The service also wanted to look at the App for self-referral processes.

- For marketing the service to be first choice and letting people know

how good it was, would the service have a presence at Rotherham Show?
- Yes this was planned.

- Cllr Roche confirmed that smoking cessation in pregnancy was funded by the Council. It was closely monitored as one of the performance indicators and had met the target last year. Rotherham was strict in how smoking cessation was measured as when pregnant women presented they had a CO2 test every time unlike other places which simply asked if they smoked. This whole area was also taken to the Place Board which in turn reported to the Health and Wellbeing Board.

- Statistics for smoking cessation were requested together with statistics on breastfeeding.

Members were invited to attend one of the open events.

June was thanked for her comprehensive presentation and would be invited back to report on progress.

Resolved:-

1) To note the information provided on plans for maternity services and meeting the requirements of the “Better Births” guidance.

2) That statistics on smoking cessation and breastfeeding be provided for the Health Select Commission.

30. HEALTHWATCH ROTHERHAM

No issues had been raised by Healthwatch in advance of the meeting.

Members raised concerns that Healthwatch had not been in attendance at the meeting.

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

The Governance Advisor confirmed that the committee had not met since the last Health Select Commission meeting but that a meeting was currently being arranged, probably to be held in October.

With regard to the Hospital Services Programme, the hosted networks for the five specialties were now operational. The intention was to let these gain traction and deliver changes through transformational work for 12-18 months before considering any potential service reconfiguration.

32. MINUTES OF THE PREVIOUS MEETINGS HELD ON 13TH JUNE AND 11TH JULY, 2019

Consideration was given to the minutes of the previous meetings of the Health Select Commission held on 13th June, 2019 and 11th July, 2019.

Further to Minute No. 3 (Minutes of the previous meeting held on 11th April, 2019) the Autism Strategy had been confirmed for the meeting in November and possibly an update on the Carers Strategy for February, although that could be later in the year in light of the discussion on Intermediate Care and Reablement.

With regard to Minute No. 4 (Yorkshire Ambulance Service) the service might be looked at by the joint health scrutiny body later in the year.

Members raised the possibility of the Health Select Commission setting up a working group before this if further investigation identified a need for local scrutiny, as various issues had been raised anecdotally. The Chair was actively following up the previous issue that had been raised.

Further to Minute No. 5 (Sexual Health Strategy) and a question regarding the gender imbalance in new STI diagnosis for people aged 15-30 and how Rotherham compared with other areas – further research had shown a similar distribution in other areas. The recommendations from Health Select Commission would be discussed at the Strategy Group meeting on 17th September, 2019 with feedback expected for the HSC meeting in October. The Equality Analysis was being finalised to go with the final refreshed strategy and would be sent through.

From Minute No. 6 (Response to Scrutiny Workshop – Adult Residential and Nursing Care Homes), follow up information on capturing service user voice in residential and nursing care homes had been provided. Healthwatch had not undertaken a great deal of this to date but were keen to do more and had been involved in the engagement work on intermediate care and reablement. They had legal powers to “Enter and View” and had discussed how they would look to introduce these at a recent Registered Managers Meeting.

From an Adult Care perspective, capturing the service user voice formed part of the work on quality. It was also being looked at across the Yorkshire and Humber region as well through Association of Directors of Adult Social Services (ADASS), so there would be more concrete activity to report on early in 2020.

Councillor Roche informed the Select Commission that two care homes which had previously closed, in Maltby and in Greasbrough, would be re-opening after being taken over by two new organisations. Adult Care were working with the new companies and would keep a close eye on the quality of those care homes. It was also reported that at that time Rotherham had no care homes in measures.

Resolved:- That the minutes of the previous meetings held on 13th June, 2019 and 11th July, 2019 be approved as a correct record, subject to the following correction from July regarding Minute No. 5 Recommendation 4 which should refer to the Sexual Health Strategy Group.

33. COMMUNICATIONS

The Chair congratulated Cllr R Elliott on his appointment as Vice Chair.

Information Pack
Contained within the information pack disseminated to the Commission were:-

- Presentation from the My Front Door seminar
- Presentation from Healthy Weight Declaration seminar – with questions for Members to send a response to the Cabinet Member or Public Health team
- Notes from the quarterly health briefing with health partners
- Health and Wellbeing Board minutes from July
- Year end Performance Report for the Rotherham Integrated Health and Social Care Place Plan

No questions were asked or comments made on the information pack.

Improving Access to Psychological Therapies (IAPT) Service
It was confirmed that the IAPT team had now moved from Clifton Lane to a more central location at the Centenary Clinic on Effingham Street (formerly Clearways).

Infertility Treatment
Proposals to improve access to services, including for same-sex couples, had previously been circulated. No further information was requested.

Drug and Alcohol Treatment and Recovery Services
A small number of Members would have a further visit to Carnson House to learn more about the challenges faced by people with long term methadone use in giving up their methadone prescriptions.

34. URGENT BUSINESS

There was no urgent business to report.

35. DATE AND TIME OF NEXT MEETING - THURSDAY, 10TH OCTOBER, 2019, COMMENCING AT 2.00 P.M. IN ROTHERHAM TOWN HALL

Resolved:- That the next meeting of the Health Select Commission take place on Thursday, 10th October, 2019, commencing at 2.00 p.m.

Rotherham SEMH Strategy

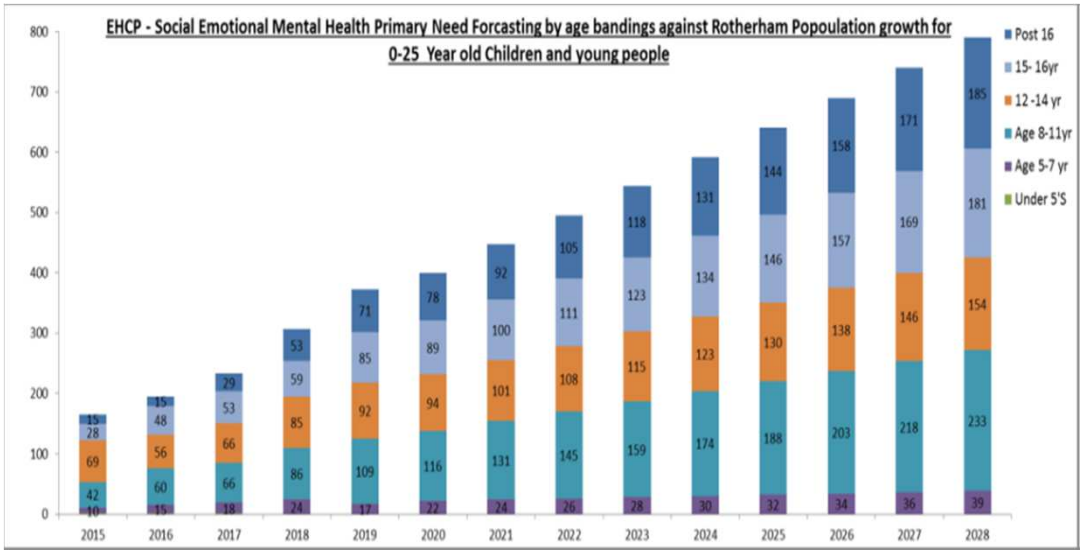
www.rotherham.gov.uk

Rotherham
Metropolitan
Borough Council

Context

- Provides a strategic framework to underpin activity
- Builds on the foundation of existing work and policy drivers but tries not to over-complicate
- Does not identify every activity or action in detail
- Has been co-produced with headteachers; and reflects the views of children and young people

Understanding Demand



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

- Be based on the equitable use of resources which is affordable, with realistic expectations and clearly defined outcomes
- Be a whole Borough response which is informed by transparent information and data and knowledge of local and national good practice;
- Recognise the importance of early intervention and be family and person centred;
- Recognise the importance of collective responsibility, which includes education, health and care partners and is based on a shared understanding of what is expected of all parties;
- Provide a graduated response with thresholds to prevent escalation into expensive out of borough provision;
- Provide local and flexible solutions which are developed and managed by schools;

Vision

Rotherham meets the social, emotional and mental health needs of all children and young people through seamless access to the right services at the right time and a confident and resilient workforce

Priorities

- Sufficiency: develop local education provision that responds to need – this will include flexible and specialist provision

- Seamless Pathways: ensure that pathways to support are connected and aligned and develop a clear behaviour pathway that includes responses to attachment and trauma

- Partnerships: develop and sustain robust inclusion partnerships that enable schools to meet need through a collective approach to responding to the needs of individual children

Priorities

- Evidence-Based Approaches: ensure that the local authority offer (from Early Help and Inclusion services) responds to need and is underpinned by evidence-based approaches and aligned with clear pathways

- Workforce: develop a robust training and support offer, enabling professionals to feel confident in responding to the needs of children and young people with SEMH needs

- Outcomes Focused and Value for Money: ensure that all activity can demonstrate a clear outcomes and value for money

Rotherham Metropolitan Borough Council

BRIEFING	**TO:**	Health Select Commission
	DATE:	10th October 2019
	LEAD OFFICER:	Janet Spurling Governance Advisor, Assistant Chief Executive's Directorate 01709 254421
	TITLE:	Draft Rotherham Social, Emotional and Mental Health Strategy

1. Background

1.1 The work programme of the Health Select Commission has included a strong focus on mental health and wellbeing, across all age groups, but especially for children and young people, over a number of years.

