

HEALTH SELECT COMMISSION
Thursday 10 December 2020

Present:- Councillor Keenan (in the Chair); Councillors Albiston, The Mayor (Councillor Jenny Andrews), Bird, Clark, Cooksey, R. Elliott, Ellis, Fenwick-Green, Jarvis, John Turner, Williams, Evans, Vjestica, Walsh and Short.

Apologies were received from Cllr Roche, the Cabinet Member for Adult Social Care and Health.

The webcast of the Council Meeting can be viewed online:-

<https://rotherham.public-i.tv/core/portal/home>

119. MINUTES OF THE PREVIOUS MEETING HELD ON 22 OCTOBER 2020

Resolved:-

That the minutes of the meeting held on 22 October 2020 be approved as a true and correct record of the proceedings.

120. DECLARATIONS OF INTEREST

There were no declarations of interest.

121. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

The Chair confirmed that no questions had been submitted by members of the public or press.

122. EXCLUSION OF THE PRESS AND PUBLIC

The Chair confirmed that there was no reason to exclude members of the public or press from observing any of the items on the agenda.

123. MENTAL HEALTH TRAILBLAZER IN SCHOOLS

Consideration was given to a report and presentation by the Joint Assistant Director of Commissioning, Performance and Inclusion; the Service Manager for CAMHS; and the Clinical Lead for the Mental Health Support Teams. The report and presentation included information in respect of Rotherham's Child and Adolescent Mental Health Services (CAMHS) pathways. The presentation indicated how the THRIVE model was being implemented by RDASH and provided an update on progress in respect of the Mental Health Trailblazer in Schools. It was noted that the Trailblazer, known as 'With Me in Mind,' employed a tailored approach for each school and remained available to everyone through the online resource at www.withmeinmind.co.uk. The Trailblazer was described in the context of the wider CAMHS service and the COVID-19 pandemic. The report depicted the results of two phases of data collection via a

survey of young people as part of an annual lifestyle survey initiative. The first data collection efforts took place during the first period of national lockdown and again during October, with the survey having closed just before the second national lockdown began.

In discussion, Members noted the resilience of young people during the pandemic and the possibility of an element of attrition in the data. It was noted that HELIOS likely came into service at the optimal time, just as the pandemic was starting. Members expressed hope that young people would be encouraged to see any positive efforts and progress that have come with the pandemic. The response noted the importance of the Wellbeing for Education returning, and the importance of mental wellbeing of staff remaining at the forefront of priorities so that staff can be more resilient as well. Some children have a lot of protective factors as far as family environment and economic factors, but some children will not have as much protection from these areas, so flexibility has to be built into the programmes to reflect and respond to children's needs. The engagement of young people via digital technology has been really positive, and some young people are more likely to engage with digital support as a gateway, which is something that will continue to be utilised after the pandemic.

Members observed the distribution of values for male and female patients, and the apparent movement of cases from severe to less severe over the course of treatment. The response noted that the numbers are still low for statistical significance, but if, after a year of data collection, gender-based trends persist, this would certainly receive attention.

Members also requested clarification around the percentage of children who reported feeling that their mental health had worsened. The response clarified that in October 2020, 48% of respondents said their mental health had not changed and 13% said it had improved.

Further clarification was also requested around the role of schools in collecting the survey information. It was clarified that all responses are anonymous, so there is no way to know which person had responded. Assurance was given that all schools took the survey seriously and identified which age groups responded at which times, so that whole group interventions and appropriate support could be made available. Assurances were provided that the service had followed up with the schools to ensure that the appropriate support had been provided.

Members also requested additional information about the provision of mental health services to special schools and young people with autism and disabilities. The response noted that the pilot included only 22 schools currently, which have adopted the 'With Me in Mind' programme. These do include Rowan and Aspire which had high numbers of students with education health care plans (EHCPs). The programme did not include the special schools at the moment, because the links into special schools already had well-established pathways, and it was understood that the learning disability pathway within the CAMHS service was already

very strong. Many students with disabilities receive support through that pathway instead of 'With Me in Mind.' Aspirations are to bid for a school to host the programme in future. This bid would be submitted as soon as it is announced, and that opportunity would include the special schools. Further assurances were requested and offered in a future update regarding the learning and intellectual disability pathway.

