HEALTH SELECT COMMISSION

Date and Time :- **Thursday 1 May 2025 at 5.00 p.m.**

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

Membership:- **Councillors Keenan (Chair), Yasseen (Vice-Chair), Baum-Dixon, Bennett-Sylvester, Clarke, Duncan, Garnett, Ismail, Havard, Lelliott, Rashid, Reynolds, Tarmey, Thorp and Fisher**

Co-opted Members – Robert Parkin and David Gill representing 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. Minutes of the previous meeting held on 27 March 2025 (Pages 5 - 24)

To consider and approve the minutes of the previous meeting held on 27 March 2025 as a true and correct record of the proceedings.

3. Declarations of Interest

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

For Discussion/Decision:-

6. Adult Mental Health Pathway Update (Pages 25 - 82)

To receive a report and presentation to provide an update and overview of changes in respect of the mental health service review.

7. Health Select Commission Work Programme - 2024/2025 (Pages 83 - 84)

To consider the Health Select Commission's work programme for 2024/2025.

For Information/Monitoring:-

8. South Yorkshire, Derbyshire and Nottinghamshire Joint Health Overview and Scrutiny Committee

Since the last Health Select Commission meeting no meetings of the South Yorkshire, Derbyshire and Nottinghamshire Joint Health Overview and Scrutiny Committee have taken place.

The dates for 2025/26 municipal year JHOSC meetings are due to be confirmed in May, however, the next JHOSC meeting is expected to take place on 23 July 2025.

Anticipated agenda items for that meeting include:

- Non-emergency Patient Transport Service Update
- Continuing Healthcare Commissioning Arrangements.

JHOSC agenda packs are published 5 working days prior to the meeting taking place. Published agenda packs can be accessed by the following link:

South Yorkshire, Derbyshire and Nottinghamshire Joint Health Overview and Scrutiny Committee

Members who have comments or queries regarding an item on any JHOSC agenda should refer these to the Health Select Commission Chair and Governance Advisor at the earliest opportunity to ensure they are reflected in debate during the relevant public meeting.

9. Urgent Business

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

10. Date and time of next meeting

The next meeting of the Health Select Commission will be held on 26 June 2025 commencing at 5.00 pm in Rotherham Town Hall.

SHARON KEMP OBE,
Chief Executive.

This page is intentionally left blank

HEALTH SELECT COMMISSION
Thursday 27 March 2025

Present:- Councillor Keenan (in the Chair); Councillors Yasseen, Bennett-Sylvester, Clarke, Garnett, Havard, Rashid, Tarmey and Thorp.

Apologies for absence:- Apologies were received from Baum-Dixon, Duncan, Ismail and Mr R Parkin.

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

50. MINUTES OF THE PREVIOUS MEETING HELD ON 23 JANUARY 2025

Resolved:-

That the minutes of the meeting held on 23 January 2025 were approved as a true and correct record of the proceedings.

51. DECLARATIONS OF INTEREST

The following declarations of interest were made:-

Member	Agenda Item	Interest Type	Nature of Interest
Councillor Garnett	Agenda Item 6 and 7	Personal Interest	Employment at TRFT

52. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

There were no questions from members of the public or the press.

53. EXCLUSION OF THE PRESS AND PUBLIC

There were no items on the agenda that required the exclusion of the press or members of the public.

54. TRFT SAME DAY EMERGENCY CARE CENTRE DEVELOPMENT

The Chair welcomed the Managing Director, Bob Kirton and the Chief Operating Officer, Sally Kilgariff, TRFT to the meeting and invited them to introduce the presentation.

The Managing Director, TRFT explained that they had recently taken up the role previously occupied by Michael Wright who had regularly attended the Commission's meetings, having undertaken the same role

previously at Barnsley. They were now in their third month of getting to know and understand the Trust and were working closely with partners through the Health and Wellbeing Board, Place Partnership and Rotherham Together Partnership.

The Managing Director, TRFT outlined their intention to set out the plans for the Same Day Emergency Care (SDEC) Centre, which was essentially an extension of the Urgent and Emergency Care Centre (UECC) at the hospital.

They explained that the UECC was set up in 2017 and had proved very successful. The opportunity was presented to obtain some national funding through NHS England following a rigorous process that concluded in December 2024, which was pursues by the Trust with the support of the Board due to increased attendance at the UECC.

The Managing Director, TRFT explained that TRFT felt it was important to engage with the Health Select Commission at an early stage to offer an opportunity to influence the development of the SDEC in a way that reflected the needs of Rotherham people.

They described that the SDEC represented a £7 million investment through the national Additional Capacity Targeted Investment Fund (ACTIF), which aimed to increase urgent emergency care capacity and same day emergency care capacity within departments and the associated benefits to patient flow.

The Managing Director, TRFT summarised the practical purpose of the SDEC, and explained that when a patient presented at an emergency department, health professionals often knew what the patient needed but struggled to deliver the care required within the available space. The SDEC provided the additional space needed to deliver care in one location, which reduced the need for costly and time-consuming admission which did not always deliver optimal patient experience. Ultimately, its purpose was to support Urgent and Emergency Care demand, improve timely access and patient outcomes.

The SDEC implementation had also offered the opportunity to unlock additional benefits which addressed issues elsewhere within the Trust such as pre-op assessment, sexual health and the fracture clinic.

The Managing Director, TRFT explained that the Trust had had to move at pace to secure the capital, considerations around workforce and clinical models were simultaneous workstreams. They explained that staff engagement was undertaken, patient engagement and public engagement which took place the day prior to the Health Select Commission meeting. They outlined some of the areas of discussion from the public engagement event including accessibility for people with neurodiverse needs and dementia, the toilet facilities and kitchen facilities etc.

The Managing Director, TRFT explained that the aim was for the SDEC to open in June 2025, whilst the overall project comprised of a number of phases. The Chief Operating Officer, TRFT distributed and described a site plan which saw movement of a number of services and clinics to different locations across the hospital site, with the planned moves intended to improve overall patient flow. The example of the relocated fracture clinic, which delivered co-location with the orthopaedic clinics and wards and provided a dedicated facility across inpatient, elective, non-elective and outpatient areas with dedicated x-ray facilities, was cited. Sexual Health was also cited as an area of growing demand where relocation offered the welcome opportunity for growth and expansion. The final example referred to was the pre-op assessment facility which was relocated adjacent to day surgery, optimising patient flow and the patient pathway. This was to be augmented by a dedicated drop-off area and reflected a tangible improvement for patients in terms of accessibility.

It was acknowledged that some disruption to services was expected whilst services were relocated, with some aspects of care already having moved to temporary location, however efforts were made to minimise the impact of any disruption and the benefits anticipated justified the level of disruption experienced for both staff and patients.

The Managing Director, TRFT explained that there was robust governance around the SDEC development, with progress updates reported regularly through the Trust's internal governance structures. They provided an overview of the proposed layout of the SDEC, linked this to existing capacity pressures experienced within the UECC which were particularly evident at times of volume attendance and explained the positive impact this delivered to patient flow.

They emphasised that the Trust was keen to work with the public to refine the remit of the SDEC and maximise its impact. This involved an element of engagement to ensure patients understood the offer within SDEC and that the UECC wasn't always the first port of call.

The Chief Operating Officer, TRFT added that the Trust were working closely with community colleagues and teams, and the ambulance service to ensure appropriate referral pathways existed which aimed to minimise unnecessary attendances.

The Chair thanked the officers for the presentation and invited questions and comments.

Councillor Bennett Sylvester wanted to understand whether the relocation of the Sexual Health clinic would impact on the Diabetes centre.

It was confirmed that it did not and there would be no change.

Councillor Bennett-Sylvester also queried whether the SDEC development was expected to relieve pressure on the Acute Medical Unit (AMU) and Acute Surgical Unit (ASU) which anecdotal evidence reflected did not deliver a positive patient experience and represented a 'bottleneck' in terms of patient flow and treatment.

The Managing Director, TRFT commented that in many cases, people believed that Accident and Emergency, or UECC in TRFT's case was the greatest pinch point, but AMU and ASU were also highly pressurised as the reception points for all in-patients. They described those areas as rewarding but challenging places to work.

They added that the principle of the SDEC was that it was for people that didn't need full admission as an alternative route, and explained that people often thought of physicians working in emergency care as one big team but there was a distinct difference between emergency care physicians and acute care physicians. In that sense, the SDEC represented a space where those clinicians and physicians could work side by side on agreed pathways and meant that patients could be assessed in that area rather than taken into the AMU.

Councillor Clarke commented that a common concern raised through Councillors surgeries was hospital parking. Increased attendance, and increased patient flow inevitably meant an increased number of vehicles, and as such they queried whether the Trust were investing in the car parking or park and ride schemes.

The Managing Director, TRFT acknowledged that hospital parking was challenging in any setting. The Trust had implemented automatic number plate recognition to parking facilities to simplify the process, and alongside that had increased the number of parking spaces, but accepted that there was more work to do and no easy solutions. To their knowledge, park and ride facilities had not been considered specifically, but parking more generally was very much on the agenda.

Councillor Havard wanted to understand whether the SDEC would make it easier for patients with reoccurring issues to access ongoing treatment rather than having to go through complicated assessment processes each time. They cited a personal example to illustrate the barriers presented to accessing ongoing care.

The Managing Director, TRFT advised that as a general principle, the NHS was good at providing emergency care, but aftercare was the area where it struggled as a service. The purpose of the SDEC was to offer a clear pathway, predominantly concerned with medical issues such as deep vein thrombosis (DVT) to begin with, extended over time to address precisely those issues; direct access to the service at point of delivery rather than repeated triage and assessment.

Councillor Havard queried whether GPs were appraised of hospital care a patient had received so that they were mindful of this in the event that patients needed additional support in the period of time shortly after receiving treatment at hospital.

The Managing Director, TRFT confirmed that GPs were always advised of the hospital's interactions with patients, but acknowledged that through digital communication channels there were sometimes issues.

The Assistant Director of Transformation, South Yorkshire ICB added that there was a significant piece of work underway to make information sharing and communication more effective and patient centred. This work recognised differing approaches across different pathways and aimed to deliver a greater degree of consistency.

Councillor Thorp commented on the terminology used and the confusion changes to terminology can cause for patients and others accessing services and queried whether there would be sufficient clear signage to provide appropriate directions around the hospital estate.

The Managing Director, TRFT expressed the view that consistent messaging was key, but the Trust was working with staff and volunteers to ensure that patients and visitors were supported on site.

The Chief Operating Officer, TRFT added that the Trust were also exploring doing something different with signage and potentially upgrading to digital signage which was easier to update.

Councillor Thorp noted the SDEC's clear intent to deliver improvements in terms of patient flow and outcomes, but queried how TRFT proposed to measure success.

The Managing Director, TRFT confirmed that the level of funding secured necessitated comprehensive monitoring and evaluation throughout. The premise was a different approach to delivering services in the face of increased demand and stagnant budgets, with the expectation that services operated more efficiently and in less overtly pressurised environments. In order to demonstrated that, the Trust were expected to implement checks and balances around take-up and outcomes, patient experience and staff satisfaction.

The Chief Operating Officer, TRFT added that the Trust had to be clear when they submitted the funding bid what improvements would be made across a number of metrics, with focus on the 4-hour emergency care standard. The SDEC bid was based on an out of hours fracture clinic pilot which garnered positive results. The SDEC bid was modelled on those principles.

Councillor Thorp queried the relatively small waiting area detailed on the SDEC plans and that whilst there was a proposed dedicated drop off zone

for the pre-op assessment centre relocated to the rear of the hospital estate, no indication was given that the needs of those arriving on public transport had been considered.

The Managing Director, TRFT reflected that testing out the proposals and the potential shortcomings was the purpose of the engagement activities that were undertaken, and added that TRFT were working through identified issues and concerns, such as the one highlighted by Councillor Thorp, to develop solutions.

The Chief Operating Officer, TRFT expressed the view that Councillor Thorp had raised a valid point which required further exploration. With respect to the waiting area the Trust had modelled the numbers of patients coming through against waiting times and factored in the expectation that patients would be seen more quickly and would not accumulate in the waiting area. Some patients were expected to stream into existing the existing UECC waiting area or Paediatric waiting area. The overarching intent was to have different waiting areas for different categories of patients based on evidence that reflected that helped patients understand their place within and reduced friction around differing waiting periods for different types of care or clinicians and physicians.

The Managing Director, TRFT noted that it was amazing that the team had worked so quickly to put the bid together, but emphasised that the proposals shared in the agenda pack were the best first attempt and there was the opportunity to be flexible with the space based on feedback received.

The Chair queried the reference made to making better use of existing resources. They wanted to know whether that meant there were no additional staff resources to support the SDEC, and if so whether that would adversely impact other hospital services.

The Chief Operating Officer, TRFT explained that all of the services that were being brought together under the SDEC umbrella were functional elsewhere within the hospital and the intention was to create space and capacity through co-location, collaboration and efficient pathways. Significant investment in staffing within the service areas that comprised the SDEC had already been made, such as the increased UECC workforce in terms of Doctors, Clinical Fellows, Nursing and Reception staff. Further recruitment was planned as needed.

Councillor Yasseen applauded the effort that went into securing the SDEC investment capital. They commented that it would have been helpful if the information provided in the agenda pack had provided some basic data concerning the drivers for the SDEC development such as the increased levels of attendance at the UECC, perhaps illustrating Rotherham's comparative position to other Accident and Emergency environments to allow the Commission to consider the impact over time.

The Managing Director, TRFT advised that the drivers of emergency care attendance were an extremely complex area, and one which had dominated conversations within and beyond the Trust. Increased attendance was the national trend within Accident and Emergency Departments and Rotherham was no exception to this. Some drivers were due to epidemiology, population health, co-morbidities and health inequalities, the latter of which were perhaps felt more acutely in Rotherham than in other areas. It was also noted that there was increased incidence of working age patients due to the perception that hospitals were a faster route to accessing care than primary care services.

The Chief Operating Officer, TRFT added that the Trust were engaged in collaborative work with Healthwatch Rotherham around understanding attendance behaviours. Growth was seen in both walk-in and ambulance attendance, and it was felt important to understand the finer detail. It was suggested that it may be appropriate to share those findings with the Health Select Commission once that work was complete.

Councillor Yasseen echoed Councillor Clarke's comments relating to parking at the hospital, and added that they didn't feel that the Trust always understood its role as part of a wider residential community, with a significant proportion of the impact of increased attendance around access and parking being borne by the hospital's residential neighbours, where permit boundaries were imposed sequentially when parking concerns were displaced from one location to another. They wanted to know how the Trust intended to respond to that element of their community responsibility.

The Managing Director, TRFT explained that the Trust understood the concerns around parking and accepted that it was a big issue and one that they were happy to work to resolve.

Councillor Bennett-Sylvester commented that, relevant to discussions around car parking, having attended the Badsley Moore Lane site recently, they were aware of a number of vacant or disused units and queried whether the possibility of relocating certain services there to alleviate pressures on the main hospital site had been considered.