1.2 In October 2017, the Commission considered information presented by Rotherham schools with details of their response to children and young people with social, emotional and mental health (SEMH) needs. Further to this report, a monitoring update on the first SEMH Strategy was scrutinised in October 2018. Members noted the progress made to support children and young people and supported development of a new multi-agency SEMH Strategy. The draft strategy is attached at Appendix 1, with the graphs contained within it reproduced and enlarged on a separate sheet at Appendix 2.

2. Key Issues

2.1 The six overarching priorities in the strategy are :

1. **Sufficiency:** develop local education provision that responds to need – this will include flexible and specialist provision

2. **Seamless Pathways:** ensure that pathways to support are connected and aligned and develop a clear behaviour pathway that includes responses to attachment and trauma

3. **Partnerships:** develop and sustain robust inclusion partnerships that enable schools to meet need through a collective approach to responding to the needs of individual children

4. **Evidence-Based Approaches:** ensure that the local authority offer (from Early Help and Inclusion services) responds to need and is underpinned by evidence-based approaches and aligned with clear pathways

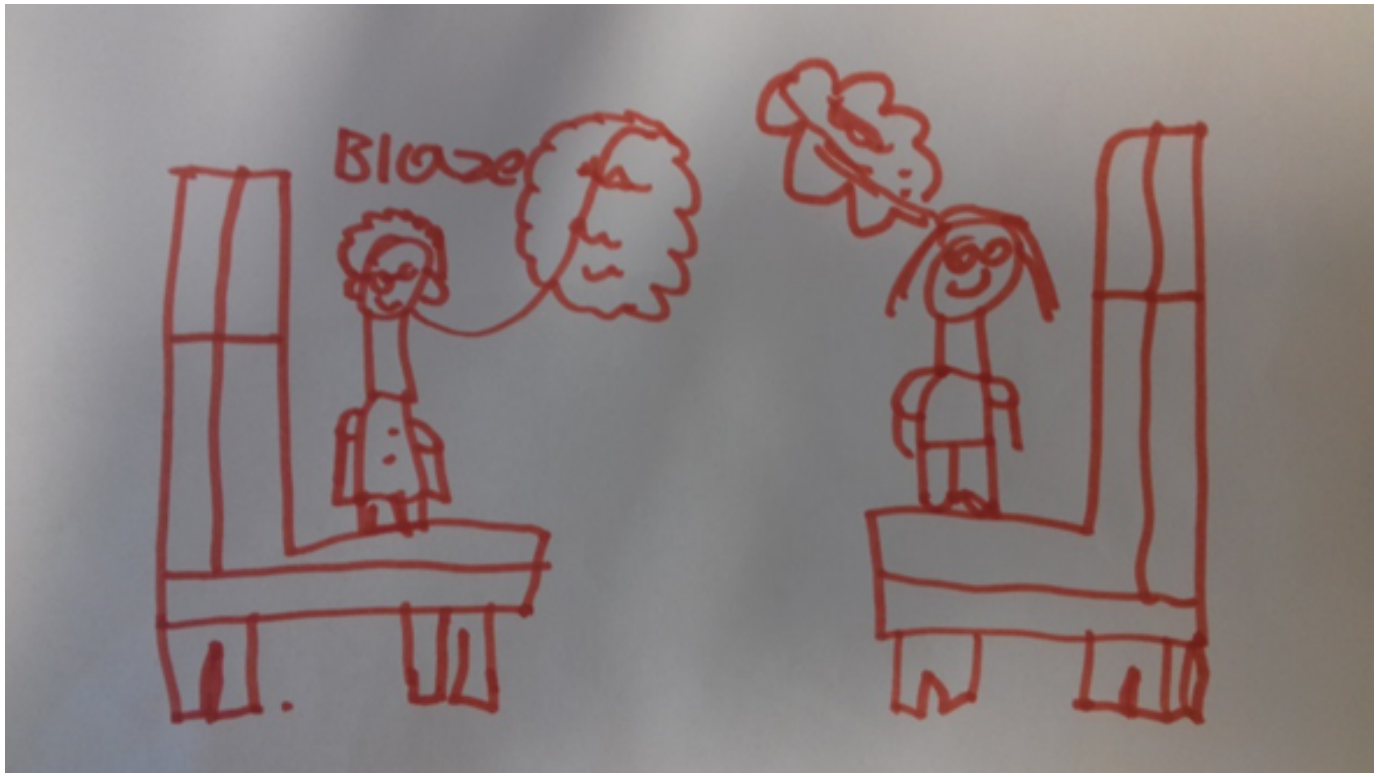
5. **Workforce:** develop a robust training and support offer, enabling professionals to feel confident in responding to the needs of children and young people with SEMH needs

6. **Outcomes Focused and Value for Money:** ensure that all activity can demonstrate a clear outcomes and value for money

3. Key Actions and Timelines	
3.1	An action plan covering the six priorities is incorporated within the draft strategy.
3.2	Initial actions commenced in October 2018 with the development of robust data on Special Educational Needs and Disability (SEND) Sufficiency and will culminate in new provision being introduced in a phased approach by September 2021.
3.3	The action plan also sets out the timescales to implement the Mental Health Trailblazer which will pilot a new approach to delivering mental health support in schools. The Mental Health Trailblazer will be a key enabler for the SEMH Strategy.
4. Recommendations	
4.1	That the Health Select Commission: Consider and comment on the draft strategy and the information provided in the presentation. Note progress on the implementation of the Mental Health Trailblazer pilot.

Appendix 1

Rotherham SEMH Strategy



Introduction

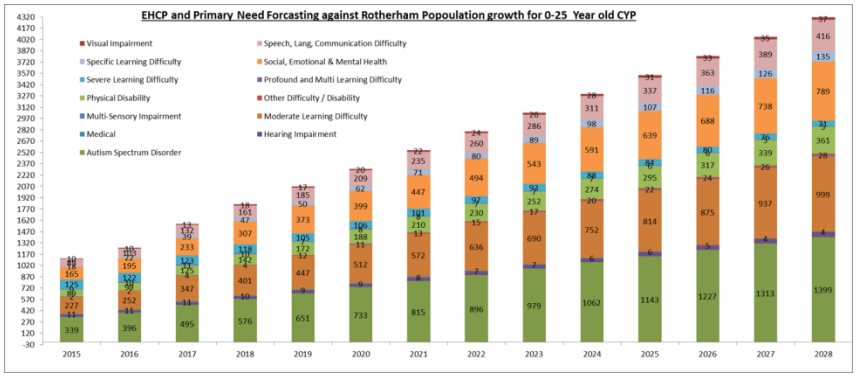
There is intense focus on meeting the needs of children and young people who need support to have good social, emotional and mental health. This terminology is used to describe children who have diagnosed mental health problems but is equally applied to those whose behaviour is triggering concerns about their overall wellbeing. Such a wide range of need cannot be met by a single organisation or be described using a simple pathway. There is a requirement for the whole system to mobilise to ensure that need is identified and met appropriately and as early as possible. This strategy will set out key priorities and actions that will enable work to be coordinated across the system, aligning the local response to key government strategies such as Future in Mind, with commissioning, sufficiency, workforce development and curriculum design planning. The goal is that, whether you are a child or young person, a parent or carer or a professional, your experience should be that there is no wrong door when it comes to meeting the needs of children who need support with social, emotional and mental health needs.