Members also requested further interpretation of the responses from young people who described feeling angry, which was a new emotion surfacing in the October survey. Members expressed interest in knowing what might be the contributing factors behind this change. In response, officers noted that the addition of anger to the responses reflects the overall population. The response of "With me in Mind" and the response of supporting the workforce was to better provide the needed support to young people who are presenting with the whole range of emotions, including anger. It is true that young people's experiences were unique to them and different from the usual, but the data shows some respondents being able to place the emotion and a mixture of emotions. Especially among older children whose future plans and exams have been disrupted, this mixture can include anger. It was noted that no major trends were displaying in terms of young people's anger. So much has happened in a short period of time, and as time goes by, a more complete picture will be available.

Members lauded the positive outcomes the programme is expected to continue to achieve and requested clarification around when schools were closed in relation to the survey period. The response clarified that the data taken from April to June 2020 was during a period that the schools were closed. Members observed that based on the time frame of the survey, perhaps not much can be taken from the data collected while schools were closed. Members further observed that the data seemed overly positive because it often happens that unless there is a relationship with the person who is collecting the information, children often report more positive feelings than they really feel. Members requested that future data be benchmarked to national research reports. The response from officers clarified that these are not the figures for the wider CAMHS service, but for "With Me in Mind." The sample size was noted to be still rather small currently, but evidence-based approaches had delivered reliable outcomes as represented in the report.

Members noted the complexity of children's lives, and that for many children being home was not safe but rather stressful during the pandemic. Members requested clarification around digital interventions and how these were being delivered safely. Members also expressed interest in knowing how service providers respond to dropping connectivity during a session, or how to handle risks around triggering and emotional needs during the remote sessions given the possibility of the session being suddenly disconnected. Partners and officers noted their awareness that some children had difficulty with digital interventions and access, so remote interventions were offered alongside face-to-face

so that children can share openly with the provider. There was an app that has been implemented that allows young people to chat confidentially and openly with the provider, but it was understood that some children would not naturally choose a remote intervention. The digital offer did have its limitations, for example, in the cases of specialised therapies such as those for trauma. Sometimes the support that was needed was best delivered in person, but the service was using a range of approaches to ensure that the service was delivered effectively.

Members requested information about how children with complex needs were being identified and reached; furthermore, how early was “early intervention” and were preventative interventions being used. The response described how children were identified through consultation and that the whole school approach was being developed and strengthened to respond faster. Preventative interventions were facilitated by the whole-school approach and the whole workforce approach, because part of the intention was to get entire groups of children receiving preventative interventions rather than relying on specialised services.

Members requested further long-term updates that consider how the programme was serving and meeting the needs of a variety of different young people. The response from officers averred that as the one-year anniversary of the programme was just passing, more long-term equalities implications will become clear and will be included in future assessments of the programme.

Members requested information around any negative response from schools. The response from officers was that engagement from schools had been very strong overall, but a few schools had been unable to prioritise the survey with their students. This decision by a few of the schools reflected the strategic mobilising of their response in terms of supporting young people at this time. The education wellbeing return had been rolled out across the term, with 140 people represented at these events, which were focused on strategies. Attendees then cascaded these approaches more widely within their organisations. This suggested that schools were taking the emotional wellbeing and mental health of their students very seriously and were making proactive decisions about how to mobilise support to their students based on the resources available to them during this time.

Members requested information about technological poverty in terms of young people being unable to access online resources. The response from officers reported that some young people had been loaned equipment from schools to be able to access the services remotely, and that process has been straightforward and had been easily arranged with the schools. During lockdown, government funding supported laptops being sent out and distributed to children during the summer term.

Members expressed curiosity if the service was prepared for a delayed spike in demand related to the pandemic. The response from officers noted that they were monitoring it closely and expecting an increase in demand, and ensuring they were agile enough to respond to a spike if one presents. The response is being prepared through the front end of the service as well, through consultations, advice, and coordinated support work with the partner network to respond early in the event of a spike.

Further detail was requested as to the efforts in place to keep from having long wait times for young people in need of services. From a CAMHS point of view, the service maintained a response time within a 24-hour period. A designated team responded to urgent and crisis referrals. Processes were in place to guide young people to the right point in the service for them. Data was analysed to detect and understand bottlenecks and remove any delays.

Members requested further clarification around wait times. The response from officers reaffirmed that there was no wait time in terms of initial access, as the response is within 24 hours. There were waits for psychological therapy and into the neurodevelopmental pathway, but not for referrals. The service reviews all referrals into the service within 24 hours, and comprehensive assessments for starting a more structured intervention for a young person were done in a timely manner, so that the young person is seen within 8 weeks for the initial appointment.