The Managing Director, TRFT confirmed that this was discussed and outlined a Barnsley project that had successfully relocated a community diagnostics centre which reduced visits to the main hospital site by approximately 60,000 annually. They agreed that there was scope to consider alternate solutions to service accessibility and conversations were being taken forward regarding the overall estates strategy, particularly with respect to community delivery.

The Chief Operating Officer, TRFT added that the Trust had already moved quite a few services into the breathing space facility and accepted the benefits around parking and accessibility. The Trust were considering

further services that could be offered from that site, mainly diagnostic services, and were considering further funding bids to extend services at that location.

The Chair wanted to understand how the SDEC development aligned with the findings and recommendations in the Darzi report and whether investment in hospital-based delivery of NHS serviced best served the needs of Rotherham residents in the long term.

The Managing Director, TRFT confirmed that Same Day Emergency Care featured as an example within the Darzi report and in terms of improved outcomes, responsiveness to the population need, improved productivity and improved accessibility, the proposed SDEC was a great fit but acknowledged the targeted shift for the NHS as a whole from hospital into community services. They reflected that the response from the Commission in relation to the SDEC in terms of both the support and challenge was helpful, and clarified the emphasis the Trust had placed on accessibility and which had justified its location at the hospital in Rotherham's case due to service interdependencies and targeted pathways. The intention was that SDEC would augment facilities like the transfer of care hub, which was a multi-team co-ordination centre for Rotherham, comprised of social care, community care, primary care, and the ambulance service, enabling them to direct patients straight into SDEC pathways, avoiding the UECC.

They also explained that alongside the SDEC development, work was underway on a community services review in conjunction with partners which considered primary care, social care, mental health and voluntary sector service modelling and configuration, which they felt reflected that work in progress was not solely hospital centric.

The Assistant Director of Transformation, South Yorkshire ICB added that, linked to Councillor Bennett-Sylvester's previous question, considerations around what services should rather than could be delivered in what setting were important and necessitated a strategic approach which included all place partners. They acknowledged that whilst there was an opportunistic element to the SDEC funding bid, there was real commitment to that collaborative strategic direction setting to best serve Rotherham people.

The Chair queried how public engagement event which took place on 26 March 2025 was publicised, whether it was well attended and whether there were any clear emerging themes from feedback received.

The Chief Operating Officer, TRFT advised that early feedback was positive and provided opportunities to take further discussions forward. The Trust's Patient Engagement Team were involved in promoting the event, but more specific details were not known.

The Chair asked whether any other engagement activities were undertaken or planned with stakeholders.

The Chief Operating Officer, TRFT confirmed that the Trust had engaged with all staff groups involved in the SDEC development and involved them in developing the plans and defining service requirements. Staff and Patient governors were consulted as were unions.

The Chair thanked officers for their responses to comments and questions.

Resolved:-

That the Health Select Commission:

1. Noted that the investment secured by TRFT to address patient flow and capacity challenges through the development of the SDEC (Same Day Emergency Care) and the UECC (Urgent and Emergency Care Centre) expansion at Rotherham Hospital was welcomed.

2. Requested that members be provided with an overview of feedback received via the public event that took place on 26th March 2025, and any other consultation activities undertaken relating to the SDEC development/UECC expansion.

3. Requested a further update be provided regarding the SDEC development/UECC expansion at an appropriate stage during the next municipal year, to give members the opportunity to consider its impact for Rotherham residents post implementation. The appropriate update method would be confirmed at a later stage.

4. Requested that TRFT provide an update regarding the collaborative work with Healthwatch Rotherham regarding attendance behaviours. The appropriate update method would be confirmed at a later stage.

55. 18 WEEK WAITING TIME CHALLENGE

The Chair invited Bob Kirton, Managing Director, TRFT and Sally Kilgariff, Chief Operating Officer, TRFT to introduce the presentation.

The Managing Director, TRFT explained the purpose of the presentation was to illustrate planned care waiting times. They wanted to emphasise that the Trust recognised the personal impact on individuals on waiting lists, and acknowledged that whilst the presentation contained a lot of numbers, they remained focussed on recognising that each number represented an impacted individual, and that each individual impact was felt more widely through family members, colleagues, employers and so on.

They described the data provided within the presentation as an overview of the operational context of referrals into TRFT, but added that every aspect of planned services delivered were measured.

The Managing Director, TRFT felt that it was important for Councillors to note that there had been significant increases in waiting lists post pandemic, which was a national issue. In addition, the impact of industrial action in 2024 had impeded ability to reduce waiting lists.

Their intention was to provide an overview of the current waiting list, an overview of current performance in relation to the referral to treatment standard (RTT), which was the national 18 week standard, but also the diagnostics six week standard. The national ask of the NHS at the time of the meeting was not to have anyone waiting over 65 weeks for treatment, and an updated on TRFT's position in relation to that would be outlined, alongside details of initiatives planned to improve quality and delivery of patient care.

With respect to elective and diagnostic referrals, the key point to note was the volume of referrals to the Trust, which for 2025 was approximately 9 ,000 a month in the year to date. That was higher than 2024 and significantly higher than prior years. The same level of increase was seen in diagnostic referrals as well, all of which exerted pressure on the service.

From an improvement initiative perspective in respect of referrals, the teams were digitally working clinical triage at the point of referral. Where specialist advice could be provided this was done, and the Trust linked up with primary care and others to provide that advice and support. This was intended to ensure that TRFT was also optimising outpatient clinical clinic capacity. A comprehensive review was also underway to ensure processes aligned with the Trust access policy, and national policy to ensure that high quality care was delivered to the patients who needed it most. Things were increasingly evening out since the pandemic, but during that period there was the need to prioritise patients based on clinical need.

There was a range of public health initiatives that were integrated to improve demand management and patient outcomes. GPs held frustrations with certain pathways such as orthopaedics, where ongoing opiate prescriptions were required for pain management whilst awaiting treatment. The 'Waiting Well' initiative was one of the mechanisms intended to address those frustrations, which considered the offer to those awaiting treatment.

In terms of the size of the wait list, Councillors would note from the presentation that this had reached a peak in excess of 33,000 people waiting, which was notably higher than pre Covid waiting list sizes. This was borne of a rising amount of elective care in conjunction with some of

the socioeconomic challenges experienced across Rotherham which impacted TRFT's ability to manage demand and there was also complexity of patient need which had driven delays in delivering treatment.

The Managing Director, TRFT described the overwhelming sense, from discussion with frontline staff, of financial challenges compounded by demand challenges in both urgent and planned care pathways but that the experiences of practitioners in other discipline and sectors such as social care, mental health and the voluntary and community sector were all identifying the same themes; people needed more. They felt that in the face of the pressures described, a 'one size fits all' approach was no longer feasible and the Trust needed to be more flexible around what they did and how they did it.

This was the driver for implementing improvement initiatives which provided additional capacity for outpatients, diagnostics and elective surgeries in order to reduce the waiting list, and as the data in the pack reflected, the Trust had had some success with that. There was also an ongoing external review that considered waiting list data quality, to improve accuracy and progress pathways. New care models including 'Super Clinics' and 'High Impact Theatre Lists' were implemented to maximise capacity, and collaborative work had been undertaken in conjunction with others to address Rotherham's public health challenges aimed to optimise health prior to treatment.

In terms of performance against the standard, which was the main way that TRFT were measured, this had improved from 60% in April 2024 to just below 64% in February 2025. Whilst the trust remained focussed on the offer to Rotherham patients, comparatively that positioned TRFT 30th nationally which was top quartile.

At the time of the meeting, the national ask was to have no patients waiting over 65 weeks. TRFT had worked diligently in 2024 to reduce the number of patients waiting over 65 weeks, and had consistently maintained this in low single figures since Autumn 2024. Those low single figure cases were driven by individual personal reasons for delaying treatment, and not by the inability to deliver on TRFT's part.

Whilst it was recognised that the Trust was having a lot of success around reductions on medical pathways, it was acknowledged that surgical was a pinch-point, particularly with respect to theatre time and access to anaesthetists. As such, orthopaedics, gynaecology and oral maxillofacial surgery remained the biggest challenges.

The Managing Director, TRFT explained there were two orthopaedic patients who had been waiting more than 65 weeks, however, the expectation was that there would not be anyone in that category by the end of March 2025.

In those greatest remaining areas of challenge, the Trust had undertaken performance meetings with the clinical and operational teams and confirmed that there were effective plans in place to address issues, which noted that continual improvement was evident. The Managing Director, TRFT commented that whilst the position in those areas was not where they wanted to be, the situation was moving forward positively.

In terms of diagnostics, the Managing Director, TRFT remarked that what Rotherham had achieved was remarkable, being ranked second nationally against the 6-week diagnostic standard. In practice, this meant that less than 1% of people were waiting more than six weeks for diagnostics including imaging, cardiology, endoscopy, audiology and urodynamics amongst others. As such, this was consistent delivery across a range of services, which reflected the wider organisational mindset achieved and the pervasive desire to get it right for the public. It was noted that positive performance in this area benefitted physicians and surgeons, and enable them to develop appropriate courses of treatment, whereas poor performance in this area could adversely impact that planning and patient outcomes in turn.

The Chief Operating Officer, TRFT discussed some of the improvement initiatives implemented to address the waiting time challenge. They explained that there was an elective delivery programme which focussed on pathways in the four specialities that represented particular challenges around wait times, trauma and orthopaedics, ear, nose and throat, oral and maxillofacial surgery, and gynaecology, alongside theatre and anaesthetics and endoscopy.

This work involved optimising administrative processes to deliver efficient and effective scheduling, maximise clinic utilisation and reduce follow-up in line with the nationally advocated patient initiated follow up (PIFU) initiative and maximise utilisation of community pathways. A significant aspect of the delivery programme concerned theatre and anaesthetics. This sought to maximise utilisation of theatre capacity, ensure effective pre-assessment and involved the introduction of a locally generated new theatre scheduling tool and a review of theatre workforce needs to ensure staffing capacity aligned with operational requirements. The third element of the programme was endoscopy, which also aimed to deliver efficiency whilst maintaining quality of care, focussing on productivity and resource utilisation, which included reconfiguration work involving estates and infrastructure to improve patient flow.

The Chief Operating Officer, TRFT described the Further Faster 20 transformation programme implemented in 20 Trust nationally in areas where there were high waiting lists coupled with economic inactivity in local populations, which Rotherham was part of. Through that programme the Trust were able to access national support through the ‘Getting It Right First Time’ (GIRFT), via which national clinical experts worked with TRFT in support of that elective delivery programme,

positively augmenting work already undertaken and facilitating change at pace.

They added that additional activity had also been undertaken to address waiting times. This had involved running additional clinics through a mixture of insourcing internally and outsourcing to private sector organisations.

The Managing Director, TRFT cautioned that whilst there was dedication to improvement and a commitment to innovation and partnership working, they held reservations regarding the funding settlement for the coming year and what it was feasible to deliver within the constraints that applied. They confirmed TRFT's desire was to work at faster pace than reflected nationally, and suggested that the data presented indicated the dedication to positive performance improvement within the organisation.

The Chair thanked the Managing Director, TRFT and the Chief Operating Officer, TRFT for the presentation and invited questions or comments.

Councillor Thorp wanted to address the increasing trend in respect of elective and diagnostic referrals and the reference to insourcing and outsourcing. Whilst outsourcing was perhaps understandable as a concept at face value, they wanted to understand what was meant by insourcing in practical terms, whether these initiatives increased outpatient clinic capacity and whether either or both approaches were financially sustainable in the longer terms and represented options which priorities patient safety and experience. Councillor Thorp cited personal experience of NHS care being outsourced which had caused difficulties when additional support from NHS services was subsequently required.

The Managing Director, TRFT advised that insourcing was bringing teams onto site to work outside of normal operating hours, or in the absence of appropriate medical cover. The Chief Operating Officer, TRFT added that both approaches enabled the effective use of resources to increase clinic capacity, using existing staff, estates and infrastructure so far as possible, but acknowledged that there was a balance to be struck with respect to staff health and wellbeing and that this represented a challenge.

In terms of patient experience and safety, the Trust was working closely with staff to ensure broad understanding of the different ways in which NHS services were delivered including insourced and outsourced care and treatment options, and recognised that this was a change for many. It was acknowledged that there may be misconceptions amongst some NHS staff that independent providers didn't do 'the full job' and culturally there remained work to do address that.

Councillor Havard referred to page 30 of the agenda pack around new models of care, the 'Super Clinics' and the 'High Impact Theatre Lists' being trialled. They wanted to know what these new care models were in practice, how they were expected to assist in reducing waiting list sizes

and if there were any risks associated with trialling and adopting those models in terms of patient safety?

The Chief Operating Officer, TRFT explained that there were different models in place at different parts of the pathway. One aspect was an increased offer of advice and guidance to GPs to avoid unnecessary clinic referrals which involved waits for affected patients, instead increasing GP led treatment programmes. Another aspect was around the PIFU initiative, utilising virtual and telephone follow up model as appropriate, with due regard given to clinical need applying standard operating procedures and criteria to ensure those patients that need to be seen in person receive the appropriate follow up.

Part of the learning adopted through the Further Faster 20 team's national evidence related to the 'Super Clinics' and High Intensity Theatre Lists'. This was where lots of the same procedure were undertaken, usually at the weekend, where additional support was brought in to facilitate delivery as this had proved successful in other areas. This was at an early stage of development within the Trust. The practical example of cataract procedures and how these types of approach could positively impact on waiting lists was provided.

Councillor Havard wanted to understand whether the outsourcing referred to included where patients were sent to other NHS hospitals for treatment.

The Managing Director, TRFT explained that whilst there were lots of services which could be delivered locally, certain services such as paediatric orthopaedics, revisions, spinal work etc. were only undertaken via the teaching hospitals or specialist children's hospitals. The outsourcing referred to typically related to independent providers for adults. The Trust did receive mutual aid, all of which is beneficial to the waiting list because it allows patients to be seen more quickly, alongside mutual aid between NHS sites for diagnostics or elective, however given TRFT's favourable position, they were more likely to be the provider of mutual aid than the recipient.

Councillor Clarke queried the integration of public health initiatives referred to on page 29 of the agenda pack. They specifically related that to the cancer pathway in terms of the initiative to ensure patients were fit for operations and cited personal experience of the fantastic facility at Attercliffe. They wanted to understand whether those types of service were to be delivered more locally given that some Rotherham residents may not have family members able to take them to facilities further afield and the nature or treatments and surgeries may make the use of public transport inappropriate or increase risks to patients.

The Chief Operating Officer, TRFT explained that the Trust worked in partnership with Yorkshire Cancer Alliance who had piloted fitness for treatment/surgery in parts of South Yorkshire which had seen the offer in Rotherham expanded. They outlined that the difficulty was whether that

could be extended to non-cancer pathways and delivered at scale, however they were aware that the Trust was running services at the Badsley Moore Lane site rehabilitation centre as part of the Active Together programme.