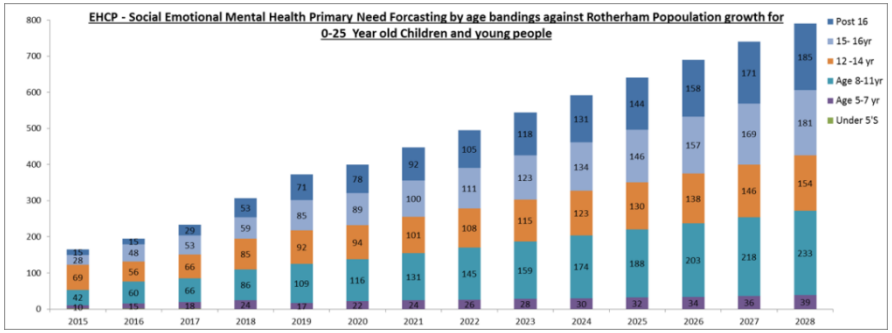
The context

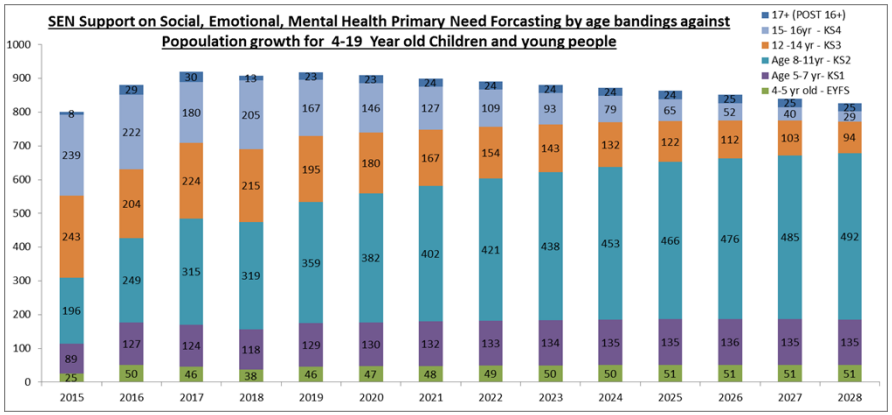
Rotherham is not unique in being worried about how best to respond to growing concern about levels of social, emotional and mental health problems experienced by children and young people.

In 2018, the Prince's Trust Macquarie Youth Index, which gauges young people's happiness and confidence across a range of areas, found young people's wellbeing was it its lowest level since the annual survey was launched in 2009. Four out of ten (39%) young people did not feel in control of their lives, two in ten (21%) felt their life would 'amount to nothing no matter how hard they try' and one in four (28%) said they would not ask for help if they were 'feeling overwhelmed by something'.

In Rotherham, there has been a sharp increase in the number of children and young people who are being issued with an Education, Health and Care Plan, with social, emotional and mental health needs being identified as one of the most prevalent presenting needs.







These graphs show that, as well as children with an Education, Health and Care Plan there are many who are registered for Special Educational Need Support in this category. If these increases in need are projected forwards using the existing trends and population data, the demand for services is likely to continue to rise. The school workforce experience is that there are many more children who are not represented in these graphs who need help and support.

"I don't think the person you talk to needs to be a qualified counsellor or anything, it's more important that it's someone you trust and who gets you"

The Policy Context

In 2015, *Future in Mind*, the report of the Children and Young People's Mental Health Taskforce (appointed by the Government in 2014), recommended local models with seamless pathways of care and support which recognised 'the diversity of circumstances and issues with which families and young people approach mental health services.' *Future in Mind* called for a fundamental culture shift, and set out a blueprint for a system focusing on prevention, early intervention and recovery, with the NHS, public health, local authorities, schools and youth justice working together to deliver joined-up services with easier to navigate care pathways.

In 2015 Rotherham published *Five Steps to Collective Responsibility* which outlined an approach to addressing the needs of children and young people with SEMH needs, with a focus on improving education provision. The principles identified in this strategy remain valid and relevant in 2019.

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

Be based on the equitable use of resources which is affordable, with realistic expectations and clearly defined outcomes

- Be a whole Borough response which is informed by transparent information and data and knowledge of local and national good practice;
- Recognise the importance of early intervention and be family and person centred;
- Recognise the importance of collective responsibility, which includes

education, health and care partners and is based on a shared understanding of what is expected of all parties;
- Provide a graduated response with thresholds to prevent escalation into expensive out of borough provision;
- Provide local and flexible solutions which are developed and managed by schools;

In a similar timeframe, local delivery of Child and Adolescent Mental Health Services (CAMHS) has undergone a significant transformation. The *Local CAMHS Transformation Plan* was first published in October 2015, and is refreshed on an annual basis.

Alongside this, the local authority's leadership of arrangements to fulfil the statutory responsibilities set out in *Working Together 2015* (refreshed in 2018) are now robust. The Ofsted inspection report published in January 2018, recognised Rotherham's significant improvement journey; and Rotherham Children's Services is now rated 'good'. The improvement journey has included the implementation of a robust Early Help offer, and these arrangements can make a significant contribution to meeting the SEMH needs of children and young people.

Governance and Accountability

Partners are fully committed to working together to make decisions on a best for Rotherham basis to achieve the transformation. The Place Board provides governance to the Integrated Care Partnership Arrangements, including the delivery of the Local CAMHS Transformation Plan. Taking action to meet the social emotional and mental health needs of Children and Young People has also been identified as a priority for the Rotherham Strategic Education Partnership.

Vision

Rotherham meets the social, emotional and mental health needs of all children and young people through seamless access to the right services at the right time and a confident and resilient workforce

Priorities

1. **Sufficiency:** develop local education provision that responds to need – this will include flexible and specialist provision

2. **Seamless Pathways:** ensure that pathways to support are connected and aligned and develop a clear behaviour pathway that includes responses to attachment and trauma

3. **Partnerships:** develop and sustain robust inclusion partnerships that enable schools to meet need through a collective approach to responding to the needs of individual children

4. **Evidence-Based Approaches:** ensure that the local authority offer (from Early Help and Inclusion services) responds to need and is underpinned by evidence-based approaches and aligned with clear pathways

5. **Workforce:** develop a robust training and support offer, enabling professionals to feel confident in responding to the needs of children and young people with SEMH needs

6. **Outcomes Focused and Value for Money:** ensure that all activity can demonstrate a clear outcomes and value for money

"Somewhere or somebody to go to if you're feeling troubled- everybody should have that."

"We need a healthy place to learn."

Rotherham Mental Health Trailblazer Pilot

In December 2017 the Government published a Green Paper on children and young people's mental health; proposals focused on early intervention and reducing the number of children and young people needing specialist services. The three core proposals emphasise the role of schools as a hub for mental health support:

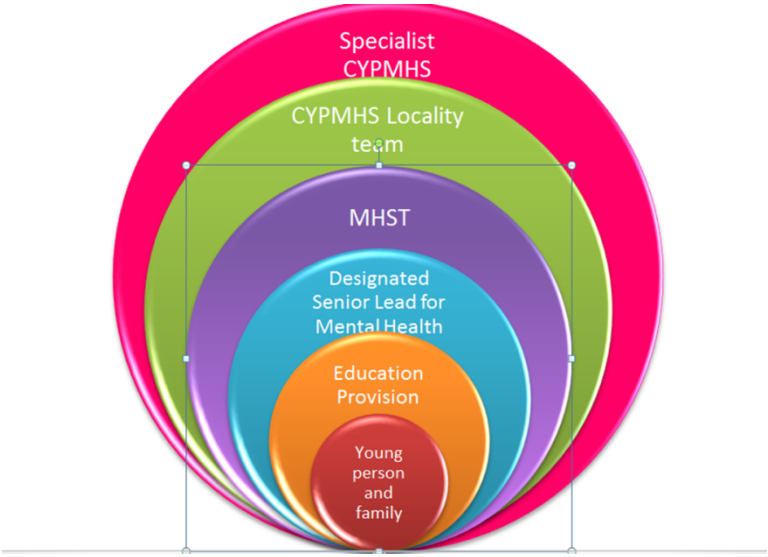
- Development of mental health leads in schools
- Mental health support teams who are school based but linked into CAMHS
- A four-week waiting time standard for children and young people referred for mental health treatment

Rotherham and Doncaster submitted a joint bid to be part of wave 1 of the trailblazer and were successful.

