

HEALTH AND WELLBEING BOARD

**Venue: Voluntary Action
Rotherham, The
Spectrum, Coke Hill,
Rotherham**

**Date: Wednesday, 21st September,
2016**

Time: 9.00 a.m.

A G E N D A

1. To determine if the following matters are to be considered under the categories suggested in accordance with the Local Government Act 1972
2. To determine any item which the Chairman is of the opinion should be considered as a matter of urgency
3. Apologies for absence
4. Declarations of Interest
5. Questions from members of the public and the press
6. Minutes of the previous meeting (Pages 1 - 4)
Minutes of meeting held on 13th July, 2016

For Discussion

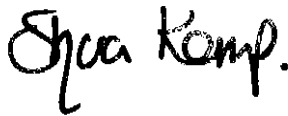
7. Health and Wellbeing Strategy (Pages 5 - 21)
Presentations:-

Aim 1 All Children get the best start in life
Richard Cullen, CCG

Aim 2 Children and young people achieve their potential and have a healthy
adolescence and early adulthood
Ian Thomas, RMBC
8. Better Care Fund (Pages 22 - 41)
Chris Edwards, CCG
9. Sustainability and Transformation Plan (Pages 42 - 68)
Chris Edwards, CCG

10. Community Transformation (Pages 69 - 73)
Dominic Blaydon, CCG
11. Safeguarding Children Annual Report (Pages 74 - 133)
Christine Cassell, Local Safeguarding Children Board
12. Healthwatch Rotherham Annual Report (Pages 134 - 169)
Tony Clabby, Healthwatch Rotherham
13. SEND Joint Commissioning Strategy (Pages 170 - 200)
14. Update from Self-Assessment Workshop (Pages 201 - 204)
Kate Green, RMBC
15. Date, Time and Venue of the Next Meeting
Wednesday, 16th November 2016, at 9.00 a.m. venue to be agreed

Future Dates
11th January, 2017
8th March, 2017



SHARON KEMP,
Chief Executive.

HEALTH AND WELLBEING BOARD**13th July, 2016****Present:-****Members:-**

Councillor David Roche	Cabinet Member for Adult Social Care and Health (in the Chair)
Graeme Betts	Interim Strategic Director, Adult Social Care and Health
Tony Clabby	Healthwatch Rotherham
Richard Cullen	Governance Lead, Rotherham CCG
Chris Edwards	Chief Officer, Rotherham CCG
Sharon Kemp	Chief Executive, RMBC
Julie Kitlowski	Clinical Chair, Rotherham CCG
Councillor Janette Mallinder	Chair, Improving Lives Select Commission
Mel Megs	CYPS, RMBC
Terri Roche	Director of Public Health, RMBC
Janet Wheatley	Voluntary Action Rotherham

Report Presenter:-

Andrew Clayton	Rotherham CCG
----------------	---------------

Officers:-

Kate Green	Policy Officer, RMBC
Dawn Mitchell	Democratic Services, RMBC

Observers:-

John Deffenbaugh	
Gordon Laidlaw	Rotherham CCG
Councillor Sansome	Chair, Health Select Commission
Janet Spurley	Scrutiny Officer, RMBC
Councillor John Turner	

Apologies:-

Robert Odell (South Yorkshire Police), Kathryn Singh (RDaSH), Ian Thomas (RMBC)

13. DECLARATIONS OF INTEREST

There were no Declarations of Interest made at the meeting.

14. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

There were no members of the press and public present.

15. PROFESSOR GRAEME BETTS

The Chair reported that this would be the last Health and Wellbeing Board before Graeme left Rotherham next month.

Board members thanked Graeme for all his help in getting the Board to its much improved position and wished him well for the future.

16. MINUTES OF THE PREVIOUS MEETING

Resolved:- That the minutes of the meeting held on 1st June, 2016, be approved as a correct record.

17. ROTHERHAM LOCAL DIGITAL ROADMAP

Andrew Clayton, Head of Health Informatics, presented the draft Local Digital Roadmap (LDR) for the Rotherham Health and Care Community for the Board's endorsement.

The roadmap had been agreed by the Rotherham Interoperability Group, the multi-agency Rotherham IT Strategy Group and Rotherham CCG Operational Executive before submission to NHS England on 30th June, 2016. It had been supported by information provided by the Foundation Trust, RDaSH, Rotherham Hospice and the Council, along with knowledge of the local health and care agenda. The LDR narrative had been developed to present a vision for the future of digitally supported health and care services in Rotherham and plan for delivery of the services for the next 4 years.