Councillor Clarke asked whether data was gathered relating to patients who had participated in that programme, and the level of success achieved.

The Chief Operating Officer, TRFT confirmed that data collection and analysis was part of the process, given that this was a pilot programme and therefore was closely monitored in terms of impact.

The Managing Director, TRFT added that there was more work to do in that area, but noted that since they had taken up the role at TRFT, they were pleasantly surprised by the amount of work underway in Rotherham. They had attended the Badsley Moore Road Breathing Space site and observes a large number of participants utilising the hydrotherapy pool, gyms and taking classes which was incredibly positive.

Councillor Tarmey reflected on the financial pressures NHS Trusts were subjected to across the country, and noted that some had implemented recruitment freezes or had taken the decision not to replace staff members on retirement. They queried whether TRFT were considering something similar and what impact that could have on waiting times if it were necessary.

The Managing Director, TRFT advised that there was significant external scrutiny around finance and financial controls which had resulted in enhanced control mechanisms with a predominant focus on reducing agency spend across different staff groups and delivering a permanent workforce capable of meeting delivery needs.

It was acknowledged that some bank and agency spending would remain, and it was clarified that vacancies in clinical areas were being filled. They advised that the Trusts approach was to consider how things could be done differently and more efficiently, such as the role of Advanced Clinical Practitioners within specific teams, improved collaborative and partnership working with any staff reductions drawn from non-clinical areas and governed by quality assessment processes.

Councillor Yasseen noted that the Trust's position with respect to the 6-week diagnostic standard was excellent and reflected the dedication of staff within those teams. They queried whether the learning from that success could be utilised in other areas where less progress had been made.

The Chief Operating Officer, TRFT commented that focussed support had played a critical role in that achievement, which had led to a strong grasp of what drove positive performance in relation to diagnostics at all levels

of delivery and ultimately reduced waiting times. They advised that the Trust were applying the same principles across other pathways, but in the case of diagnostics, that was an area where they could focus on a number of pathways intensely.

Over the last few months, with the support of the national team, focus had shifted to those specialties that represented challenges, with deep dives and intense focus on capacity and plans, using those same principles. Councillor Yasseen wanted to focus on 65 week waits, and commented that a year and four months was a substantial period of time. They acknowledged that there had been improvement in the Trust's position, but held concerns for patients who faced significant waits or extended economic inactivity through no fault of their own who were reliant on welfare and could be adversely affected by welfare reforms. They queried whether the Trust were considering those impacts when making clinical and scheduling decisions against those on waiting lists to reduce the overall taxpayer burden.

The Chief Operating Officer, TRFT referred to the intention behind the Further Faster 20 programme which was to look at areas within high waiting lists. Work had been done to analyse data against the working age population and affected specialities, although that specific data was not included in the presentation within the agenda pack. The theatre scheduling tool developed in conjunction with prioritisation of working age cases was to be trialled, and whilst early days, this was expected to address the concerns raised. They added that there was also a broader focus on prioritisation with respect to health inequalities, and that whilst the primary focus was reducing the overall waiting list, the Trust were layering on those additional factors in an appropriate manner.

The Managing Director, TRFT added that there were a number of national initiatives relating to health and work, and that South Yorkshire was one of the trailblazers looking at issues such as health and growth accelerators. They commented that whilst there were approximately 10 million people of working age considered economically inactive nationwide, Rotherham was in a strong position in terms of initiatives to address economic inactivity such as Skills Street. However, they acknowledged that it would be nice to arrive at a position where barriers to economic activity presented by the type or speed of health service required by an individual factored into decision making as this was based on clinical priority at present. They postulated that whilst the conversation was in relation to waiting lists in this particular case, arguably there was the need to become more sophisticated in relation to long-term conditions which required ongoing treatment and management also, such as mental health, musculoskeletal and respiratory/cardiological issues to deliver more responsive to the needs of the working age population, working in partnership with the Council, employers and other stakeholders.

Councillor Bennett-Sylvester queried the extent to which industrial action over the last 12 months and other exceptional circumstances such as

Covid had impacted upon the current waiting time position. They explained that they understood that Rotherham had not been significantly adversely affected by industrial action, but wanted to understand whether the Trust's comparative positive position had resulted in patients electing to receive care at Rotherham, and driven waiting list growth during that period.

The Chief Operating Officer, TRFT explained that the main impact of industrial action at TRFT was having to stand down some elective care work to support emergency care. Different trusts were affected in different ways but one of the challenges was understanding who was taking industrial action. The Trust tried to minimise that wherever possible, but it did see some impact. It was believed that patients did not transfer elsewhere, and remained on existing pathways. This was not something the Trust tracked and may not be possible to review retrospectively, but was certainly not something TRFT had seen or had any anecdotal evidence of.

Councillor Bennett-Sylvester referred to the referral to treatment standard set out on page 31 of the agenda pack. They were interested to know whether there was any temptation to chase easy fixes to drive waiting lists down, and sought reassurance that there was no data driven directive to pick off the 'low hanging fruit'.

The Managing Director, TRFT clarified that the Trust had taken the opposite approach. Nationally the focus had been on eradicating 78 week waits, then 65, then 52 and so on. At TRFT, focus on the 18-week standard was never lost through strict clinical prioritisation and robust governance practice.

The Chief Operating Officer, TRFT added that when trying to drive down waiting times, the Trust considered every service and every speciality in line with the approach the Managing Director outlined. Over the coming months the intention was to further reduce outpatient waits.

Councillor Havard suggested that it would be helpful if the data provided could be broken down further to identify the affected services and specialities, allowing the Commission to consider any areas they might want to review in more detail.

The Managing Director, TRFT advised that the Trust held sufficient data detail that hundreds of pages of data could have been presented to the commission, but it was felt best to focus on the key headlines, identifying key areas of concern in the commentary accompanying the graphs and data points. The key concerns were orthopaedics, gynaecology and oral and maxillofacial surgery where it was acknowledged there were a lot of challenges, but equally a lot of ongoing work with commissioners, place partners and rigorous governance processes ensuring that focus was maintained on driving forward improvements in those areas.

Councillor Havard had become aware of concerns around the funding allocation for Rotherham Hospice and wanted to understand from the Assistant Director of Transformation, South Yorkshire ICB whether any progress had been made in this area.

The Assistant Director of Transformation, South Yorkshire ICB advised that the ICB was in a very challenging financial position locally, with uncertainty around certain budget allocations. That said, there was an absolute commitment to ensure that partners knew funding arrangements and had the ability to ensure service continuity as soon as possible. The ICB were working really closely with hospice colleagues and they were confident that that position would be resolved as soon as possible.

Councillor Thorp echoed Councillor Havard's request for a more detailed breakdown of the data by service/speciality.

The Chief Operating Officer, TRFT advised that there had been discussions around the level of data to submit to the Commission, and it was acknowledged that on this occasion it may not have been pitched at quite the right level. Some of the data requested may have been included in the TRFT board public meeting pack, so may be accessible from there, but otherwise would need to be provided separately. The Trust's next target was to reduce the longest waits to 52 weeks, where almost all waits sat within 5 specialities; orthopaedics, gynaecology, oral and maxillofacial surgery, urology and general surgery and more detailed data on those areas could be shared with the Commission.

Councillor Bennett-Sylvester asked whether the impact of socio-economic factors would be considered within the external review of data quality, and able to influence and improve access to advice and guidance for patients already on a pathway.

The Chief Operating Officer, TRFT clarified that the external review was intended to eradicate duplicate entries, ensure waiting times were correctly reflected etc. However, there was work being conducted by the Public Health Consultant jointly appointed by the Trust and the Council in terms of understanding where there were differences from a health inequalities and deprived communities' perspective. This included reviewing waiting lists to ensure that patients weren't facing disproportionate waits, considering the drivers of non-attendance within certain populations and demographics and implementing initiatives to address any barriers identified. There was also early pilot work being conducted around the use of AI to identify patients at increased risk of failing to attend and provide reminders, or other appropriate means of support attendance.

The Chair remarked that whilst all Commission members would agree that the reduction in patients waiting over 65 weeks was encouraging, but wanted to understand whether there was a clear plan and a target

timescale for reducing this consistently over time to an agreed national standard or indeed an internal target, and if so what was that target and timescale and when did TRFT realistically expect to achieve that.

The Managing Director, TRFT advised that the national ask for this year was to have no one waiting over 65 weeks, so TRFT were already delivering on that. However, they wanted to do more and appreciated that the people of Rotherham would want more. They explained that the Trust was working with NHS England amongst others who were surprised that they were still discussing the Referral to Treatment 18 week standard, as many other Trusts were solely focussed on the 65 week ask. The next specific target for the Trust was to achieve no one waiting over 52 weeks, which was particularly relevant to the 5 specialities the Chief Operating Officer referred to. The longer-term goal was to work towards the national constitutional standard which was what people would expect and what the Trust wanted to deliver. The specific timescales associated with that were not yet known, due to reliance on ongoing work with commissioners relating to the 2025/2026 plan. There was no targeted trajectory agreed with the Trust Board aside from the general intent to continually reduce the waiting time, however once there was certainty around the financial plan, the Trust would be in a position to set out a more detailed response in terms of the targeted trajectory, ideally broken down by service as it was anticipated that this would vary by service. The performance seen in diagnostics was cited as the performance the Trust aspired to across the board.

The Chief Operating Officer, TRFT added that the national ask in terms of diagnostics was to deliver 5% of patients waiting no more than 6 weeks by March 2026, and as TRFT were already delivering under 1% they were significantly ahead of target on that. Within the year, TRFT had delivered a 3.5% improvement on the referral to treatment standard, against which the target was 65% or a 5% improvement, with the Trust already having achieved 63.

The Chair thanked the Managing Director and Chief Operating Officer for the presentation and their thorough and considered responses to members' questions.

Resolved:-

That the Health Select Commission:

1. Noted the exceptional performance in relation to the diagnostic 6 week standard, and requested that TRFT consider what had driven the level of success in order to replicate it reliably and consistently in other areas.

2. Requested an update on progress towards achieving the targeted waiting times at relevant intervals based on the achievement timeline

to be confirmed following certainty regarding the financial plan. The appropriate update method would be confirmed at a later stage.

3. Requested that data provided in future in respect of waiting times be broken down by service/speciality, so that Councillors can consider any potential areas of concern they may wish to explore further.

56. HEALTH SELECT COMMISSION WORK PROGRAMME - 2024/2025

Resolved:-

That the Health Select Commission:

1. Approved the work programme.

2. Agreed that the Governance Advisor was authorised to make any required changes to the work programme in consultation with the Chair/Vice Chair and report any such changes back to the next meeting.

57. SOUTH YORKSHIRE, DERBYSHIRE AND NOTTINGHAMSHIRE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Members were advised that the JHOSC meeting scheduled for 12 March 2025 was cancelled. The meeting dates for the next municipal year were to be confirmed. Relevant updates and copies of minutes would be shared following each meeting held.

58. URGENT BUSINESS

There was no urgent business to discuss. However, the Chair reminded members that Quality Accounts were expected imminently and requested that any members interested in reviewing and responding to Quality Accounts that had not already made themselves known to the Governance Advisor do so at the earliest opportunity to ensure their inclusion in meeting arrangements.

Rotherham Metropolitan Borough Council

Public Report
Health Select Commission

Committee Name and Date of Committee Meeting
Health Select Commission – 01 May 2025

Report Title
Mental Health Service Review Update

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

Strategic Director Approving Submission of the Report
Ian Spicer, Strategic Director of Adult Care, Housing and Public Health

Report Author(s)
Andrew Wells Head of Service – Safeguarding and Mental Health
Andrew.wells@rotherham.gov.uk

Ward(s) Affected
Borough-Wide

Report Summary
This report provides an update on the Adult Social Care Mental Health review which was implemented in April 2024. The report details the impact and outcomes since implementation.

Recommendations
It is recommended that the Health Select Commission note the:

1. Impact of the Adult Social Care Mental Health model of provision since it was implemented in April 2024.

2. And the planned development of a co-designed Council Mental Health Strategy which will be presented to Cabinet for approval in December 2025.

List of Appendices Included

Appendix 1 Adult Social Care Mental Health Review - Report to Cabinet (December 2023)
Appendix 2 Mental Health Service Review - Report to Cabinet (February 2023)

Background Papers
Care Quality Commission (CQC) Assessment Framework for Local Authorities

Consideration by any other Council Committee, Scrutiny or Advisory Panel
None

Council Approval Required
No

Exempt from the Press and Public
No

Mental Health Service Review

1. Background

1.1 In December 2023, Cabinet approved the implementation of a new Adult Social Care Mental Health model for Rotherham which included:

- Implementation of a revised Mental Health Pathway.
- Realignment of Council employed staff to deliver social care roles and responsibilities.
- Alignment of Approved Mental Health Professionals (AMHPs) under Council management and co-location with the Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH) Crisis Team at Woodlands.
- Provision of a collaborative approach to crisis alongside RDaSH.
- A commitment to strengthen effective partnerships, working to align the revised mental health pathway with RDaSH and Community Mental Health Transformation.

1.2 The report acknowledged that a joint approach between health and social care delivered the most personalised offer for residents. The model was therefore designed around a collaborative delivery of both clinical and social care needs, in partnership with RDaSH and the South Yorkshire Integrated Care Board (SYICB).

Benefits

1.3 The revised model was intended to realise the following benefits:

- Provide a collaborative, preventative approach to ensure people get the right support
- Raise the social care profile and solidify the social care contribution to the mental health pathway
- Provide an effective, holistic and equitable response for people with mental ill-health
- Strengthen the recovery model by providing preventative, proportionate social care interventions
- Ensure that across the pathway, social care staff work to the legislative and statutory duties, enabling the Council to better evidence social care interventions
- Prepare the Council for formal regulation of Adult Social Care by the Care Quality Commission
- Support Rotherham Place to achieve its priority to collectively strengthen the mental health crisis pathway

2. Update

2.1 The revised pathway was implemented in April 2024 following a partnership approach with the Council, SYICB, RDaSH, Primary Care and Urgent Care. Initial impact analysis has identified no impact to partners whilst achieving positive impacts for residents through a more appropriate approach focussed on enablement and recovery.

2.2 As part of the pathway, Adult Social Care embedded a consolidated, enhanced front door. This has provided an all-inclusive point of contact, ensuring a simpler and consistent approach and experience for people.

2.3 The support provided focuses on a preventative and early intervention approach and builds upon preventative and enabling offer and supports independence and resilience, providing people with personalised support options. The enhanced front door also refers people with identified unmet social care needs into the mental health enablement offer.

2.4 A new Mental Health Enablement Pathway operates from a variety of community and health venues namely:

- Wellgate Court
- Dinnington Old Library
- Swallownest Court
- Ferham Clinic

2.5 Activity in the community and enablement pathways was summarised at the mid-point review held in June 2024:

- 178 referrals into the 12 – 15-week enablement pathway and the team provided 55 packages of personalised support.
- 5 peer support groups within different community settings were providing support for up to an hour and on average the service supported 7 people per session.
- 2 dedicated sessions are held at Wellgate Court every week (Wednesday and Friday) and supports on average 8 people per session.
- 65 people were screened either not appropriate or declined the enablement offer.
- The 55 people and 16 carers who historically had support from the service remain and continue to be supported.