Mental Health Support Teams (MHSTs) in schools will provide evidence-based early intervention and support for children and young people with mild to moderate mental health problems, and signposting to NHS and other appropriate services for further support.

The Four Week Waiting Time Pilot aims to reduce the waiting time from referral to treatment down to four weeks. The aim is to undertake assessment and formulation at receipt of request for support (day 1) and within seven days to have allocated the child or young person to the most appropriate clinician. Interventions will then commence within the subsequent three weeks. It is anticipated that the early intervention provided by the MHSTS will, in time, reduce demand for more specialist services and therefore contribute to this element of the trailblazer indirectly.

The diagram below illustrates the delivery model for the Mental Health Support Teams.



Rotherham's Mental Health Trailblazer bid will provide direct insight to the social, emotional and mental needs of children in schools and how best to meet their needs quickly and effectively. This understanding will contribute directly to joint commissioning decisions and will enable us to achieve the priority of establishing seamless pathways to support.

What Does Success Look Like?

"I used to get excluded a lot but its better now because I have a lead worker and I see him every day which helps, even though he is annoying, haha!"

Each year, a detailed action plan will be developed to identify the activity to support the priorities of this strategy. All activity will demonstrate how it will contribute to improved outcomes for children and young people. NHS England will develop a specific outcomes framework to evaluate the success of the trailblazer work.

However, the overall success of the strategy can be measured through the following criteria.

- A reduction in the number of permanent exclusions from all Rotherham schools
- A reduction in the number of referrals to Child and Adolescent Mental Health Services
- An increase in the confidence of the children's workforce in responding to the needs of children and young people with SEMH needs

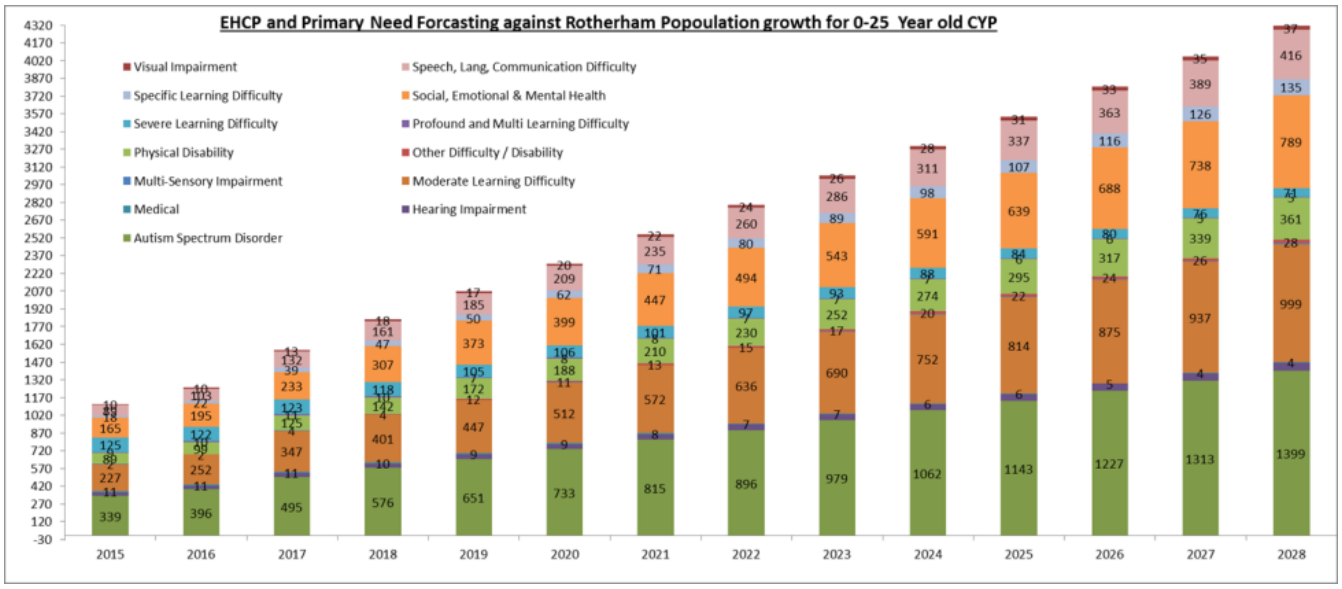
	Action	Progress updates	Target date	Owner
(1) Sufficiency: develop local education provision that responds to need – this will include flexible and specialist provision				
1.1	Develop robust SEND Sufficiency Data	Complete	October 2018	RMBC Head of Inclusion
1.2	Share SEND Sufficiency Data with school partners	Complete	November 2018	RMBC Head of Inclusion
1.3	Cabinet approval to use SEND Sufficiency Data to consult with schools	Complete	April 2019	RMBC Head of Inclusion
1.4	School consultation events	Complete	May 2019	RMBC Head of Inclusion
1.5	Bid submission and evaluation	Complete	May 2019	RMBC Head of Inclusion
1.6	Develop timelines for successful bids	In Progress	July 2019	Various leads; oversight by SEND Sufficiency Group
1.7	New provision becomes operational	In Progress	Phased approach September 2019 – September 2021	Various leads; oversight by SEND Sufficiency Group
(2) Seamless Pathways: ensure that pathways to support are connected and aligned and develop a clear behaviour pathway that includes responses to attachment and trauma				
2.1	Recruit Education Mental Health Practitioners	Complete	April 2019	RDaSH CAMHS Service Manager
2.2	Training for EMHPs (including school placements)	In Progress	December 2019	RDaSH CAMHS Service Manager
2.3	Appoint project lead for Mental Health Trailblazer	Complete	June 2019	RCCG Commissioning Manager
2.4	Project Lead to visit all schools & audit current provision	In Progress	July 2019	Rotherham Trailblazer Project Lead
2.5	Mental Health Support Teams operational in schools	In Progress	December 2019	Rotherham Trailblazer Local Reference Group
2.6	Review impact and learning of Mental Health Support Teams in schools	In Progress	April 2020	RDaSH CAMHS Service Manager
2.7	Ensure a clear evidence base & outcomes framework to evidence good practice	In Progress	December 2019	RDaSH CAMHS Service Manager