LDRs would be assessed in July, 2016, within the broader context of the assessment of Sustainable and Transformation Plans (STPs). Whilst a signed-off STP would be a condition of accessing the Sustainability and Transformation Fund in the future, a signed off LDR would be a condition for accessing the £1.8bn Driving Digital Maturity Investment Fund. Draft guidelines for the LDR assessment indicated that those LDRs assessed as "Investment Ready" would be eligible to apply for 2017/18 funding in the autumn of 2016; LDRs which were not assessed as "Investment Ready" would be given feedback and support to revise their plans and would be expected to make a further LDR submission in November, 2016.

Discussion ensued with the following issues raised/highlighted:-

- Liquid Logic that the Council would be implementing was seen as a move in the right direction
- Work was to take place on GP Practice websites to ensure they gave a consistent message to patients on how they were expected to access healthcare as well as prevention
- Linked into the Social Prescribing network but a need to also include Connect2Support, E-Market and Gismo
- Acknowledgement of the excellent engagement of partners in the process

- Healthwatch Rotherham had invested in a new CSM system which had trebled the number of comments being received which could be linked in to improve services
- Communications with Elected Members and the wider public and ensuring there was consistency and reassurance

Resolved:- That the Local Digital Roadmap be endorsed.

18. SOUTH YORKSHIRE AND BASSETLAW SUSTAINABILITY AND TRANSFORMATION PLAN

Chris Edwards gave an update on the South Yorkshire and Bassetlaw Sustainability and Transformation Plan process.

The NHS Shared Planning Guidance had asked every local health and care system in England to come together to create its own ambitious local plan for accelerating implementation of the Five Year Forward View. The blueprints, called Sustainability and Transformation Plans (STPs) would be place-based, multi-year plans built around the needs of local populations.

To deliver STPs, local health and care systems had come together to form 44 footprints which collectively covered the whole of England. The geographic footprints were of a scale which should enable transformative change and the implementation of the Five Year Forward View vision of better health and wellbeing, improved quality of care and stronger NHS finance and efficiency by 2020/21.

Rotherham sat within the South Yorkshire and Bassetlaw footprint. The Rotherham place based plan was currently being developed and summarised local ambitions for the STP. It was jointly produced by the Rotherham CCG, Council, Rotherham Foundation Trust, RDaSH and Voluntary Action Rotherham.

Discussion ensued with the following issues raised/highlighted:-

- The final first submission was estimated to be around September
- There was to be an All Member seminar and consideration by the Health Select Commission in October
- The important role the Board had to play
- Feeling that inclusion was required of sections on Primary Care as a provider and also on children and young people
- A user friendly version was required to communicate to the general public

- There needed to be a clear message to public on what was sustainable and transformative about the Plan

Resolved:- (1) That the progress be noted.

(2) That responsibility be delegated to individual organisations to sign off the September STP submission.

(3) That the September submission be submitted to a future meeting of the Health and Wellbeing Board for information.

19. ANY OTHER BUSINESS

Tony Clabby reported that there was to be an Older People's Summit at the New York Stadium on 7th October, 2016.

20. DATE, TIME AND VENUE OF THE NEXT MEETING

Resolved:- That a further meeting be held on Wednesday, 21st September, 2016, commencing at 9.00 a.m. venue to be confirmed.

Rotherham Health and Wellbeing Strategy

Aim 2: Children and young people achieve their potential and have a healthy adolescence and early adulthood

Ian Thomas

Aim 2: Children and young people achieve their potential and have a healthy adolescence and early adulthood

Board sponsor: Ian Thomas, RMBC

Supported by: Shafiq Hussain VAR & Tracy Guest YWCA

- Reduce the number of young people at risk of child sexual exploitation
- Reduce the number of young people experiencing neglect
- Reduce the risk of self-harm and suicide among young people
- Increase the number of young people in education, employment or training
- Reduce the number of young people who are overweight and obese
- Reduce risky health behaviours in young people



The story in Rotherham

Reduce the number of young people at risk of child sexual exploitation

- The Jay Report (2014) Independent Rotherham CSE Inquiry (1997 -2013)
- Responding to historical short comings
- Some indications that 'on line' and street grooming increasing
- No. of CYP presenting at risk of CSE: 352 (15/16)
- Governance: Improvement Board / Plan, Safeguarding Children's Board, CSE sub group
- Services: MASH, Evolve, VCS commissioned services, Barnardos 'Reach Out'

The story in Rotherham

Reduce the number of young people experiencing neglect

- Approx. 10% of new referrals to social care have primary reason neglect (455 in 2015/16).
- Reality much higher. Other factors for neglect: Domestic violence, parental substance misuse and mental health issues
- Neglect: 'rungs of ladder' / continuum of need
- 2,231 open children's social care cases at the end of 2015/16 (1,430 CIN, 369 CPP, 432 LAC)
- Child protection plans started in the year, where neglect is main category or a feature, 304 (15/16) 51.9% of all new CPPs.
- Services not specifically designed for 'neglect'

The story in Rotherham

Reduce the risk of self-harm and suicide among young people

- Mortality from Suicide and Injury Undetermined 2010-2014 in 0-19 years: 5 males 0 females
- Self-harm is recognised in Rotherham as an area of concern particularly among health professionals and young people.
- However, nationally data collected suggests we do well compared to England averages for Self-Harm although suicide is slightly above average.