2.6 The Mental Health Enablement Team have developed a feedback leaflet and have captured feedback from people using the new enablement pathway. People who the service have told us:

”without this service, I wouldn’t be here, it has saved my life”

“ we want you to know what great support we have had, LC has helped us to sort out our bills and helped to make our home, our home again”

“CB is the only person to ever really support us, he has helped with our housing application and practically in our home”

“I am really happy with the support I have had, I haven’t felt judged”

“KL has been such an amazing support for me, in the weeks we’ve done so far I have gotten more sorted than in the year previous and things had just begun to pile up. She is always bright and chirpy, level headed in a panic, extremely empathetic and we get on really well which is rare for me. An amazing service that I can’t thank enough as it has really had a massive impact on my daily life and my mental health”

“More support from MB and JG in the last few weeks than I have had over the last few years from others”

"I feel the plan is going well and that I would like to continue focusing and working towards the same goals, as I has already made steps towards progress, the support is working well and is positive, and she also listens on the phone and doesn't rush me”

“I wouldn’t have been able to do the things I’ve achieved without this support”

“I couldn’t have sorted some of my problems out without this help”…

“LC has done a fantastic job, and has literally changed our lives, we were overwhelmed we now have the house and our health back, thank you”

Adult social care will continue to seek feedback from people who draw on our services to evidence the positive impact and outcomes to residents’ lives.

2.7 The Council and RDaSH had agreed that the AMHP (social care response) and Crisis Team (Health response) would be co-located and is now delivered from Woodlands. The rationale was to ensure a robust partnership approach to crisis intervention, utilising both health and social care expertise and to have a dual response if required.

2.8 Due to the co-location, the Council and RDaSH have a robust offer and can undertake urgent partnership visits if required. This negates having two separate approaches, and potentially two visits to the person in crisis and can quickly ascertain how to support each person or situation effectively, and who has what responsibility and legal duty. This in turn supports the right support at the right time for the person in crisis.

2.9 As part of the AMHPs coming under the direct management of the Council, the Council can now provide holistic social care interventions as part of the crisis pathway, and this can be evidenced via the social care case management system. The Council has for the first time in over 15 years,

direct access to information and data on activity and performance and can benchmark against other Councils.

2.10 A Mental Health Partnership Crisis Specification was also developed with support of the SYICB to complement the review and provide clarity on roles and responsibilities across the partnership.

2.11 All Council employed staff including AMPHs and Support Workers are now under the line management of the Council. This means that staff are receiving appropriate support and supervision with a focus on their wellbeing, to ensure compliance with our duties as an employer.

2.12 In addition, the Council have developed a dedicated training programme for the AMHP staff to ensure that they continue to meet their Continued Professional Development (CPD). Furthermore, we have developed a continuity plan to ensure that Social Workers who join the mental health team in Rotherham can go onto train as an AMHP, thereby ensuring succession planning to meet the Councils statutory duties and have the appropriate numbers of qualified AMHPs required to meet the remit of the Mental Health Act 1983.

Conclusion

2.13 The overall impact of the revised pathway has been the development of a prevention and early intervention approach, meaning that people get the right support at the right time, this includes a social care intervention, crisis intervention, Mental Health Act assessment, a health intervention or a combination of both health and social care or signposting to the most appropriate support or service.

2.14 In addition, roles and responsibilities in mental health services are clear and understood across the partnership through the development of the Crisis Specification led by SYICB and supported and signed off by each agency.

As a result of the review, the following benefits and impacts for Rotherham residents have been achieved:

- Enhanced partnership working across Rotherham within mental health services.
- Clarity on roles and responsibilities of each partner agency, and each partner understands each other's contribution to the new pathway.
- Development of a partnership Mental Health Crisis Specification.
- A co-located Mental Health Crisis offer.
- Dedicated Health and Social Care offer, or combination of the two if required to support a personalised approach.
- Enablement pathway to realise a preventative offer, preventing people coming into the service who do not need to and providing alternatives.

- Enhanced personalised community offer for both people experiencing mental ill health and unpaid carers.
- Development of peer support groups
- Readily available data and performance on crisis activity
- Succession planning for the AMHPs
- Social care evidence to meet the requirements of the CQC assurance of local authorities.

2.15 Planning for delivery of a co-designed Mental Health Strategy for the Council has commenced and it is anticipated that the strategy will provide the framework for future evolution of our mental health pathway. The strategy will be presented to Cabinet in December 2025 for consideration and approval.

3. Options considered and recommended proposal

3.1 Health Select Commission note the outcomes and impact of implementing the new Adult Social Care Mental Health model.

3.2 Health Select Commission offer any further recommendations or insights.

4. Consultation on Proposal

4.1 Not applicable

5. Timetable and Accountability for Implementing this Decision

5.1 The proposal to implement a new Adult Social Care Mental Health model was approved by Cabinet in December 2023 and formally implemented in April 2024.

6. Financial and Procurement Advice and Implications

6.1 There are no financial or procurement implications associated with this report.

7. Legal Advice and Implications

7.1 There are no legal implications associated with this report.

8. Human Resources Advice and Implications

8.1 There are no HR implications associated with this report.

9. Implications for Children and Young People and Vulnerable Adults

9.1 The implementation of the new Mental Health pathway ensures that all young people in crisis or preparing for adulthood can:

- Grow up prepared for the future.
- Have improved health and wellbeing.
- Are able to exercise control over the support they receive.
- Are able to receive support locally from a range of services that everyone values.
- Have an opportunity to have their own 'front door'.
- Can access the right support in the right place, based on where the young person lives.

10. Equalities and Human Rights Advice and Implications

10.1 The proposals in this report support the Council to comply with legal obligations encompassed in the:

- Human Rights Act (1998), to treat everyone equally with fairness dignity and respect with a focus on those who are disadvantaged as a result of disability and Page 12 of 13
- Equality Act (2010) to legally protect people from discrimination in the wider society

11. Implications for CO2 Emissions and Climate Change

11.1 There are no direct CO_2 Emissions and Climate Change implications associated with this report

12. Implications for Partners

12.1 All relevant partners and key stakeholders including RDaSH and the SYICB were engaged in developing the new model for Mental Health and are actively engaged through the Rotherham Mental Health and Learning Disability Transformation Board.

13. Risks and Mitigation

13.1 There were risks associated with the previous mental health model in operation to ensure a robust social care identity, a pathway which provided support to people at the right time and was focussed on enablement and recovery. The new model has addressed these associated risks.

14. Accountable Officers

Ian Spicer, Strategic Director of Adult Care, Housing and Public Health ian.spicer@rotherham.gov.uk

Approvals obtained on behalf of Statutory Officers:

	Named Officer	Date

Chief Executive		Click here to enter a date.
Strategic Director of Finance & Customer Services (S.151 Officer)	Choose an item.	Click here to enter a date.
Assistant Director, Legal Services (Monitoring Officer)	Choose an item.	Click here to enter a date.

Report Author(s): Andrew Wells Head of Service – Safeguarding and Mental Health
Andrew.wells@rotherham.gov.ukk
This report is published on the Council's website.

This page is intentionally left blank

Appendix 1

Rotherham Metropolitan Borough Council

Public Report
Cabinet

Committee Name and Date of Committee Meeting
Cabinet – 18 December 2023

Report Title
Adult Social Care Mental Health Review

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

Strategic Director Approving Submission of the Report
Ian Spicer, Strategic Director of Adult Care, Housing and Public Health

Report Author(s)
Claire Green, Programme Manager Claire.green@rotherham.gov.uk

Andrew Wells, Head of Safeguarding and Mental Health Services
Andrew.wells@rotherham.gov.uk

Ward(s) Affected
Borough-Wide

Report Summary
Following approval by Cabinet in February 2023 to commence a review of the Council's Adult Social Care Mental Health model, this report summarises the review findings and outcome of the consultation. The report proposes a new model for the Council's Adult Social Care mental health provision across the Borough, built on the principles of enablement and recovery, that will be delivered through a collaborative approach with partners.

Recommendations

That Cabinet:

1. Note the proposals for a new Adult Social Care mental health model of provision for the Borough.

2. Approve the development of a co-designed Council Mental Health Strategy for Rotherham, with the strategy being presented back to Cabinet for approval in 2025, prior to publication.

List of Appendices Included

Appendix 1: Consultation Report
Appendix 2: Part A - Equality Analysis screening
Appendix 3: Part B - Equality Analysis Form
Appendix 4: Carbon Impact Assessment

Background Papers
Mental Health Review Cabinet Paper, 13 February 2023

Consideration by any other Council Committee, Scrutiny or Advisory Panel
None

Council Approval Required
No

Exempt from the Press and Public
No

Adult Social Care Mental Health Review

1. Background

1.1 In February 2023, Cabinet approved a recommendation to review the Council's Adult Social Care Mental Health model which included a period of consultation with people with lived experience, their families, and carers.

1.2 The review was proposed following completion of a scoping exercise of the Council's Mental Health Service in 2020. However, due to the impact of the pandemic on Adult Social Care, the recommendations to review the existing mental health service model were temporarily put on hold.

1.3 The scoping exercise acknowledged that social care staff, including Approved Mental Health Professionals (AMHP) and Support Workers integrated into Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH) were completing health-focused co-ordination functions within a model of generic working. Operating clinical rather than social care activities has led to a loss of their social care identity and has limited social care interventions.

1.4 The proposals outlined in this report intend to enhance the benefits of continued joint working between health and social care whilst defining and developing the social care offer to best effect. Research and evidence support that such approaches provide the best opportunities for personalised support to maximise recovery and independence. A recent policy paper published by the Department of Health and Social Care in 2022 focussed on shared outcomes through partner collaboration and set out how person-centred care should be central to reform. These proposals build on this policy approach to ensure person-centred practices within our mental health provision for the borough.

2. Key Issues

2.1 Social work has a crucial role in improving mental health services and outcomes for people, supporting where biological, psychological, social and environment determinants meet. The College of Social Work notes that the social work contribution to mental health pathways can relieve people's suffering, ensure social justice, and improve the lives of individuals and their communities. These proposals aim to maximise the social work impact.

2.2 It is critical to ensure that the distinct social and rights-based perspective that social work offers, supports the health and care system by humanising and personalising mental health services, empowering people, and countering institutional and clinical approaches. The ethos to intervene proportionately prevents discrimination, promotes equality, and protects vulnerable people from harm. Along with specialist knowledge, advanced relationship-based skills and a focus on personalisation and recovery, this can support people to make positive, self-directed change.

2.3 The proposals in this report enhance the delivery of the statutory role and function of social workers under the Care Act 2014 and AMHPs, through the Mental Health Act 1983, to deliver client-focused preventative and crisis-based services to individuals and families in need of support.

2.4 Working with other relevant local organisations, the Integrated Care Board (ICB) is responsible for planning and delivering joined up health and care services to improve the lives of people in their area. The proposed model recognises the importance of continued commitment to partnership working and identifies collaborative, co-located approaches offering partner organisations mutual benefit.

2.5 Demographics are a key consideration in the future model for mental health in the borough; Rotherham is one of the 20% most deprived authorities in England which impacts on the prevalence of mental health related needs.

2.6 When designing models of provision, the person's voice should be integral. People with lived experience of mental ill-health, their families, and carers, along with the workforce, statutory, voluntary and community partners have therefore been consulted and the feedback analysed to inform the final model (Section 4).

The proposed model

2.7 Based on the outcome from the consultation, and collaboration with partners during the review period, a new personalised mental health pathway has been designed. The pathway focusses on the person and sets out the core components of the model to deliver the statutory social care duties which includes:

- A new information and guidance offer.
- Early Solutions (the Adult Social Care Front Door and Enablement offer).
- Care Act Social Care Assessment.
- Mental Health Act duties.
- Crisis care and recovery.

2.8 The key change the proposed model brings is a realignment of Council employed Adult Social Care staff to deliver roles and responsibilities that meet the requirements of the Care Act 2014, the Mental Health Act 1983, and the Mental Capacity Act 2005, as well as associated statutory guidance and codes of practice. This will better balance the clinical and social models to provide a collaborative model of delivery which further strengthens co-location and integration. This will be achieved by:

- Implementing dedicated mental health information, guidance, and digital access.
- Embedding the mental health service into the Adult Social Care Front Door.
- Introducing a new Adult Social Care out of hours provision, replacing the existing services to provide an Adult Social Care and statutory Mental Health Act joint 'making safe' duty, on a 27/4 basis.
- Enhancing the current day and community opportunities offer to include Mental Health Enablement. This would be available to new and existing people in receipt of the service to prevent crisis and promote recovery. People accessing the current service will continue to receive support as they do now, which is reflective of the voice of people engaged as part of the consultation.

- Strengthening the crisis response offer by embedding social care expertise during crisis triage to ensure proportionate assessments are undertaken and the provision of preventative social care interventions.
- Embedding social care expertise to begin discharge planning as part of admission, through referral to Adult Social Care.

2.9 Each element of the model is described in the subsequent sections in further detail.

A new information and guidance offer

2.10 The proposed model is designed to support different types and severity of mental ill-health, by effectively triaging and signposting people with lower-level mental health concerns to the most appropriate support, via preventative pathways and connecting people to a digital, voluntary and community offer.

2.11 A dedicated mental health information and guidance offer aims to empower members of the community that are experiencing mental health difficulties as well as their families, carers, and friends, through a 'self-directed' pathway for people wanting to find their own solutions. It will offer information about sourcing support; advice and guidance on what services are available; assistive technology; and how to make a referral. This will ensure better targeted and preventative support services that will, in turn, reduce the number of people contacting Adult Social Care as people's needs will be met through alternative channels of support.

Enhanced Adult Social Care Front Door

2.12 Adopting a consolidated, enhanced Adult Social Care front door will seek to combine multiple disciplines, including mental health expertise, to provide a holistic point of contact. This will also make accessing Adult Social Care simpler for residents as the number of access points will be reduced.

2.13 People will be supported with a proportionate initial response. This will focus on prevention and resilience, providing people with personalised support and contingency planning. Where appropriate, people with identified unmet social care needs will have access to an equitable enablement offer, including young people transitioning from Children's services. The potential assessment function following enablement, for anyone needing longer-term care and support need will be assessed by the relevant community team.

2.14 People known to Adult Social Care will be triaged to determine the best solution for them, this will include access to enablement if appropriate. Safeguarding Section 42 Initial Enquiries will be completed by the relevant team. However, the enhanced front door will complete the Section 42 Initial Enquiry when any person is not known to services. People known to the service will be allocated to the involved worker or relevant community team.

2.15 **Out of Hours/Making Safe Duty**

The Out of Hours Making Safe Duty function will consolidate the existing dispersed offer currently sitting across the Council's social care teams into one response.