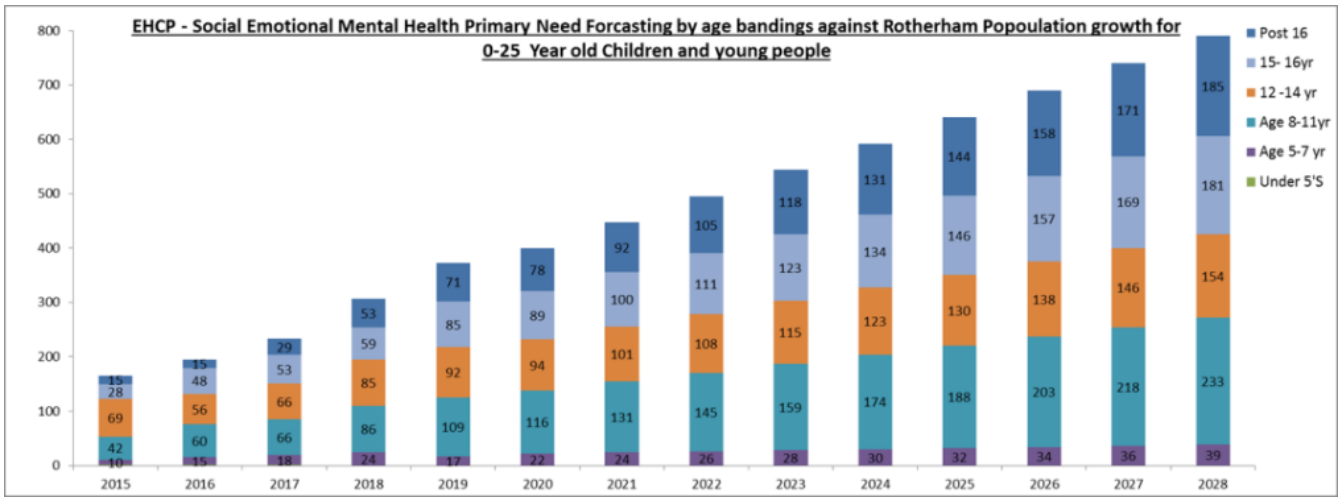
2.8	Implement clear governance structures to ensure that good practice is shared across the system	In Progress	December 2019	Joint AD Commissioning, Performance & Inclusion
(3) Partnerships: develop and sustain robust inclusion partnerships that enable schools to meet need through a collective approach to responding to the needs of individual children				
3.1	Establish a task and finish group to review and develop Alternative Provision arrangements in Rotherham, including additional outreach support	Not Started	September 2019	Joint AD Commissioning, Performance & Inclusion
3.2	Implement Primary Outreach Team, linked to Aspire provision (funding arrangements already agreed)	In Progress	September 2019	RMBC Head of Inclusion
3.2	Ensure that Rotherham's Pupil Referral Units are fit for purpose: Complete a best value review Review governance arrangements Review pupil numbers Agree funding arrangements Agree pathways for multi-agency support Review designation and re-designate where appropriate Map pathways in and out of Pupil Referral Units	In Progress	November 2019	Joint AD Commissioning, Performance & Inclusion
3.3	Agree accommodation strategy for Alternative Provision	Not Started	January 2020	Joint AD Commissioning, Performance & Inclusion
3.3	Identify options to support Secondary Inclusion Partnerships	In Progress	September 2019	Joint AD Commissioning, Performance & Inclusion/ Head of Finance CYPS
3.4	Identify options to support Primary Inclusion Partnerships	In Progress	September 2019	Joint AD Commissioning, Performance & Inclusion/ Head of Finance CYPS
3.5	Review impact of new Alternative Provision arrangements & refresh where necessary	Not started	July 2020	Joint AD Commissioning, Performance & Inclusion

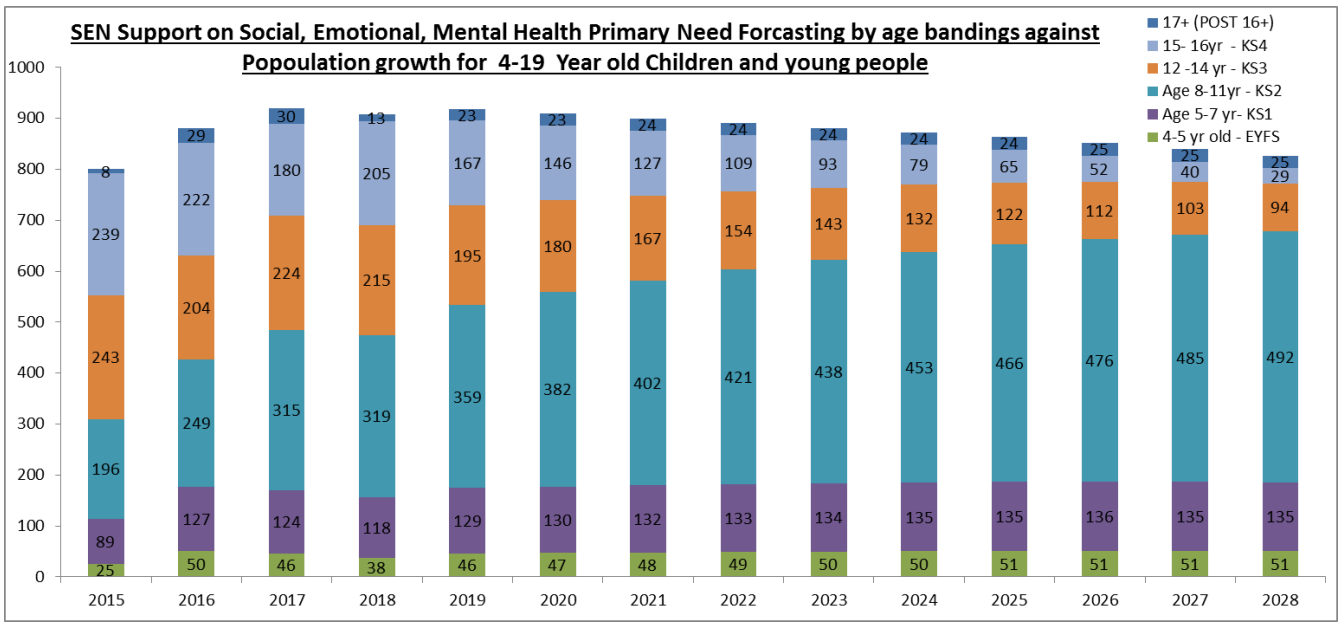
(4) Evidence-Based Approaches: ensure that the local authority offer (from Early Help and Inclusion services) is underpinned by evidence-based approaches and aligned with clear pathways				
4.1	Establish an Evidence-Based Practice Hub in Early Help; ensure that the offer is clearly articulated and linked to pathways of support	In Progress	July 2020	Service Manager, Early Help
4.2	Review Inclusion Services and agree evidence-based programmes of delivery for each team / service (linked to priority 5)	In Progress	September 2020	RMBC Head of Inclusion
4.3	Map pathways for support with clear links to evidence-based practice and programmes (refresh of graduated response)	In Progress	November 2019 & refreshed July 2020	RMBC Principal Psychologist
4.4	Ensure that evidence-based approaches are complementary across the system (Early Help, Inclusion, Education) (linked to priority 5)	Not Started	September 2020	Joint AD Commissioning, Performance & Inclusion
(5) Workforce: develop a robust training and support, enabling professionals to feel confident in responding to the needs of children and young people with SEMH needs				
5.1	Recruit a dedicated workforce lead to review the SEND / SEMH	In Progress	October 2019	RMBC Head of Inclusion
5.2	Undertake an audit of the existing training offer for SEND / SEMH as delivered by health, education and social care	Not Started	April 2020	Joint Workforce Project Lead
5.3	Design a single point of access for all practitioners (health, education and social care) to training associated with Special Educational Needs and Social, Emotional and Mental Health Needs.	Not Started	April 2020	Joint Workforce Project Lead
5.4	Identify any gaps in the current training offers, and recommend evidence-based models to underpin the Rotherham approach to responding to SEMH.	Not Started	July 2020	Joint Workforce Project Lead
5.6	Design a training needs assessment to guide service users to access the right training	Not Started	April 2020	Joint Workforce Project Lead
5.7	Ensure that the training offer is clearly articulated and supports the workforce to meet presenting need	Not Started	July 2020	Joint Workforce Project Lead

5.8	Implement the new training model and monitor take-up and impact	Not Started	September 2020	Joint Workforce Project Lead
(6) Outcomes Focused and Value for Money: ensure that all activity can demonstrate clear outcomes and value for money				
6.1	Ensure a clear evidence base & outcomes framework to evidence good practice from Mental Health Trailblazer	In Progress	December 2019	RDaSH CAMHS Service Manager & Rotherham Trailblazer Strategic Lead
6.2	Develop clear outcomes and milestones for CAMHS priority (part of Rotherham Place Plan)	In Progress	April 2020	RCCG Senior Commissioning Manager
6.3	Develop an Inclusion Scorecard with clear outcomes and quality standards for all teams and services	In Progress	April 2020	RMBC Head of Service, Performance & Quality
6.4	Refresh SEND sufficiency data and track impact against baseline data	Not Started	July 2020	RMBC Head of Service, Performance & Quality
6.6	Collate outcomes data for SEND cohort (including SEMH)	In Progress	September 2020	RMBC Head of Service, Performance & Quality