Resolved:-

1. That the report be noted.
2. That the next update be brought in 12 months' time.
3. That the Chair of Improving Lives Select Commission give consideration to investigating young patients' access to technology with a view to preventing digital exclusion from mental health services.

124. NEURO-DEVELOPMENTAL PATHWAY

Consideration was next given to a related report on the redesign of the neurodevelopmental pathway. The presentation described the significant challenges that had led to the redesign of the pathway and the progress that had been achieved. It was noted that formerly, the rate of referral that could be accommodated for assessment by the pathway was 15 children per month. The average referral rate was 50 per month, creating a considerable waiting list. In the six months that led up to school closures in early 2020, the rate had increased to an average of 69 referrals per month. Wait times varied based on the child's journey, and the interventions they had received previously, and what had been available to them in their particular circumstances. These interventions included those for autism, ADHD or both of these together. These variables made it

difficult to calculate an average wait time, but it was known that the wait times were too long. Therefore, a bid had been completed for the digital pilot of HELIOS and the redesign was undertaken. The bid requested funding to add 180 assessment. Starting with the families who had been waiting longest, the waiting list had been progressed. 220 families had requested digital pathways. Anyone waiting had begun to be picked up by HELIOS, working with the CCG and RDASH, who were putting in place a trust-wide compact with several different approaches available.

Details regarding the impact on families and the funding breakdown were also provided as part of the presentation. Initially, the clinical team had been quite disconnected from the rest of the process and the providers. The emphasis had been formerly on clinical diagnosis. Therefore, the new vision was to meet the needs of children who present with neurodiversity. There is a network in place to put support strategies in place. Families can then decide whether to progress to a formal diagnosis or not.

Whole school approaches were being implemented in tandem with specialist approaches, provided free to schools at the point of access. Previously, this support was offered at a cost to schools, but because of the funding in place, it can now be offered for free to schools.

A structured and consistent resource pack had also been developed. Some schools were prepared to provide a robust and secure response, while other schools may not be able to provide such a strong response. A website was provided that would provide the resources to any staff who are supporting children and who may themselves need support or to access education.

The stated aspiration was that, rather than training programmes sitting behind a diagnostic threshold, these trainings would now be available without a diagnosis, and families can even self-refer. This removed previous challenges that prevented families from accessing support.

The clinical team had formerly been quite isolated from the rest of the team, which meant they had not had access to all the contextual information that was needed to feed into the diagnostic process. Part of the investment had enabled a multidisciplinary team to be established, including a licensed clinical psychologist. This team had helped with triaging and providing vital contextual information where more information was required for diagnostic work. This team also provided support and advice to families awaiting an assessment. In the new year, it was expected that more work would be done to find out how to provide additional support to people on the waiting list.

Between March and August, schools were closed; therefore, the rates of referral has dropped to 46 new referrals. At this rate, it was possible to keep pace with the number of referrals. It was likely to be a three-year trajectory to progressing through the waiting list and ensuring that the waiting list does not build back up.

In discussion, Members wished to receive clarification around the waiting times and the size of the waiting list. Members reaffirmed concerns that referral rates may likely go up. Officers responded that the size of the waiting list was indeed concerning, and that all the leadership of the Rotherham Place Board were owning the situation and investing in working to resolve it. The reduction in the waiting list relies on the team's being able to manage the number of cases coming in. If previous levels of 69 referrals per month return, this would create a problem for bringing down the waiting times. The money had been invested as effectively as possible, but the size of the challenge could not be underestimated and had to be watched closely. Locally and nationally within this area, it was very specialised work, and there had been real challenges with recruiting. It was observed to be also a national problem.

Further interpretation was requested around the resources required to respond to Rotherham's statistical rate of autism diagnosis which is nearly twice the national average. The response from officers noted that it would be unlikely that the rates of autism in Rotherham would be significantly higher than other areas, but it could be that because of good practice and a strong parent/carer forum, awareness in Rotherham could be higher. There may be higher rates of diagnosis in Rotherham than in other areas, and for this reason, it is important to move support outside of the diagnosis threshold. This way strategies and resources that respond to the range of need are available regardless of whether the child has received a formal diagnosis.

Members noted that scaling the response and support would be possible based on the current pathway and the changes that had been implemented under the redesign. The response from officers likewise noted that expanding would be possible despite limitations on the capacity of the physical team and the ability to recruit.