2.16 The principal responsibility of out of hours and making safe are to provide a social care response to referrals received out of hours and where intervention from the Council is required to safeguard an adult in need or at risk, and where it would not be safe, or appropriate, to delay that intervention to the next working day. This function will offer the 'making safe' and the Mental Health Act statutory duty with 24/7 access for AMHPs. There will be a strong link between the RDaSH 24/7 Clinical Crisis Team and the Adult Social Care out of hours making safe duty, to ensure a safe and holistic response.

Mental Health Enablement Offer

2.17 This element of the model introduces an enablement offer to deliver person-centred support to individuals through identification of realistic steps to achieve personalised goals over a defined timeframe. This will involve enabling people to make connections to sustainable support in the community.

2.18 An enablement offer will provide an early solution from the Adult Social Care Front Door for people with unmet mental health social care needs. This will prevent needs from escalating and support people to re-engage into the community following crisis. It is intended that the enablement offer will include a 'rapid response' element as a preventative alternative to crisis which will be accessible to clinical partners via Adult Social Care.

2.19 The enablement offer has been designed based on what people with lived experience and professionals told the Council during the consultation. It will:

- Provide a viable option to prevent mental health crisis and support recovery.
- Deliver a blend of support types to ensure personalised, proportionate intervention, over a 12 to 15-week timeframe.
- Source and make connections to groups of interest and meaningful activities through a 'graded exposure' approach, to encourage longer-term, sustainable support, post-enablement.
- Be offered from a central building based in the community, with outreach into different environments to support people to achieve their goals.
- Be provided in a group and one to one setting, including in a person's own home, tailored to individual need.

2.20 The consultation highlighted that people in receipt of the current community support offer highly valued the service due to the stability and continuity that it offers, which people associate with staying well and preventing crisis. People continue to value the social connections which they have formed, and the support provided by trusted, experienced staff.

2.21 People did however make a distinction between the support and the building, whilst feedback placed significant importance on the service, it also highlighted concerns about the current building being fit for purpose. It is therefore proposed that alongside the new enablement offer the ongoing provision will be further improved by relocating to a more suitable building base which is conducive to an enablement environment. The development of a case with health partners to occupy a central location in Rotherham Town Centre, will consider accommodating the existing provision that is currently based at Wellgate Court.

Social Care Assessment and Review

2.22 The proposed model seeks to retain the existing assessment and review function whilst improving links to Adult Social Care at key points throughout the pathway.

2.23 The revised pathway will enhance current social care legislative duties, offering social work interventions as part of an assessment and crisis pathway as the service would begin to receive referrals from RDaSH Crisis Triage and discharge from acute care via the Adult Social Care Front Door. The function will offer short term interventions and longer-term care management for people with complex needs, including forensic and Section 117 eligible individuals.

Crisis Care and Recovery

2.24 The AMHP role is a statutory function that ensures the rights of people in mental health crisis are protected, that detention is avoided where appropriate, that social issues are considered and that the views of people and their families are included in Mental Health Act Assessments.

2.25 The role, knowledge, and expertise of the AMHP workforce is recognised and will continue to deliver statutory Mental Health Act duties. Additionally, within the new model, as per statutory expectations, the role will further contribute by providing social care interventions, as part of the crisis pathway. If social care needs are identified, the AMHP will follow this up with a proportionate Care Act assessment and short-term review. This will realise more person-centred practices for the person experiencing mental-ill health.

2.26 The model supports a continued collaborative, and co-located approach with RDaSH. It strengthens the Council's contribution to mental health crisis by enabling experienced AMHPs to focus on early intervention by introducing a pathway to social care from crisis triage for people with unmet care and support needs, avoiding the health-led crisis care pathway, where appropriate.

2.27 For people entering acute care, that are detained or admitted informally, collaborative discharge planning will begin at the point of admission. This will introduce a referral route via the Adult Social Care Front Door to ensure a timely and effective social care response to meeting a person's needs.

2.28 Longer term, future developments have been identified for exploration with partners, including interoperability of health and social care systems, a pre-crisis preventative telephony support offer, reciprocal assessments for people placed in care outside of the Rotherham borough and a flexible purchasing system to

stimulate mental health provision. In addition, there is an appetite across statutory, non-statutory and community partners to work collaboratively to develop a 'community hub' model as part of the national Community Mental Health Transformation agenda.

2.29 The consultation identified the need to ensure parity of mental health provision with wider Adult Social Care functions. Within this context, it is important that there is clear strategic direction for mental health provision across the borough, articulated within a co-designed Mental Health Strategy.

3. Options considered and recommended proposals for noting

Option 1: Maintain the existing Mental Health Model

3.1 This option seeks to retain the current model. This is not recommended due to the challenges and risks this presents. The model does not offer a collaborative, partnership approach and whilst not intentional, organisations are working in silos. There is a limited social care pathway currently offered which leaves the Council at risk of not evidencing its statutory duties.

Option 2: Adopt the proposed Adult Social Care Mental Health Model and co-design a Mental Health Strategy

3.2 This option seeks to implement a revised mental health pathway for Adult Social Care in collaboration with partners and develop the current community support service into a hybrid model of mental health enablement and day opportunities, linked to the Voluntary and Community Sector and Social Enterprises.

3.3 Option two would also seek to co-design a Mental health Strategy for Rotherham with people with lived experience, their families, and carers, as well as partners and other key stakeholders. The strategy would be designed in 2024, post-implementation of the new model, and launched in 2025, subject to Cabinet approval. This approach ensures prioritisation of the immediate issue to address the risks linked to operational delivery and compliance with statutory duties.

3.4 Option 2 is preferred as it provides a collaborative, preventative approach to ensure people get the right support, at the right time, in the right place by:

- Raising the social care profile and clarifying the social care contribution to the mental health pathway, providing a recovery-focused, sustainable solution, thus benefitting the people that use services, their families and carers, the workforce, and partners, possibly contributing to alleviating pressures across the system.
- An effective and equitable response for people with mental ill-health, ensuring all people are offered the right information, advice, and support at the right time, with a preventative focus to build resilience.
- Strengthens the recovery model by providing preventative social care interventions as part of a holistic mental health pathway, ensuing the least restrictive option and improved outcomes for people.

- Ensures that across the pathway, social care staff work to the legislative and statutory duties within the Mental Health Act 1983, Care Act 2014, Mental Capacity Act 2005 and Health and Care Act 2022.
- Enables the Council to better evidence social care interventions.
- Supports the Council in preparing for formal regulation of Adult Social Care by the Care Quality Commission, from 2024.
- Supports Rotherham Place achieve its priority to collectively strengthen the mental health crisis pathway and supports an NHS National Objective target to increase the number of adults supported by community mental health services by 5% yearly.
- Solidifies commitment to form the foundations to progress a collaborative 'community hub' model in the future.

4. Consultation on proposal

4.1 The consultation took place from 7 August 2023 to 1 October 2023. The full findings of the consultation are available in Appendix 1.

4.2 The consultation adopted a blended approach utilising questionnaires, drop-in events and one-to-ones with people accessing the current service. During this time, broader feedback about the mental health pathway was obtained from the workforce and partners, through focus groups and workshops.

4.3 A total of 159 people participated in the consultation.

4.4 In relation to the online questionnaire, 97 people responded with 63% of people being in receipt of mental health services, their family, and carers and 27% of respondents being professionals.

4.5 Across all respondents, findings evidenced support for the enablement component of the model to provide both preventative support (89%) and to support recovery (83%). These were two of the most selected support types across all respondents.

4.6 Qualitative feedback further evidenced that people with lived experience value preventative, holistic and person-centred approaches to care and support. It was apparent that people in receipt of the current community support service value the support it provides, which they connected with helping them to stay well.

4.7 Workforce and partner engagement identified three core themes for the model to encapsulate:

- **Approaches** – holistic, person-centred care and support which is strengths-based, personalised, and focussed on recovery. Collaborative, enabling and blended approaches, along with effective triage to support people to navigate the health and care system and access specialist services. Community-based, proportionate interventions, providing early solutions for people to prevent care and support needs from worsening. Using data and feedback to shape service and inform decisions.

- **Pathway** – one consolidated pathway with clear remits, criteria and roles and responsibilities, to ensure the right response first time. Access to a variety of options to meet the varying aspects and severity of mental ill-health.
- **Quality** – safe, accessible, and timely access to information, advice, guidance, and support, that is well communicated across the borough. A knowledgeable, skilled, and experienced workforce that are caring and share a common understanding of pathway and approaches, including the use of appropriate language.

5. Timetable and Accountability for Implementing this Decision

5.1 Subject to Cabinet approval, implementation planning of the pathway and service model will commence on 1 January 2024. This will involve:

- Staff structures, role profiles and agreeing new terms and conditions required to operationalise the model, including delivery of a consultation with staff affected by the proposed changes (January – February 2024).
- Scoping recording requirements and implementing system changes (January – March 2024).
- Training needs analysis and training plan (February – March 2024).
- Operating procedures and guidance with defined pathway criteria and remits (March 2024).
- Aligning the mental health review with RDaSH Crisis and the Community Mental Health Transformation (January – March 2024).

The new mental health model will be operational from 1 April 2024.

6. Financial and Procurement Advice and Implications

6.1 There is no immediate procurement associated with the recommendations detailed in the report. However, any activity with third party providers to assist in the delivery of the new pathway will be subject to the Council's Financial and Procurement Procedure Rules, and the Public Contracts Regulations 2015 (as amended).

6.2 The Council does already have an established Flexible Purchasing System (FPS) for the provision of community mental health care and support, which commenced in May 2023. The FPS remains open for new providers to apply.

6.3 There are no immediate financial implications. Any redesign of the process and team would need to be contained within the existing budget envelope.

7. Legal Advice and Implications

7.1 The report seeks to change the way in which the local authority delivers mental health services to the citizens of Rotherham. This is a legitimate legal exercise and the proposals contained within the report are an appropriate exercise of the local authority's powers and duties.

7.2 The report has identified the appropriate legislation and has drafted a proposal which Cabinet can consider and determine whether it feels that it is the most appropriate way forward. Users and family/carers/friends have been appropriately consulted and the outcome has informed the recommendations contained in the report.

8. Human Resources Advice and Implications

8.1 The current establishment of the Mental Health Team includes 49 staff which equates to a £2,179,686 spend per year.

8.2 A large-scale change programme will need to be undertaken to support the mental health review and this will include other service areas which will be affected by the change.

8.3 The staffing establishment supporting the current service model will need to be reviewed in line with the transformation of the service. As such, a robust consultation will commence with all affected employees as per Council policy on restructure and change management.

9. Implications for Children and Young People and Vulnerable Adults

9.1 The new delivery models for mental health services outlined in this report will improve the service offer for all the adult supported by the Council. Also in scope are Young People who are in Rotherham's Preparing for Adulthood cohort, through provision of enablement and assessment, including Care Act Assessment, Mental Capacity Assessment (from age 16 years and over), and continued provision of Mental Health Assessments for children.

10. Equalities and Human Rights Advice and Implications

10.1 Equalities Assessments have been completed to inform the proposals – see Appendix 2 and 3. The proposals in this report support the Council to comply with legal obligations encompassed in the:

- Human Rights Act (1998), to treat everyone equally with fairness dignity and respect with a focus on those who are disadvantaged because of disability.
- Equality Act (2010) to legally protect people from discrimination in the wider society.

10.2 Section 149 of the Equality Act 2010 establishes the Public Sector Equality Duty (PSED) which requires that the Council, as a public body, in carrying out its functions must have due regard to the need to:

- Eliminate discrimination, harassment, victimisation, and any other conduct that is prohibited by or under the Equality Act.
- Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it.
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

10.3 The relevant protected characteristics referred to in the Equality Act are age; disability; gender reassignment; pregnancy and maternity; race; religion or belief; sex; sexual orientation. Public authorities also need to have due regard to the need to eliminate unlawful discrimination against someone because of their marriage or civil partnership status.

10.4 There is a duty on the Council to keep a record to demonstrate that it has genuinely and consciously had due regard to the PSED.

10.5 It is important to ensure that services are effective and accessible to all communities including to groups with protected characteristics. Referrals from partner agencies to Adult Care Mental Health are monitored to ensure there is community wide access to support.

11. Implications for CO2 Emissions and Climate Change

11.1 A Carbon Impact Assessment has been completed, see Appendix 4.

11.2 The Mental Health Team will continue to work to the hybrid working arrangement. It is not anticipated that there will be an increase in CO2 emissions resulting from this decision.

11.3 Mental Health staff will need to travel to fulfil the statutory duties under the Care Act 2014 and Mental Health Act 1989. The amount of travel needed will be managed to make best use of resources while minimising CO2 emissions. Travel is monitored and only essential travel is authorised.

12. Implications for Partners

12.1 Implementation of the proposed model will realign Council employed staff within a social, rather than clinical, model of delivery. This will lead to a workforce resource impact of 9 Full Time Equivalents for RDaSH within the health-led Crisis Team, Early Intervention and Home Treatment Teams.

Funding for health-related crisis is the responsibility of the ICB, rather than the Council. The proposed model realigns responsibility for clinical interventions under the ICB, as the statutory lead organisation. This ensures that the ICB, in partnership with RDaSH, meet this responsibility, rather than the Council.

An impact assessment has been completed in partnership. This has identified reduced capacity of the Crisis Team to manage clinical tasks as AMHPs focus on assessing people on the crisis pathway under the appropriate framework and, where social care needs are identified, delivery of short-term interventions under the Care Act.

Transitional protections can be adopted initially to mitigate some of the associated risks. This will include AMHPs continuing to cover the early crisis shift (7am – 9am) where there are challenges for clinical cover, with a phased withdrawal of this arrangement over a maximum 6 months. This approach will ensure that the

Council is not funding NHS clinical, crisis provision as it falls outside the scope of its statutory responsibilities.

Further impact is acknowledged during the night as a move towards an on-call model of response to referrals for MHA assessments (only) will withdraw AMHP availability to cover visits and respond to other clinical tasks. RDaSH will consider lone working contingency plans for short notice absence.

In addition, the annual contribution to the RDaSH administration roles will cease. It should also be noted that the previous funding for the administrative roles is a legacy arrangement and the administrative staff roles were removed from the structures in 2021.

In light of the outcome of the review, it provides the opportunity for a crisis specification to be developed by the ICB, RDaSH and the Council which will clearly define mental health crisis and the social care contribution.

13. Risks and Mitigation

13.1 Failure to adopt the new revised model would mean that the pathways for mental health responsibilities between health and social care will remain blurred.

- **Risk:** staff subject to role changes and new terms and conditions may decide to leave the service and vacancies will arise, putting the implementation and delivery of the new pathway and service at risk.

  Mitigation: transparent approach to change, involving staff along the journey. And in formal consultation. A rolling recruitment is in place to mitigate impact.

- **Risk:** introducing social care expertise and interventions to crisis triage and discharge from acute care could increase demand for social care assessment.

  Mitigation: the proposed model re-focusses AMHP roles and responsibilities to deliver social care interventions.