Appendix 2 Graphs from SEMH Strategy







Mental Health Trailblazer

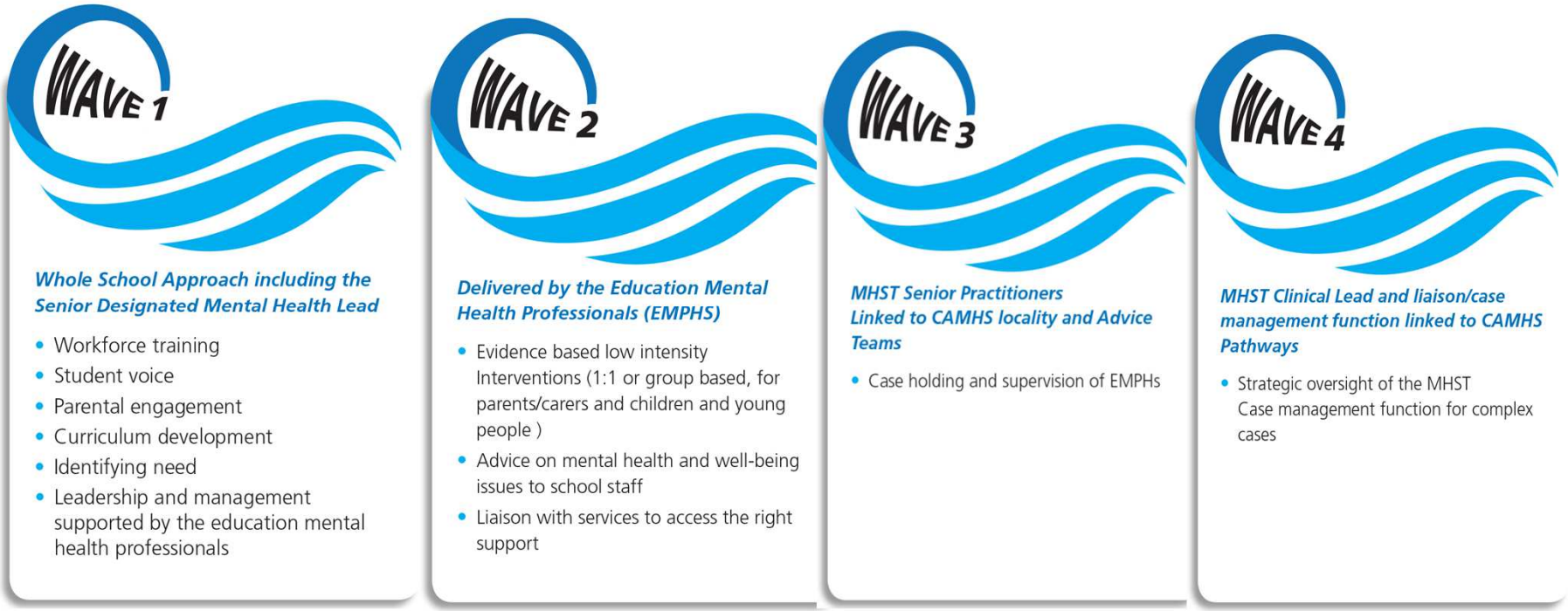
Health Select Commission

10th October 2019

The Rotherham NHS Foundation Trust · Connect Healthcare Rotherham CIC · Rotherham Metropolitan Borough Council · NHS Rotherham Clinical Commissioning Group · VoluntaryAction Rotherham · NHS Rotherham Doncaster and South Humber NHS Foundation Trust

Mental Health Support Team Service Model

The mental health trailblazer pilot will see mental health support teams established in 22 schools and education settings across Rotherham. Up to 8,000 children and YP will receive face-to-face support to help address and prevent mild to moderate mental health problems



Mental Health Support Teams: Role

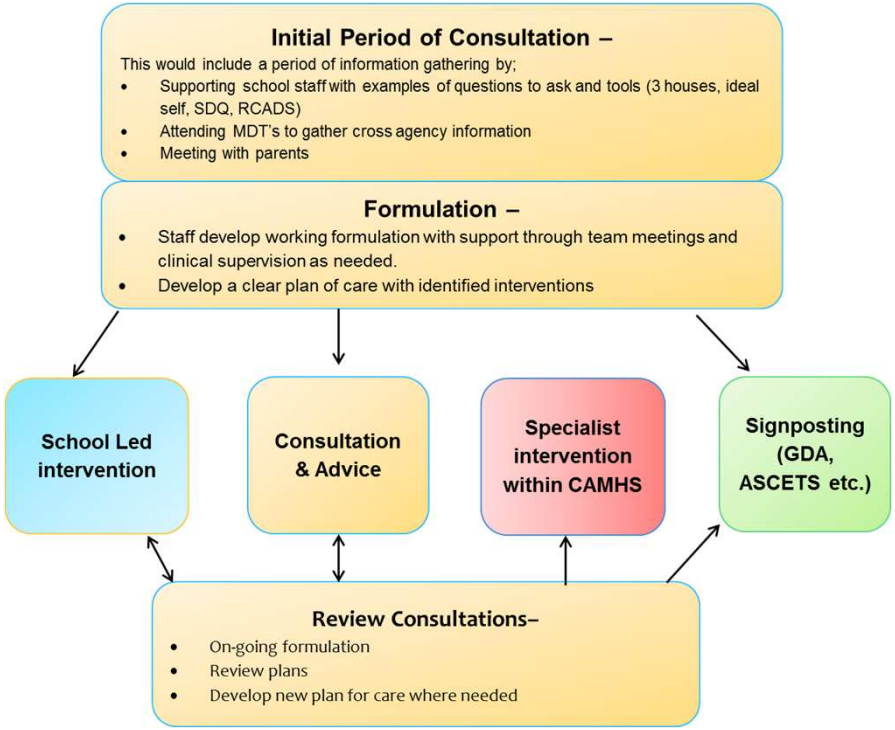
DfE have agreed nationally that the **three key roles** of Mental Health Support Teams are to:

- Deliver evidence-based interventions 1:1 and to groups of children and young people, building on the support already in place, not replacing it
- Support the senior mental health lead to introduce or develop a whole school approach
- Give timely advice to school staff, and liaise with external services, to help children and young people get the right support and stay in education.

Education Mental Health Professional: Role

- Delivering evidence-based intervention for children and young people, with mild to moderate mental health problems, in schools.
- Helping children and young people who present with more severe problems to rapidly access more specialist service.
- Supporting and facilitating staff in education settings to identify, and where appropriate, manage issues related to mental health and wellbeing.

MHSTs will compliment CAMHS Locality Model



Mental Health Support Team Recruitment

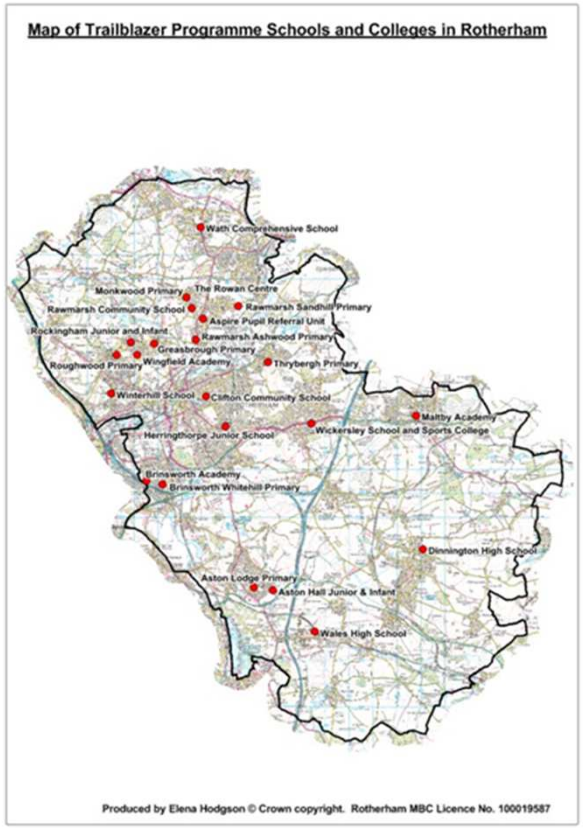
There will be two Mental Health Support Teams in Rotherham; both are now fully recruited to:

Role	Training	In-post/in schools
8 x Education Mental Health Professionals (EMPHs)	Manchester University	Placements with schools from June 2019. Fully operational Dec 2019
4 x Specialist Mental Health Practitioners	N/A	In post from June 2019
1 x Clinical Lead	N/A	in post from July 2019
1 x Temporary Project Lead	N/A	Handover to 3rd Sector Lead June 2019