Members requested more information around digital poverty as a factor within the model for parents and carers. The response from officers noted that any pathway or intervention that relies on people having the equipment and the data bandwidth would have limitations as a result. The HELIOS platform relied on a certain level of technical equipment and broadband. One of the difficulties was that HELIOS could not work with families who did not have that level of technology available to them. This was not unique to the neurodevelopmental pathway, and it was noted that, whilst migrating to digital potentially creates capacity, the service was mindful of families who were not able to access it this way. The other priority was patient choice. Whilst the team were always offering the choice of digital, some families chose to wait for access to interventions by face-to-face means.

Members noted the progress that had been made and noted the positive trajectory over the years and anticipated to continue in the years ahead. It was asked whether the children receiving interventions were able to

speak out clearly, or whether the parents speak over the children. The answer was offered in writing following the meeting.

Members also noted that the patient satisfaction rate dipped only slightly when the cohort was the largest, which suggested that the high approval numbers for small cohorts were genuinely positive and much the same as those for the largest ones.

More information was requested as to the support that was available to children and families whilst awaiting assessment. The response from officers noted that an information sharing agreement had been made between CAMHS and the Local Authority, to enable the team to see which schools the children attend, and whether early help or social care were involved. Those schools who had the largest number of children waiting for assessment were prioritised for group strategies for support, but as work in schools has had to be put on hold this year, it was work that would be revisited and continued.

Resolved:-

1. That the report be noted
2. That the next update be brought in 12 months' time, and that information about support for children with learning disabilities be included in the report.

125. HEALTHWATCH UPDATE

An informal briefing was provided by Lesley Cooper of Healthwatch Rotherham. The briefing provided an update on activities since October. This included two new staff on board and settled into post, two newsletters had been published on the last Friday of each month.

The report on Discharge from Hospital had been circulated and well received locally. There had been only 12 responses from Rotherham on the national survey, but the case studies included had been quite powerful and received recognition from Healthwatch England and the CQC. One of these had even garnered further media attention and subsequent publishing nationally. A response had been promised from the Hospital and policies were being reviewed following the report.

Other projects had moved forward as well. Collaborative work had been undertaken with HARP (Health Access to Refugees Project) to address a gap in attention on the experience and needs of refugees' access to health. Two third-year medical students had spent four weeks with Healthwatch to look at loneliness and obesity, with a report by each student forthcoming on the website. Work also continues on visiting in care homes, but with less response than anticipated, which suggested that either the problem in Rotherham was not as substantial as has been

raised nationally, or this issue is not something that people are eager to discuss. Therefore, a strategy would be developed to guide further work around this topic. It was also noted that a future report may focus also on the vaccination programme for COVID rather than a sole focus on the vaccination programme for flu. Now that the Healthwatch Newsletter is in circulation on a regular basis, intentions for the new year will also be examined after a breather, perhaps with a view to setting up coffee mornings and Healthwatch Hours to get public engagement as much as possible on a different topic each week.

The Chair announced that the Governance Advisor had offered to circulate the newsletter to Members.

In discussion, Members noted their appreciation for the newsletter and the Hospital Discharge Report. It was further observed that previous anecdotal experience of the discharge process seemed quite chaotic and lengthy, although, with COVID, delays are understandable. Members were very interested in the response elicited by the report.

The Chair also thanked Lesley for the update and lauded all the work that had been undertaken by Healthwatch Rotherham.

Resolved:-

1. That the update be noted.

126. OUTCOMES FROM MENTAL HEALTH WORKSHOP 13 NOVEMBER 2020

A briefing report was provided by the Governance Advisor regarding outcomes from the 13 November Scrutiny Workshop on Rotherham's response as a place in terms of mental health service provision. Four presentations from the CCG, RDASH, Public Health, and Adult Social Care comprised the workshop, including information on COVID 19, suicide prevention campaign, challenges that have been encountered, and responsive mitigation plans that are in place. These presentations gave a thorough picture of the response to mental health provision in Rotherham.

Resolved:-

1. That the briefing be noted.
2. That arts avenues for suicide prevention be explored.

3. That suicide prevention and self-harm prevention trainings for mental health professionals be prioritised for delivery in response to the mental health implications of COVID-19.
4. That all partner organisations proactively publicise available resources to support access to mental health services.
5. That basic mental health first aid training for suicide awareness and prevention be included as part of the Member Development Programme.

127. URGENT BUSINESS

The Chair confirmed there were no items of urgent business for consideration at the meeting.

128. DATE AND TIME OF NEXT MEETING

The Chair announced that the next virtual meeting of Health Select Commission is on 4 February 2021, commencing at 2:00 pm.