- **Risk:** staff capability, knowledge and understanding to deliver a model which relies on increasing social care interventions.

  Mitigation: training needs analysis and training offer.

14. Accountable Officers

Ian Spicer, Strategic Director of Adult Care, Housing and Public Health
ian.spicer@rotherham.gov.uk

Approvals obtained on behalf of Statutory Officers: -

	Named Officer	**Date**
Chief Executive	Sharon Kemp	04/12/23
Strategic Director of Finance & Customer Services (S.151 Officer)	Judith Badger	30/11/23
Assistant Director, Legal Services (Monitoring Officer)	Phil Horsfield	30/11/23

Report Author: Claire Green, Programme Manager
claire.green@rotherham.gov.uk

Andrew Wells, Head of Safeguarding and Mental Health Services
Andrew.wells@rotherham.gov.uk

This report is published on the Council's website.

Appendix 2

Public Report with Exempt Appendices
Cabinet

Committee Name and Date of Committee Meeting
Cabinet – 13 February 2023

Report Title
Mental Health Service Review

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

Strategic Director Approving Submission of the Report
Ian Spicer, Strategic Director of Adult Care, Housing and Public Health

Report Author(s)
Andrew Wells
Head of Service – Safeguarding and Mental Health
Andrew.wells@rotherham.gov.uk

Marie Staves
Mental Health Strategic Lead
Marie.staves@rotherham.gov.uk

Ward(s) Affected
Borough-Wide

Report Summary

This report sets out the options and recommendations as part of the Adult Social Care Mental Health Review within Rotherham. The focus of the review will be a revised Mental Health model, the main emphasis is to enhance the early intervention and prevention offer and to ensure that people of Rotherham have an effective service offer and pathway. This will include a partnership approach to promote individual wellbeing, prevent the need for care and support, provide information and guidance, assess and review and to safeguard adults at risk of abuse or neglect.

It is proposed that as part of Rotherham Metropolitan Borough Council's continuing commitment to the delivery of Mental Health Adult Care Services a new model needs to be further developed which ensures that the Council can continue to effectively deliver its statutory duties and responsibilities under the Care Act 2014, the Mental Health Act 1983, and the Mental Capacity Act 2005.

Through engagement with staff and data analysis it is evident that more can be done to improve each customer's journey through Mental Health Services to ensure that people who use our services receive the right care, at the right time and in the right place.

Mental Health Services have seen significant developments over the years, and the Council is committed to keeping in line with the changing needs. The revised model will have an improved offer, be person centred and aims to enhance the current service provision. The revised pathway will be co-designed alongside people with lived experience, families, carers, staff and partners.

Recommendations

That Cabinet:

1. Approve the development of the Mental Health revised service offer and model with agreement for this to come back to Cabinet in December 2023 prior to implementation.

2. Approve a programme of work to co-produce a new mental health reablement and day opportunities offer with people with lived experience, their families and carers.

List of Appendices Included
Appendix 1 – Funding Commitments - Exempt
Appendix 2 – Equalities Impact Assessment Part A and Part B
Appendix 3 - Carbon Impact Assessment

Background Papers
None

Consideration by any other Council Committee, Scrutiny or Advisory Panel
No.

Council Approval Required
No

Exempt from the Press and Public
Yes.

An exemption is sought for Appendix 1 under Paragraph 4 (Information relating to any consultations or negotiations, in connection with any labour relations matter arising between the authority or a Minister of the Crown and employees of, or office holders, under the authority) of Part I of Schedule 12A of the Local Government Act 1972 is requested, as this report contains (information relating to consultations regarding roles and responsibilities of some staff within the mental health team).

It is considered that the public interest in maintaining the exemption would outweigh the public interest in disclosing the information because the report details proposals to consult on the future on the delivery of the mental health service for Rotherham, which includes workforce implications, partnership agreements and future services for people with mental ill health. The sensitive nature of these proposals mean it would not be in the best interest for this to be an open report.

Mental Health Service Review

1. Background

1.1 As part of the Council's commitment to shaping the delivery of Mental Health Services for the people of Rotherham, the Council has developed a Mental Health model of social care which ensures that the Council can continue to effectively deliver its statutory duties and responsibilities.

1.2 Through a collaborative approach it has become evident that the Council can do more to improve each customer's journey through Mental Health Services. The Council are committed to ensuring that people who use services, receive the right care for them at the right time.

1.3 Mental ill-health is widespread and can affect anyone. Mental Health Conditions vary in nature and severity, but all can have a significant impact on the lives of people who experience them, their families and carers. There is also a significant impact on society and the economy, with mental health problems being linked to homelessness, unemployment, poor physical health, and risky behaviours.

1.4 Mental health services in Rotherham have already experienced significant change in recent years. This has been the result of a shift in the market-based approach to health, which is cited as:

> … "*Market shaping means the local authority collaborating closely with other relevant partners…to encourage and facilitate the whole market in its area for care, support and related services*." (Care and Support Statutory Guidance, Section 4.6)

1.5 The purpose of market shaping is to stimulate a diverse range of appropriate services, both in terms of the types of services and the types of provider organisation and ensure the market remains vibrant and sustainable.

1.6 Alongside the market-based approach there have been further expectations placed on the Council along with the following:

- A drive to personalisation.
- A strength-based approach to social work.
- A prevention and recovery model.
- The need for a robust social care pathway.
- Significant financial pressures due to over a decade of austerity measures.

1.7 The Council's Approved Mental Health Professionals (AMHP) and social care staff working within mental health provision have been managed by RDaSH for the last 12 years, since 1st April 2011. Social workers, support workers and AMHPs prior to the onset of the pandemic were integrated into RDaSH multi-disciplinary teams which provide services to people with mental ill-health.

1.8 During this time there is an acknowledgement by the Council, RDaSH and the ICB that “integration” had evolved into a health model of care co-ordination and a model of generic working. This has been commonplace for most mental health teams across the Country. However, because of this there has been a loss of social care identity and focus. The proposed revised model would allow the development of the Mental Health service to provide a much broader offer, including early intervention and prevention, an asset-based approach that would focus on making the most out of the person’s lived experience; maximise informal support and community connections and to support personal resilience.

1.9 In 2016, the Council took the decision to recommence the line management of the Council staff within the Mental Health ‘Community Service to ensure full compliance with its duties as a responsible employer.

1.10 Social care staff have a significant contribution to supporting a multi-agency partnership approach to mental health and they will support partners to help prevent people going into crisis, provide support and interventions, alongside a recovery pathway to enable people to reconnect with their communities.

1.11 During the Covid pandemic, most social care staff came back under the management of Council and a revised proposed structure and hybrid working was tested, adapted, and tested again. This has resulted in the development of new ways of working and practice development, culture change with better outcomes for service users within social care mental health. This coincided with RDaSH revising their model of delivery and move to a locality-based model.

Social Work

1.12 There are 20,500 registered social workers in England, but there has been a lack of good quality data for the social care workforce to date (MHA Review, 2018; Skills for Care, 2018; APPG SW, 2019).

The figure overleaf provides an illustrative view of the social work contribution to care delivery.

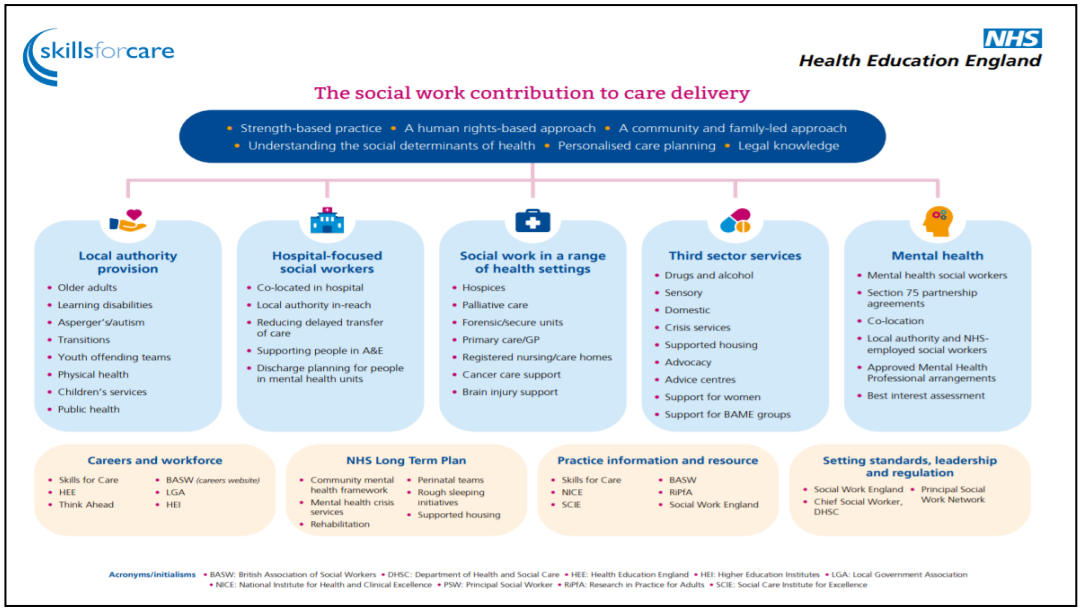

Figure one: Social work contribution to care delivery

Statutory Framework

1.13 Social Work England professional standards are specialist to the social work profession and apply to registered social workers in all roles and settings. The standards are the threshold standards necessary for safe and effective practice. The standards reflect the value and diversity of social work practice and the positive impact it has on people's lives, families, and communities.

1.14 The priority for the Council as it takes the AMHP and Mental Health social care offer through the process of transformation is to create the conditions which will not only enable high-quality social work to flourish, but also ensure that our statutory duties are met. This includes supporting social workers to embrace a change in how to approach social care, using interventions as part of the assessment process to ensure that people can be supported, using a strengths-based approach, and supporting individuals to have positive outcomes, build on community capacity and follow dreams and aspirations - as opposed to having 'services' offered as a solution to unmet need.

1.15 The core principles within the Care Act 2014 have seen the implementation of significant reforms, including:

- Establishing a new statutory wellbeing principle which sets out the outcomes that should underpin care and support;
- A national minimum eligibility threshold for care and support;
- A new duty to prevent, delay or reduce needs for care and support;
- A duty to promote the local care market, with a particular focus on ensuring diversity, quality, and sustainability of provision; and
- An expanded duty to assess the needs of carers and to provide support, on the same basis as rights for users of services.

1.16 Social work brings a distinctive social perspective to mental health. This means recognising the social antecedents and determinants of mental distress throughout the life course, such as trauma, loss and abuse and experiences in childhood and adolescence, that are often missed in purely medical, illness-led approaches. It also means going beyond this to acknowledge how illness-based and medical models can restrict and inhibit recovery and change, through focus on the illness and episodes of care rather than the person as a whole – their fundamental human potential and the opportunities they could access to bring about change building on assets and strengths.

1.17 The guiding principles for social work within Rotherham are set out in the Rotherham place plan and agreed strategically by all partners. These are:

1. **Person centred –** putting the person at the heart of everything we do. This will create an experience of a health and care service that works in a joined-up way, focuses on the prevention of ill health, drives down health inequalities and improves quality and outcomes.
2. **Needs led –** respecting and prioritising the needs of local populations. Working alongside the needs of our community and shaping the support and services to ensure that this approach targets energies and resources most effectively.
3. **Prevention focused –** an integrated approach to deliver outcomes and quality, requires a greater emphasis on prevention, not only expressed in terms of healthy lifestyles and health inequalities but at all levels of care and ability including prevention and wellbeing, supporting, and building upon strengths, a clear focus on recovery and maintaining independence.

1.18 The objectives of which are to move towards a reduced reliance on building-based specialist services, reduce unnecessary admissions to hospital, out of area placements, and only admitting people to residential care when it is the right thing to do. The service offer therefore needs to be:

- **Outward facing –** seeking feedback from the public, taking part as professionals in the informal and formal conversations with the public to shape care, make decisions and evaluate outcomes.
- **Being innovative –** continually looking to apply best practice to modernise. Staff will introduce new practices where there is a need and evidence base for success.
- **Mutuality –** respecting colleagues and working together for the greater good. Staff will seek the opinions and expertise of people who use services, their families, carers (experts by experience), colleagues and partners in shaping services.
- **Integrating care –** working together to enable effective and efficient care. Staff will continually strive for opportunities to share resources in co-ordinating care better and providing seamless services (integration at the point of delivery).
- **Being transparent –** openness, simplicity and mutual challenge and support. Staff will have open debate with partners to evaluate what we

do and how we can improve, without prejudice and within our professional codes of conduct, as well as adhering to the Caldicott principles.

- **Taking accountability –** being responsible and enabling rapid, strong decision making. Organisations are ultimately responsible for their actions and will do everything to combine strengths and champion change.

Roles and Responsibilities

1.19 Figure one cited earlier in the report are taken from Social Work for Better Mental Health – A Strategic Statement. These highlight the contribution that social care can have in adult mental health and include the statutory framework underpinning good social work. In the statement Lyn Romero – Chief Social Worker for Adults stated that:

> …"*As a profession social work has always played a key role in managing risk and complexity, working with people with the profound and enduring health and social needs and who are often the most socially excluded and at risk of harm.*
>
> *Social workers will continue to support people in crisis. However, as we move towards greater integration with health and social care with a focus on prevention and wellbeing to reduce demand for more intensive services, we have a unique opportunity to reposition social work at the heart of person centred adult social care…"* (The Role of Social Workers in Adult Mental Health, 2014).

1.20 The paper outlined The College of Social Work (TCSW) has high ambitions for the future impact of social work with mental health. TCSW has 3 key areas of practice that should frame social work, which are for social workers help to

1. Relieve people's suffering,
2. Fight for social justice; and
3. Improve lives and communities.

1.21 Social workers work to the five key roles set out by the regulator, Social Work England:

1. Enabling citizens to access the statutory social care and social work services and advice to which they are entitled, discharging the legal duties, and promoting the personalised social care ethos of the local authority.
2. Promoting recovery and social inclusion with individuals and families.
3. Intervening and showing professional leadership and skill in situations characterised by high levels of social, family, and interpersonal complexity, risk, and ambiguity.

4. Working co-productively and innovatively with local communities to support community capacity, personal and family resilience, earlier intervention, and active citizenship.
5. Leading the Approved Mental Health Professional (AMHP) workforce.

1.22 It is therefore important that social care staff work to:

- Provide information, advice, and guidance on how individuals can support themselves, with support from families and communities.
- Promote the principles of prevention and wellbeing, signposting people to enable them to be supported, engaged, and empowered, and build upon their strengths, assets, dreams, and aspirations.
- Undertake assessments, determine eligibility, and provide services under relevant social care legislation.
- Facilitate fair access to social care funding.
- Facilitate personalised support planning and personal budgets for eligible people.
- Safeguard adults, providing practice expertise and system leadership.
- Provide Mental Capacity Act and Best Interest Assessments and expert practice and leadership.
- Enable access to advocacy, especially where this is a right in law for example, Independent Mental Health and Independent Mental Capacity Advocacy.
- Undertake Care Act and Section 117 reviews and planning for those in social care funded accommodation and residential care.
- Promote carers' rights and access to assessments and resources.
- Provide access to other social services and resources, including local authorities' universal (non-means tested) offers and advice for self-funders.
- Ensure responsibilities across all care groups are met using social care rather than medical definitions of need; and
- Be involved and show professional leadership within statutory community and multi-agency partnership forums (e.g. Multi Agency Public Protection Arrangements and Multi Agency Risk Assessment Conferences).