The role of the MHST Strategic Lead

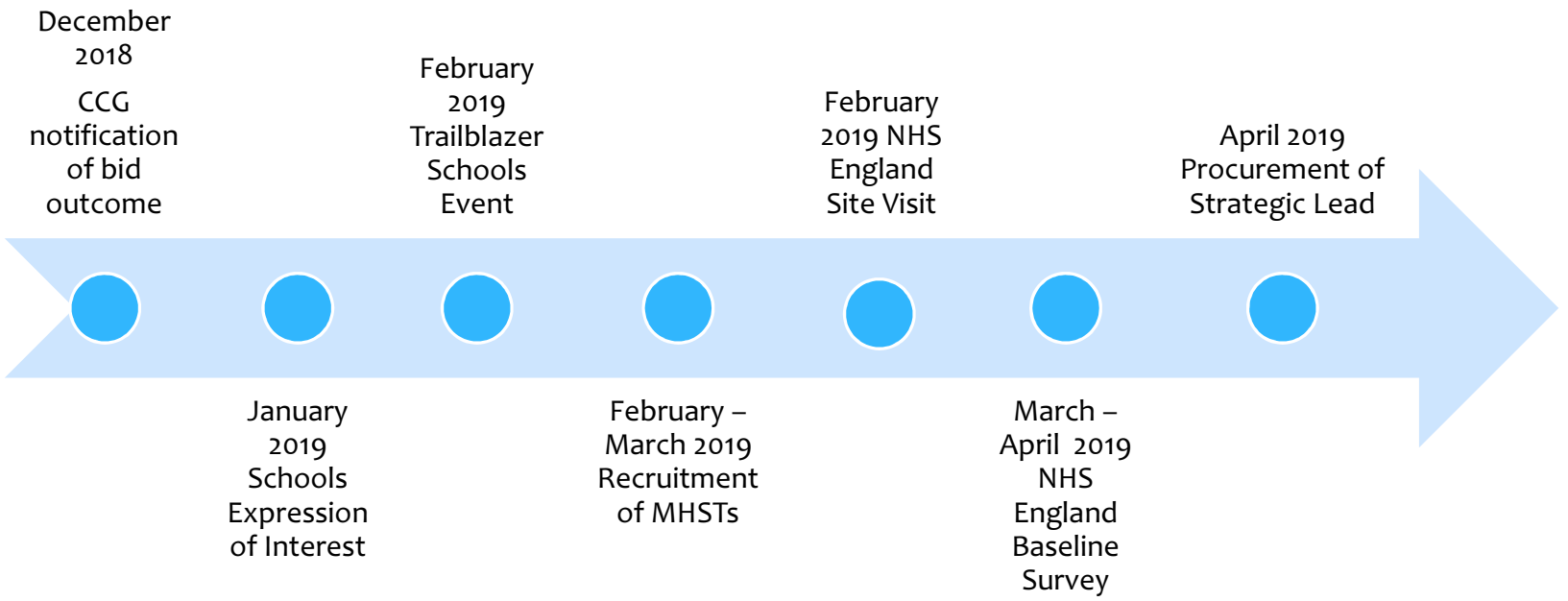
- Strategic lead from the voluntary and community sector will integrate the social model/trusted relationship approach to compliment CAMHS clinical approach
- Ensure effective dissemination of learning from the Trailblazer
- Produce a MHST service model and referral pathway
- Oversee the allocation of referrals across the schools
- Establish how the views of young people and families are collated
- Establish what schools need and how they will work together and share good practice
- Following a competitive procurement process Barnardos will lead this work
- Barnardos have significant experience of working in Rotherham schools. They currently deliver services focused on Child Sexual Exploitation, Child Criminal Exploitation, Harmful Sexual behaviour and young carers

Which schools?

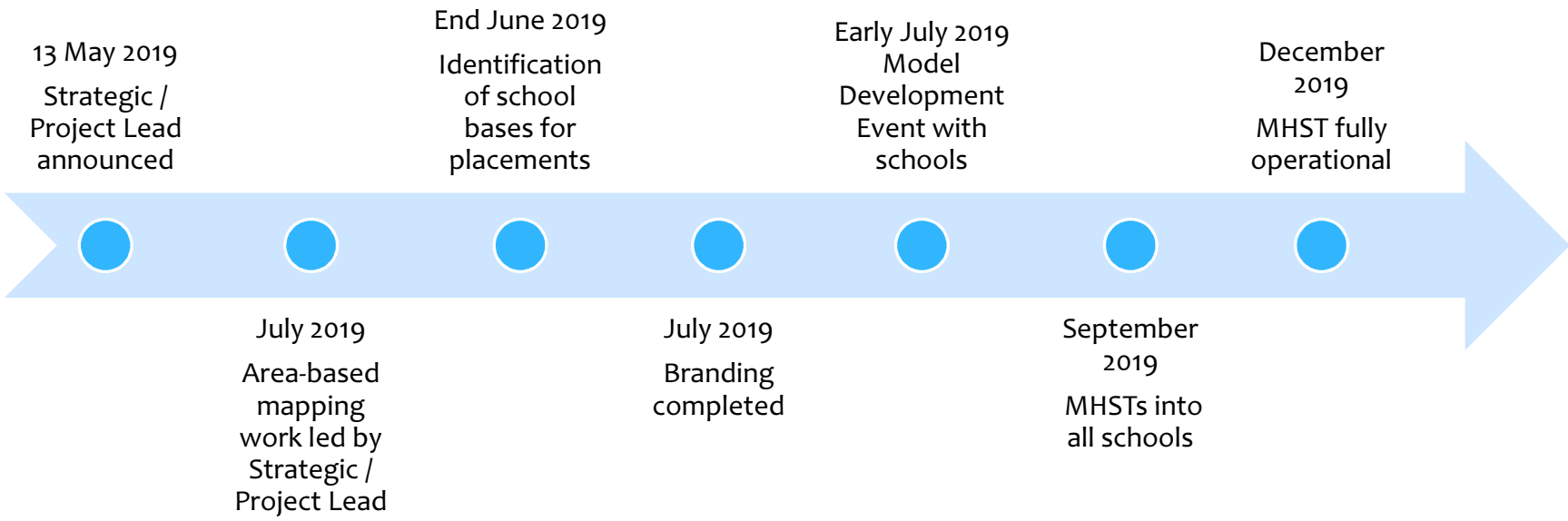


- School selection identified a mixture of primary, secondary and pupil referral unit;
- Schools with well-embedded whole school approaches & those where this is emerging
- Geographical focus
- Partnership focus (existing academy groups)

Implementation milestones



Implementation milestones



Agenda Item 9

Rotherham Metropolitan Borough Council

BRIEFING	**TO:**	Health Select Commission
	DATE:	10th October 2019
	LEAD OFFICER:	Anne Rolfe Quality Governance, Compliance and Risk Manager The Rotherham NHS Foundation Trust 01709 426017 Angela Wood Chief Nurse The Rotherham NHS Foundation Trust 01709 424153
	TITLE:	Care Quality Commission – Achieve an improved CQC rating

1. Background

1.1 This report is presented to the Rotherham Metropolitan Borough Council to update regarding the findings and the ongoing actions to improve the CQC rating for the Trust, in particular Urgent and Emergency Services.

The Care Quality Commission is the independent regulator of all health and social care services in England. They monitor, inspect and regulate hospitals and other care providers.

The Trust received the following inspections;

- core service unannounced inspection on 25-27 October 2018 of four core services;
  - Acute - Maternity
  - Acute – Children and Young People
  - Acute – Medicine
  - Acute – Urgent and Emergency Services.
- Use of resources inspection on 28 September 2018
- Community unannounced inspection on 16-18 October 2018 - Community Children and Young People core service only
- Well led inspection on 22-24 October 2018

High level feedback was given at the end of the each of the inspections and this was followed up by a letter issued to the Trust. Action plans were generated from the feedback. These have now been superseded by the publication of the report.

The final reports were published on 31 January 2019. A communication plan had been developed and various presentations were delivered towards the end of that week and the beginning of the next to ensure that staff were aware of the findings in the report.