Approved Mental Health Professionals (AMHPs)

1.23 The AMHP is a statutory role created by the amendments in 2007 to the Mental Health Act 1983, replacing the previous Approved Social Worker (ASW) role. Eligible professionals undertake the AMHP role on behalf of local authority social services departments, who are legally responsible for the AMHP service. The role is also closely linked to NHS Mental Health Trusts, who provide many of the services that AMHPs require to undertake their role. AMHPs work in very close partnership with the NHS.

1.24 The AMHP has a responsibility to organise and undertake an assessment under the Mental Health Act 1983 and, if the legal definitions are met, to

authorise detention under that Act. AMHPs have specific responsibilities to uphold the human rights of people assessed under the Act, consider the social perspective, and follow the guiding principles of the Mental Health Act and the revised Mental Health Act Code of Practice, which includes applying the least restrictive practice principle. The AMHP is also responsible for organising the complex inter-agency arrangements required to undertake the assessment and communicating with everyone involved, including the person's Nearest Relative (NR).

1.25 Recent research publications have shown that the AMHP role is under a great deal of pressure for multiple reasons. In some areas, it is increasingly hard to provide the statutory service prescribed by the Mental Health Act 1983 and the Code of Practice [Department of Health (DoH), 2014; 2015; CQC, 2018]. This can include delays for assessments, an inability to find an appropriate bed for someone detained under the Mental Health Act or a lack of community alternatives. The pressures within the AMHP service and especially within the wider services can mean that people in mental health crisis do not always receive the service quality they should expect (DHSC, 2018). These pressures also affect staff morale, recruitment, and retention. The AMHP service also has demographic pressures that are adding to these issues with an ageing workforce (Skills for Care, 2018).

1.26 AMHPs are approved and authorised by local authorities. Historically, the role has been undertaken by social workers. Since 2007, mental health and learning disabilities nurses, occupational therapists and chartered psychologists have been able to train to be AMHPs, but currently social workers still occupy 95% of the AMHP roles nationally.

1.27 The AMHP role is crucial to ensure that the rights of people in mental health crisis are protected, that detention is avoided whenever possible, that social issues are considered and that the views of people and families are included in assessments under the Mental Health Act.

Community Support

1.28 Wellgate Court and Dinnington Old Library are long and valued venues and services providing a range of peer and community-based services for many years. The name of both services is the same name as the buildings that the support is provided from.

1.29 Over time, led by the people who require the support, these services have moved to a more community-based offer with approximately fifty per cent of the service activity taking place outside of the building and within the community.

1.30 Prior to the onset of Covid 19 in March 2020, the services operated group activities both building based and within the community, with approximately sixty per cent of activity taking place in the community. The service offered support with socially inclusive activity and provided both support groups for

men and women. The service has Mentors / helpers who provide support to their peers via group activity and through providing an onsite café.

1.31 At the start and during the Covid 19 pandemic, the services adapted to continue to provide support and the team provided individual and group contact by telephone. This contact was used to enable up to five participants in a group conversation at one time. The group calls aimed to create virtual groups, which reflected the person's usual attendance within the service where possible e.g. Men's Group and Relaxation. Where this was not possible e.g., Walking for Health and Wellbeing, the group calls were used to support people to maintain their social citizenship; established support networks; friendships; to prevent isolation; loneliness and potential relapse. These calls were recognised to help people feel together and socially included, even though Government Guidance during the pandemic meant that at times, they were required to be physically distanced.

1.32 As Central and Local Government Covid guidelines have permitted, the services have adapted and changed. The services have and continue to develop Peer Support Groups within the community. These initially met outdoors at local Town Centre cafes and continue to develop, using local community groups and facilities. The aims of the Peer Support Groups are to maintain and develop social capital amongst peers who have traditionally attended the services.

1.33 At present the Peer Support Groups are supported by staff for approximately one hour per session. This is to provide a "touch point" for people to discuss any issues they may currently have, to signpost people to support where necessary and to ensure that the Council plays a part in preventing / delaying the need for a wider range of statutory services.

1.34 Working in this way is also helping people to foster greater independence, resilience, and social inclusion. Because of these changes, the current services have also been able to support individuals with short term enablement packages where appropriate and has also undertaken Care Act Assessments for both individuals who have attended Wellgate Court prior to the pandemic, and people who have not previously attended the service.

1.35 These services have been shaped by the people who use them and by focusing on positive outcomes and what is important to them, this has ensured that care is tailored to the individual and their aspirations whilst helping people maintain much valued peer support, friendships, and community activity together. This present model of working has reduced the need for a standalone building and has increased social inclusion and independence.

1.36 Currently the staff support 55 individuals and 16 carers, the services currently use a variety of community hubs, safe spaces alongside established support groups, mainstream activities like gyms, leisure centres and social clubs across Rotherham.

1.37 The services are looking to expand the community activity with an enhanced reablement service, and part of the proposed co-design would aim to seek the views of the individuals currently using the service, their families and carers. Furthermore, the staff will be consulted on as the model change will mean that they will have some changes to the way they work i.e., assessment, review and support skills, this would be in line with the mental health recovery model and include mental health reablement.

Revised Model

1.38 The proposed model change will be designed to:

- Support a health and social care integrated approach to early intervention and prevention and acknowledging that health and social care eligible needs are interchangeable, and this model will seek partners from health and social care work in a co-located integrated way.
- Meet the requirements of the Care Act 2014, The Mental Health Act 1983, and the Mental Capacity Act 2005 and associated statutory guidance and Codes of Practice.
- Represent a significant culture shift in mental health social care practice within Rotherham, placing particular emphasis on early intervention and prevention "prevent, reduce and delay" and a personalised, strength-based approach to working with adults and their carers.
- Improve our early intervention and prevention offer by strengthening the mental health social care front door.
- Be a flexible structure using our community-based one team approach that can stand alone, co-locate, and integrate with partners when and where appropriate.
- Deliver collaborative pathways with health partners, in particular RDaSH, that result in improved outcomes for people experiencing mental ill health.
- Create a culture of collaboration to support consistency, continuity and create a more positive experience for the people we work with.

1.39 The key reasons for developing a revised model are:

- Prior to the national pandemic, RDaSH revised their Locality offer for mental health services. This has been a core driver for the Council to adapt and evolve the model to achieve a collaborative partnership model which will continue to meet the needs of individuals with mental ill health.
- A core focus of the proposal will ensure that the Council can meet its duties as a responsible employer, in relation to the health, safety and welfare of our mental health social care staff by bringing them under Council line management to achieve responsible employment practices.
- To support the promotion of equality and addressing health inequalities through 'The Community Mental Health Framework for Adults and Older Adults as set out by NHS England and NHS Improvement and the National Collaborating Central for Mental Health which states that "…*Local areas will be supported to redesign and reorganise core*

community mental health teams to move towards a new place-based multidisciplinary service across health and social care aligned with primary care networks. Furthermore, this supports the general duty under the Care Act 2014 to promote integrated models of care and support with health services.

- To offer a collaborate partnership approach to support people with mental ill health at the point of service delivery to ensure a holistic mental health offer.

1.40 It is proposed that Social Workers, care staff and AMHPS, who are currently seconded into RDaSH are brought back under the management of the Council and that the Council manages all the social care teams. This approach should be supported by development of a new partnership mental health pathway and model and good quality services across Rotherham.

1.41 The services are currently delivered from community and hospital settings, namely:

- Ferham Clinic – Health and social care community based multi-disciplinary teams.
- Woodlands – Hospital accommodation and current crisis staff base.
- Swallownest Court – Acute mental health services.
- Riverside House – Social care mental health services.
- Wellgate Court/Dinnington Old Library – Day and community-based services located in community settings across Rotherham.

1.42 The mental health social care teams have been on a transformational journey since 2016, and that this journey will continue beyond the new model. The continued commitment and hard work of our staff is appreciated and valued, as well as the dedication to continuously improving the social care offer to the residents of Rotherham.

1.43 There are several strategic and operational actions which will inform the operation and management of the Council's AMHPs and wider adult social care mental health service relating to the workforce, pathways, partnership working and service level agreements. These will be incorporated into a high-level partner implementation plan which will enable the transition from the current state to the future state and delivery model – over a phased realisation period to minimise any operational, safety and quality risks. This high-level implementation plan will include RDaSH and the ICB partners to ensure the success of the revised model and this will ensure a seamless end to end service for residents of Rotherham.

2. Key Issues

2.1 The key issues can be summarised as:

- A requirement to ensure responsible employer approaches to our workforce through effective line management, supervision, and professional practice of the AMHP staff within the Crisis team.

- A requirement for a revised social care pathway and offer for mental health to be developed alongside partners, this will include enhanced social care interventions with the most complex individuals who present to services and support the suicide prevention pathway.

- A need to focus on strengthening and designing a new mental health reablement offer which will signpost and connect people back to their local community, taking an asset and strengths-based approach. This can only be achieved through a full engagement programme and consultation with regards to the final service and build design for Community Support Services based within Wellgate Court, Dinnington Old Library and Reablement with people who use the service, relatives, carers and staff. The service will not change the current offer but rather enhance the Rotherham mental health recovery model.

- The lack of a dedicated social work pathway, with a single front door for referrals, needs to be addressed as this would strengthen the Council's contribution to Mental Health Crisis. A dedicated pathway would allow experienced AMHPs and social workers to focus on prevention and early intervention and statutory social care functions which will complement the clinical model already delivered by RDaSH.

3. Options considered and recommended proposal

3.1 Adult social care and social work is no longer just about care co-ordination and allocating public resources when people's needs have deteriorated. Adult social care is about helping people to seek earlier support (the well-being principle and early intervention and prevention in the Care Act 2014), anticipate their own needs and use their personal resources and support effectively to prevent, reduce and delay dependency on higher intensity care and support services.

3.2 Further to this and in response to reduction in AMHP numbers nationally, several councils have set up dedicated AMHP teams to good effect (National Workforce Plan for Approved Mental Health Professionals (AMHPs) Published October 2019. These see AMHPs working full-time on the local authority's statutory social care priorities and Mental Health Act assessments, rather than working to the traditional Rota system where they carry caseloads when not on AMHP duty (Community Care 2016), thus ensuring that an effective timely response is provided to people who need support and people in crisis. This also supports the principles of the Care Act 2014, where AMHPs can provide interventions as part of a Care Act assessment to support crisis and complex care solutions.

3.3 Social care seconded staff have been integrated into the health offer for mental health, and work will need to commence to support realignment with their social care identity and values. Support will be initiated alongside the strength-based approach to social work training, alongside peer support and

coaching. This will ensure that staff have the skills, knowledge, and confidence to work effectively within mental health social care.

3.4 Options

Option 1

3.5 This option as it stands would maintain the status quo with all Council staff working across different service areas within a structure where the social care offer is not highly visible and there is limited flexibility to accommodate the Council's shifting priorities.

3.6 In addition to this, maintaining the current arrangement within RDaSH does not provide sufficient assurance to the Council that the AMHP role and function, core social care responsibility, for example, making safe, safeguarding and the delivery of the social care assessment and Care Act eligibility, for some of the most vulnerable individuals in Rotherham, are being met. This could present risks in relation to information sharing, as well as relying heavily on a health-based IT system solution which is not strengths based, providing little or no information of metrics on social care and finance data. This model does not enable social care to identify the social care cohort and potential risks to evidencing compliance with our statutory responsibilities and duties.

Option 2

3.7 As already identified the concept of 'integration' within mental health services is facing unprecedented challenges with local authorities nationally questioning its value; and in some areas removing or are considering removing mental health social workers from NHS oversight and management.

3.8 Therefore, the removal of staff from the integrated mental health teams has been considered as part of the transformation of services, however, it has not been pursued at the present time because:

a) Removal of social care staff from the Mental Health Trust at this point would be counterproductive and no longer aligned with the Rotherham Place Plan, and;
b) There continues to be an overarching commitment and genuine belief that if the Council is to bring about the difference they aspire to, it is arguably important for them to remain within, rather than outside of Rotherham's mental health service provision.

Option 3 – Preferred Option

3.9 As identified above the point has now been reached where maintaining the current delivery model is negatively impacting on the quality and experience of care and support for many individuals, families, and carers within the service.

3.10 In addition to this, the proposed RDaSH transformation model limits the Council's ability to provide not only its statutory duties under the Mental Health Act and the Care Act but also, the provision of a strengths based, person-centered holistic response that focuses on prevention, early intervention, supporting independence and wellbeing.

3.11 Whilst the concept of 'integration' within mental health services is facing unprecedented challenges, locally, the Council has solid relationships with health partners in RDaSH and the ICB so a collaborative model of delivery is the preferred option. This would ultimately lead to social care staff being brought back in under the Council's single line management, aligned across the following functions AMHP, Locality and Enablement and Front door and hospital.

3.12 The basis of the new Adult Social Care Mental Health Pathways would be co-designed with partners to ensure the social and clinical models operating in the locality are complimentary, with multi-disciplinary approaches and improved outcomes for the person experiencing mental ill health.

3.13 Concurrently, a programme of work to co-produce the service offer to strengthening and designing a new mental health reablement offer would be progressed and involve those people with lived experience, their families and carers.

4. Consultation on proposal

4.1 Several focus groups were undertaken to start to address the mental health social care pathway, offer and support the bedding down of the new locality structures implemented by RDaSH, this consultation has included the key partners: RDaSH and the ICB. The sessions were extremely well attended, and the outputs have been used to inform the operation and evolution of the community teams over the spring and summer of 2020 (this was delayed due to the National Covid Pandemic).

4.2 To further add to this baseline position and ensure the full and active engagement of frontline mental health social care staff, a series of four dedicated workshops were designed and undertaken across the week commencing 26 October 2020.

4.3 The sessions were specifically planned to inform the review and enable frontline staff to share their learning and experience in relation to the AMHP role and operation within the Crisis Team, and the broader mental health social care pathway.

4.4 The four workshops were attended by 41 Council staff across mental health social care, a small number of whom attended multiple sessions. A headline summary is set out below.

- There is the need to develop a mental health social care pathway.

- Work needs to be undertaken to clarify roles and responsibilities across the mental health social care pathway – clearly providing role definitions and distinctions between social care and care co-ordination.
- AMHPs and mental health social care staff need to continue to work in a co-located manner with health, under MDT structures and processes.
- There are currently very limited community alternatives to inpatient admission - a menu of options needs to be developed from both a step-up and step-down perspective.
- There is the need to develop a reablement offer within mental health social care.
- Training and development support is required to ensure staff can fulfil statutory duties – in line with the Care Act, Mental Health Act, Mental Capacity Act and Safeguarding.
- Operational issues exist with aspects such as: system access and reporting (S1 and LAS), Section 136 suite, Section 117 and Section 12 App, bed availability and access to co-located admin.

4.5 This level of engagement is central to the review and coupled with the extensive 1-2-1 and small group engagement undertaken throughout the review lifecycle, this has fostered a real sense of ownership and a commitment and desire to improve services for people experiencing mental distress and illness across Rotherham. This will be crucial to the effective implementation of service change and improvement over the next period.

4.6 Engagement is still required for all users, carers, families and staff affected by the proposed changes to Community Support services and will form part of the proposals moving forward.

4.7 The ICB, RDaSH and the Council report on individual and service strategic mental health workstreams and produce reports in a collaborative manner to the Learning Disability and Mental Health Transformation Board. Furthermore, a partnership Mental Health Operational meeting is held monthly with attendance from the partners and this report was discussed and an agreement made that a meeting would be held between January 2023 and February 2023 to overlay all mental health pathways and the revised model to discuss next steps.

5. Timetable and Accountability for Implementing this Decision

5.1 April 2023 – March 2024 Partner joint working and collaboration to co-design the revised mental health model, integrated health and social care pathway planning, development of a mental health crisis specification and Mental Health Market Position Statement.

6. Financial and Procurement Advice and Implications

6.1 The preferred option (Option 3) will be delivered at no additional cost to the Council. The current budget for the staff and running costs for these posts is £0.650m (see exempt Appendix 1).

6.2 There are no direct procurement implications arising from this report.

7. Legal Advice and Implications

7.1 The Council should consider co-production in all aspects of implementing its statutory duties under the Care Act 2014 and to promote participation to achieve its aims.

7.2 The Care and Support Statutory Guidance to the Care Act 2014 includes the concept of co-production: "Local authorities should actively promote participation in providing interventions that are co-produced with individuals, families, friends, carers and the community. 'Co-production' is when an individual influences the support and services received, or when groups of people get together to influence the way that services are designed, commissioned and delivered. Such interventions can contribute to developing individual resilience and help promote self-reliance and independence, as well as ensuring that services reflect what the people who use them want" (paragraph 2.20).

7.3 During the consultation process the Council has a duty to consider the 4 key elements of the Gunning criteria in order to make the consultation a fair and worthwhile exercise. Although co-production involves engaging people to give their views about a particular matter, it takes this a step further by people having the opportunity to be actively involved in influencing the development and delivery of services. The duty to consult consists of four key elements, known as the Gunning criteria, that are designed to make consultation a fair and worthwhile exercise:

(1) Any lawful consultation must be undertaken at a time when proposals are at a formative stage;
(2) There must be sufficient reasons advanced for any proposal to allow those consulted to give intelligent consideration and an intelligent response;
(3) Adequate time must be given for that purpose;
(4) The results of that consultation must be conscientiously taken into account before any decision is taken.

7.4 Consultation will need to take place with staff, people who use the service and their carers over the proposed changes to:

- Community Support Service held at Wellgate Court building.
- Community Support Service held at Dinnington Old Library building.

7.5 The Wellgate Court/Dinnington Old Library Consultation "Have Your Say" took place with service users on Monday the 5 December 2022.

7.6 Under s5 of the Care Act 2014, there is a statutory duty is placed on the Council to promote an effective and efficient market of care and support services for local people, also known as 'market shaping'.

7.7 Chapter 4 of the Care and Support Statutory Guidance provides information and guidance on market shaping and commissioning of adult care and support:

https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance.

8. Human Resources Advice and Implications

8.1 The staffing establishment supporting the current service model will need to be reviewed in line with the transformation of the service. As such, a robust consultation will need to commence with all affected employees as per Council policy on restructure and change management.

9. Implications for Children and Young People and Vulnerable Adults

9.1 The new delivery models for mental health services outlined in this report will improve the service offer for all the adult supported by the Council.

The proposals contained within this report support positive steps to meet objectives in the Council Plan to ensure that people have good mental health and physical wellbeing, maximise independence, and to work with some of the most vulnerable people in Rotherham to build upon their strengths and resilience, reducing the reliance on social care interventions.

Young People who are in Rotherham's Preparing for Adulthood Cohort are in scope, though the impacts will be for people aged 18 and over.

10. Equalities and Human Rights Advice and Implications

10.1 The proposals in this report support the Council to comply with legal obligations encompassed in the:

- Human Rights Act (1998), to treat everyone equally with fairness dignity and respect with a focus on those who are disadvantaged as a result of disability and Page 12 of 13.
- Equality Act (2010) to legally protect people from discrimination in the wider society.

10.2 Section 149 of the Equality Act 2010 establishes the public sector equality duty ("PSED") – which requires that the Council, as a public body, in carrying out its functions must have due regard to the need to:

- Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act.
- Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it.
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

10.3 The relevant protected characteristics referred to in the Equality Act are age; disability; gender reassignment; pregnancy and maternity; race; religion or belief; sex; sexual orientation. Public authorities also need to have due regard to the need to eliminate unlawful discrimination against someone because of their marriage or civil partnership status.

10.4 There is a duty on the Council to keep a record to demonstrate that it has genuinely and consciously had due regard to the PSED.

10.5 Ensuring that services are effective and accessible to all of our communities including protected characteristics groups is important. Referrals from partner agencies to Adult Care Mental Health are monitored to show that cases involving all parts of the community are being referred.

11. Implications for CO2 Emissions and Climate Change

11.1 The Mental Health Team will continue to work to the hybrid working arrangement which does provide Rotherham MBC office space. It is not anticipated that there will be an increase in CO2 emissions as a result of this decision.

11.2 Mental Health staff will need to travel to fulfil the statutory duties under the Care Act 2014 and Mental Health Act 1989. The amount of travel needed will be managed to make best use of resources while minimising CO2 emissions. Travel is monitored and only essential travel is authorised.

12. Implications for Partners

12.1 The proposal has been shared at high level with RDaSH and the ICB and continues to be a core part of the Mental Health and Learning Disability Transformation Board.

12.2 The intention is to explore the development of the revised model jointly to ensure a joint placed based approach to service design and delivery and to ensure that all partners can contribute to the delivery of the statutory responsibilities as set out by regulation and legislation.

13. Risks and Mitigation

13.1 The risks of doing nothing is that RMBC cannot evidence that it has fulfilled its statutory duties and responsibilities under the Care Act 2014, Mental Health Act 1983 and Mental Capacity Act 2005.

13.2 Failure to adopt the new revised model would mean that the pathways for mental health social care would remain unclear, responsibilities between health and social care blurred and people will not have their eligible needs met.

14. Accountable Officers

Ian Spicer, Strategic Director of Adult Care, Housing and Public Health ian.spicer@rotherham.gov.uk

Approvals obtained on behalf of Statutory Officers:

	Named Officer	**Date**
Chief Executive	Sharon Kemp	30/01/23
Strategic Director of Finance & Customer Services (S.151 Officer)	Judith Badger	26/01/23
Assistant Director, Legal Services (Monitoring Officer)	Phillip Horsfield	26/01/23

Report Author(s): Andrew Wells
Head of Service – Safeguarding and Mental Health
Andrew.wells@rotherham.gov.uk
This report is published on the Council's website.

Adult Mental Health Service Review Update

Health Select Commission

Andrew Wells, Head of Safeguarding

1 May 2025

Background

In December 2023, Cabinet approved the implementation of a new Adult Social Care Mental Health model for Rotherham which included:

Implementation of a revised Mental Health Pathway
Realignment of Council employed staff to deliver social care roles and responsibilities
Alignment of Approved Mental Health Professionals (AMHPs) under Council management and co-location with the Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH) Crisis Team at Woodlands

Background (cont'd)

Provision of a collaborative approach to crisis alongside RDaSH
A commitment to strengthen effective partnerships, working to align the revised mental health pathway with RDaSH and Community Mental Health Transformation

The report acknowledged that a joint approach between health and social care, therefore designed around a collaborative delivery of both clinical and social care needsdelivered a partnership approach with RDaSH and the South Yorkshire Integrated Care Board (SYICB) and the Council

Intended Benefits of the Revised Model

Provide a collaborative, preventative approach to ensure people get the right support
Raise the social care profile and solidify the social care contribution to the mental health pathway
Provide an effective, holistic and equitable response for people with mental ill-health
Strengthen the recovery model by providing preventative, proportionate social care interventions
Ensure that across the pathway, social care staff work to the legislative and statutory duties, enabling the Council to better evidence social care interventions
Prepare the Council for formal regulation of Adult Social Care by the Care Quality Commission
Support Rotherham Place to achieve its priority to collectively strengthen the mental health crisis pathway

Update

- The pathway was implemented in April 2024 the Council, SYICB, RDaSH, Primary Care and Urgent Care
- Initial impact analysis has identified no impact to partners whilst achieving positive impacts for residents through a more appropriate approach focussed on enablement and recovery
- The support provided focuses on prevention, early intervention and promotes resilience and independence
- The enhanced front door also refers people with identified unmet social care needs into the mental health enablement offer.
- The enablement pathway operates from community and health venues namely, Wellgate Court, Ferham Clinic and Swallownest Court

The community and enablement service as of mid point review (June 24)

- 178 referrals and in the 12 – 15 into enablement and the team provided 55 packages of personalised support.
- 5 peer support groups within different community settings
- Providing support for up to an hour and on average the service supports 7 people per session
- 2 dedicated sessions are held at Wellgate Court every week (Wednesday and Friday) and supports on average 8 people per session
- 65 people were screened either not appropriate or people declined the enablement offer.
- The 55 people and 16 carers who historically had support from the service remain and continue to be supported.

The AMHP Service as of mid point review (June 24)

The Council and RDaSH had agreed that the AMHP (social care response) and Crisis Team (Health response) would be co-located and is now delivered from Woodlands,

- To ensure a robust partnership approach to crisis intervention
- To allow urgent partnership visits if required, supporting right support at the right time

As part of AMHPs and support workers coming under the Council management

- Provide social care interventions
- Have available for the 1st time in 15 years have information and data on activity and performance to benchmark
- Staff recieving appropriate support and supervision with a focus on wellbeing and ensures compliance with employer duties

Conclusion

The overall impact of the revised pathway has been:

- The development of a prevention and early intervention approach
- People get the right support at the right time, and incudes
  - Social Care intervention
  - Crisis intervention
  - Mental Health Act Assessment
  - Health intervention
  - Health and social care intervention combined
  - Signposting to appropriate service/
- Effective roles and responsibilities which partners understand

Cont'd

- Enhanced partnership working across Rotherham within mental health services.
- Clarity on roles and responsibilities of each partner agency, and each partner understands each other's contribution to the new pathway.
- Development of a partnership Mental Health Crisis Specification.
- A co-located Mental Health Crisis offer.
- Dedicated Health and Social Care offer, or combination of the two if required to support a personalised approach.

As a result of the review, the following benefits and impacts for Rotherham residents have been achieved:

- Enablement pathway to realise a preventative offer, preventing people coming into the service who do not need to and providing alternatives.
- Enhanced personalised community offer for both people experiencing mental ill health and unpaid carers.
- Development of peer support groups
- Readily available data and performance on crisis activity
- Succession planning for the AMHPs
- Social care evidence to meet the requirements of the CQC assurance of local authorities.

…“ I am really happy with the support I have had, I haven’t felt judged”…

…”without this service, I wouldn’t be here, it has saved my life”…

…” I wouldn’t have been able to do the things I’ve achieved without this support”…

…”LC has done a fantastic job, and has literally changed our lives, we were overwhelmed we now have the house and our health back, thank you”…

An amazing service that I can’t thank enough as it has really had a massive impact on my daily life and my mental health”…

Co-designed Mental Health Strategy

- Planning for delivery of a co-designed Mental Health Strategy for the Council has commenced and it is anticipated that the strategy will provide the framework for future evolution of our mental health pathway.

- The strategy will be presented to Cabinet in December 2025 for consideration and approval.

Options Considered and Recommended Proposal

- Health Select Commission note the outcomes and impact of implementing the new Adult Social Care Mental Health model.

- Health Select Commission offer any further recommendations or insights.

Any comments or questions?

Health Select Commission – Work Programme 2024-2025

Chair: Cllr Keenan **Vice-Chair: Cllr Yasseen**
Governance Advisor: Kerry Grinsill-Clinton **Link Officer: Scott Matthewman**

The following principles were endorsed by OSMB at its meeting of 5 July 2023 as criteria to long/short list each of the commission's respective priorities:

Establish as a starting point:
- What are the key issues?
- What is the desired outcome?

Agree principles for longlisting:
- Can scrutiny add value or influence?
- Is this being looked at elsewhere?
- Is this a priority for the council or community?

Developing a consistent shortlisting criteria e.g.
- T: Time: is it the right time, enough resources?
- O: Others: is this duplicating the work of another body?
- P: Performance: can scrutiny make a difference
- I: Interest: what is the interest to the public?
- C: Contribution to the corporate plan

Meeting Date	Agenda Item
20-Jun-24	Introduction and overview from Ben Anderson, Director of Public Health, RMBC Nominate representative to the Health, Welfare and Safety Panel
25-Jul-24	Introduction and overview from Claire Smith, Director of Partnerships/Deputy Director of Place (Rotherham), South Yorkshire ICB Introduction and overview from Michael Wright, Managing Director/Deputy Chief Executive, TRFT Oral Health Review Report LGA Adult Care peer review
03-Oct-24	TRFT Annual Report Introduction and overview from Kym Gleeson, Manager, Healthwatch Rotherham
21-Nov-24	Place Partners Winter Planning - Annual Update Public Health Peer Review
23-Jan-25	Adult Social Care Domiciliary Care Sleep Pathways
27-Mar-25	TRFT Same Day Emergency Care Centre Development 18 Week Waiting Time Challenge
01-May-25	Adult Mental Health Pathway Update

Substantive Items for Scheduling

Jul-25	Adult Contact Team Referral Process (Adult Social Care)

Reviews for Scheduling

Early 2025/26 municipal year	Access to NHS Dentistry - Review (to follow conclusion of Access to Contraception)

Items to be Considered by Other Means (e.g. off-agenda briefing, workshop etc)

Early 2025/26 municipal year	Menopause Workshop
April/May 2025	Quality Accounts
May-25	Update briefing regarding relocation of Lung Clinic to Rotherham Hospital (SY ICB) NB. Session to take place immediately following the public meeting.
June/July 2025	ADASS Peer Review

Items for Future Consideration

TBC	Learning Disabilities Update (Castle View)
TBC	Primary Care Network (PCN) Development
TBC	Immunisation Programme Commissioning Changes
TBC	Physical Activity for Health (Sport England)
Early 2025/26 municipal year	CQC Adult Services Inspection
TBC	Nitrous Oxide Abuse - Health and Community Impacts