Four requirement notices have been given to the Trust. These are the legal requirements that the Trust were not meeting, they are as follows;

- Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
- Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment
- Regulation 17 HSCA (RA) Regulations 2014 Good Governance
- Regulation 18 HSCA (RA) Regulations 2014 Staffing

An action plan was required to be produced for each of the above, using the CQC template. These were submitted to the CQC in February 2019.

The CQC have also issued the Trust with 74 actions (a combination of Must Do (47) and Should Do (27) actions). An action plan was developed and this is monitored in the Trust and significant progress has been made.

Urgent and Emergency Services

In the 2018 inspection, 22 of the must and should do actions related to the Urgent and Emergency Core Service. The report below demonstrates the Urgent and Emergency Core Service inspection in 2018, areas of improvement and the actions taken to improve the service.

2. Key Issues

2.1 **<u>Operational Objective</u>**

Within the Trusts Operational plan, there is an operational objective in relation to the CQC - *Deliver our Quality Improvement Plan (Safe and Sound*), and as part of this we identified:

We will…

- **Achieve an improved CQC rating for Urgent & Emergency Services of 'good' overall:** and address all the 'must-do' and 'should-do' actions

<u>Safe</u>

By safe, the CQC mean people are protected from abuse and avoidable harm. *Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.*

Work has been undertaken to address the concerns identified by the CQC, including;

- Improvements in the staffing model and staffing levels in both the adults and paediatric department, following approval of relevant business cases. Rotas were provided to the CQC on the paediatric staffing levels on a fortnightly basis to provide assurance on the coverage of shifts. This is now reported on an exception basis.
- The NHS Improvement Capacity and Demand Model has been completed for paediatric and adult nursing, and is being modelled for medical staffing. However, during the 2019 CQC inspection the CQC recognised the fragility of the staffing in the department.
- The Head of Nursing has clear oversight on the incidents occurring in the department, including Serious Incidents and is involved in the action plan development. The Patient Safety Team are also providing more support to the department.
- Safeguarding support has been increased in the department along with training compliance. Weekly safeguarding supervision is provided by the

Named Nurse.

- Triage times are monitored daily along with the new metrics. There has been a reduction in triage and wait to be seen times, especially for paediatric patients, which is submitted to the CQC on a fortnightly basis.
- The Trust have developed and implemented a new SOP for PEWS and POPS in UECC in July. There has been a reduction in the incidence of reported deteriorating patients. Electronic Observations and NEWS2 have been implemented
- UECC has now been set up as a new division with a triumvirate management team with regular meetings within the team and with the senior management team through formal reporting and monthly performance meetings.

Effective

By effective, the CQC mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Work has been undertaken to address the concerns identified by the CQC, including;

- A clear audit plan is in place along with NICE Guidance assessments, which are reported through the Governance meetings. However, further work is required to embed governance into the department.
- A significant amount of work has been undertaken on mandatory training in the department, which has increased the compliance levels. However, further work is required with certain staff within the department.
- UECC has now been set up as a new division with a triumvirate management team with regular meetings within the team and with the senior management team through formal reporting and monthly performance meetings.

Caring

By caring, the CQC mean that the service involves and treats people with compassion, kindness, dignity and respect.

Work has been undertaken to address the concerns identified by the CQC, including;

- Improvements in the staffing model and staffing levels in both the adults and paediatric department, enabling staff to be able to identify and treat patients in a timelier manner.
- The Trust have been successful in recruiting volunteers to work in the department to support patients.
- The Nurse in Charge completes regular Quality Checks with patients. There are two hourly safety checks to identify if there are any issues in the department.

Responsive

By responsive, the CQC mean that services meet people's needs.

Work has been undertaken to address the concerns identified by the CQC, including;

- Improvements in the staffing model and staffing levels in both the adults and paediatric department.
- Triage times are monitored daily along with the new metrics. There has been a reduction in triage and wait to be seen times, especially for paediatric patients, which is submitted to the CQC on a fortnightly basis.
- The introduction of streaming has delivered benefits to the patients with a more direct link to the UECC.

Well Led

By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.

Work has been undertaken to address the concerns identified by the CQC, including;

- UECC has now been set up as a new division with a triumvirate management team with regular meetings within the team and with the senior management team through formal reporting and monthly performance meetings. Pathways for escalation are clearly identified, understood and communicated, including revision and embedding of the revised NIC floor report to enable clear documentation of escalation. The Trust have implemented the Freedom to Speak Up, Back to the Floor Sessions and Chief Nurse and Medical Director Clinics. Staff meetings held with the Chief Executive and UECC Speak up Guardian to listen to their concerns/opinions. Triumvirate confidential email to be established in July to allow individual responses to concerns. Regular walkabouts in the department by the Chief Executive and Chief Nurse. Monthly culture checks undertaken in UECC.
- The service is engaged with the Risk Management Committee and Risk Analysis Group. Training is being delivered to relevant staff on risk management and risk assessment. A full review of the risk register has been undertaken.
- The Trust have launched a series of initiatives to improve pastoral support these include: Safe and Sound Programme, Freedom to Speak Up, Medical Director and Chief Nurse drop in clinics, Back to the Floor Programme, You said we did e-mail, Eat and Greet Sessions in UECC

2.2 **CQC Assurance**

The Urgent and Emergency Core Service received an unannounced CQC Inspection in August 2019. The inspection commenced during the night of Monday 19 August 2019 and continued for the two following days. Initial feedback has been received, which included praise for staff for being open and honest and for supporting the inspection. They were shown the improvements that have been made since the previous inspection, and this was reflected by staff comments especially with regards to the paediatric part of the department.

During the inspection the CQC request copies of data. Following the inspection the Trust identified additional information that they wished to send to the CQC to ensure that they had a complete picture of the department. 90 pieces of evidence were submitted to the CQC.

The next stage is for the Trust to receive a copy of the draft report for comment via the factual accuracy process and then the final report will be published. The CQC confirmed that the inspection will enable a re-rating of the core service.

3. Key Actions and Timelines

3.1 As detailed above

4. Recommendations

4.1 It is recommended that the progress being made with the 2018 and 2019 Inspection process is noted.

Trainee Nursing Associate

Health Select Commission
10th October 2019

The Rotherham NHS
NHS Foundation Trust

Background

- Shape of Caring Review 2015 recommended bridging role between unregulated support role and RN
- Recognised the need for defined principles of practice, a competency framework, and a defined career pathway
- Registered Nursing (RN) workforce is an all-degree profession
- Significant shortages of RN across the UK

The Rotherham NHS
NHS Foundation Trust

What is a Nursing Associate?

- Band 4 role working in Health and Social Care
- Working with RN's to complement the existing teams in primary, secondary, community and social care
- Help to plan, coordinate and deliver care
- NMC regulated
- Nursing Associate role is to supplement, not substitute, clinical decision-making

A Nursing Associate…

- Will actively contribute to holistic care
- Will work to a nationally-recognised code of conduct
- Can deal with non-routine and unpredictable nature of the workload
- Will be able to integrate an academic and work-based programme of learning
- Is aware of the limitations of their practice
- Reflects on their practice

The Rotherham NHS
NHS Foundation Trust

What does the training involve?

- A 2-year programme of study and clinical practice leading to a level 5 Foundation Degree
- One day each week at University
- Work in Clinical practice as member of nursing team
- Work-based learning
- Supervisor – sign off competencies
- Placements each year - hospital, close to home, and home.

The Rotherham NHS
NHS Foundation Trust

What is a Foundation Degree?

Developed in response to clinical request it is:

- 2 year course
- Equivalent to 1st two years of a traditional degree (Level 5 qualification)
- Facility to ‘top-up’ to a BSc RN

The Rotherham NHS
NHS Foundation Trust

Recruitment to date UK

- In 2017, 2,000 student nursing associates started pilot programmes at 35 Health Education England test sites across England.
- The first nursing associates joined the NMC register when it opened on 28 January 2019.
- Over 5,000 people were recruited as trainee nursing associates in 2018, with the ambition to attract a further 7,500 in 2019.

The Rotherham NHS
NHS Foundation Trust

Recruitment to date TRFT

- In 2017, five staff became Trainee Nursing Associates in a joint pilot with Barnsley
- The first five nursing associates qualified and joined the NMC register April 2019
- During June 2019, a further 22 commenced training on the apprenticeship
- TRFT will continue to support future cohorts as part of wider workforce planning.

Any questions or feedback?