The story in Rotherham

Increase the number of young people in education, employment or training

15/16

16/17 (June 16)

Rotherham: 5.26%

5.6%

Statistical neighbours: 5.16%

5.6%

Regional: 4.76%

4.9%

National: 4.2%

4.5%

Rotherham NEET Cohort: as at 01/08/16

525: 273 [52%] male

252 [48%] female

The story in Rotherham

Reduce the number of young people who are overweight and obese

- In Rotherham 9.9% of 4-5 year olds were identified as obese (2014/15), higher than the England average of 9.1%.
- This figure more than doubles at Year 6 as 21.6% of 10-11 year old pupils in Rotherham were identified as obese, worse than the England average of 19.1%.
- Rotherham ranks similarly among Children's Services statistical neighbours (6th of 11 including Rotherham at Reception, 2nd highest at Year 6).

The story in Rotherham

Reduce risky health behaviours in young people

Some of the contributory factors:

- Sexual Health – chlamydia 1738 per 100K (Nat Ave 1887, target 2,300) *aged 15-24, in 2015*
- Teenage pregnancy - 28.9 per 1,000 (Nat ave 26.4) *aged 15-17, in 2014*
- Alcohol and Drugs – 3yr average 21.4 hosp. admissions for alcohol per 100K (Nat ave 36.6) *aged 0-17, 2012-2015*
- Smoking - 7.2% regular smokers (Nat ave 5.5%) *aged 15, 2014/15*
- Self esteem
- Self harm – 312 hosp. adm per 100K, (Nat ave 399), *aged 10-24 in 2014/15*
- School absence – 5.3% (Nat ave 4.6%) *aged 5-15 in 2014/15*
- Domestic abuse (general) – 30 per 1,000 pop (Nat ave 20.4) *aged 16+, 2014/15*

Aim 2: Workshop: 5 August 2016

- Over 40 attendees from across partnership, inc. reps from:
- RMBC, Police, Healthwatch, Public Health, VCS & Training Providers
- Six focus group workshops, considered each objective:
 - What's the situation in Rotherham
 - What currently works well
 - Are there any gaps
 - Priority areas
- Participants came up with key actions for each objective...

Reduce the number of young people at risk of child sexual exploitation...

1. Focusing more work on perpetrators:
leading on research and preventative
work starting in primary schools
2. Keeping the public engaged;
communicating current messages
through public campaign

Reduce the number of children and young people experiencing neglect...

1. Develop a consistent understanding of identifying neglect
2. Develop assessment tool / shared responsibility
3. Think Family Model

Reduce the risk of self-harm and suicide amongst young people...

1. Targeting young people at key transition points in their lives, by linking through peer support

Increase the number of YP in education, employment or training

1. NEETs case conference approach, supported by Early Help
2. All providers 'around the table' focusing on NEETs
3. Pre 16 alternative provision - partners around the table working collaboratively to provide a suitable offer

Reduce the number of children and young people who are overweight and obese

1. School Pilot: a different approach than the existing weight screening programme, using a 'whole school approach'

Reduce risky health behaviours in young people

1. Campaign that addresses 'respect' both for self and others: e.g. personal space, community
2. Resilience: encourage all adults in child's life to address resilience with young people
3. Organise a similar event as today's workshop with schools: open dialogue and encourage conversation

Discussion

- Do these actions feel correct?
- Is there one or two areas that the HWb Board think should be prioritised?
- What can partners offer to support the priorities?

Thank you!

Key contacts:

Ian Thomas, HW Being Aim 2 Board Sponsor:

Ian.Thomas@rotherham.gov.uk

Shafiq Hussain, lead officer aim 2

Shafiq.Hussain@varotherham.org.uk

Tracy Guest, lead officer aim 2

Tracy.Guest@ywcayorkshire.org.uk

Kate Green, Support officer for HWbB

Kate.Green@rotherham.gov.uk

Health and Wellbeing Strategy:

http://www.rotherham.gov.uk/hwp/homepage/6/joint_health_and_wellbeing_strategy

1.	Meeting:	HEALTH AND WELLBEING BOARD
2.	Date:	21 st September, 2016
3.	Title:	Better Care Fund Quarter 1 Submission

4. Summary

The purpose of this report is to note the contents of the first quarterly report to NHS England regarding the performance of Rotherham's Better Care Fund in 2016/17.

5. Recommendations

That the Health and Wellbeing Board note the:

- (i) Details for submission to NHS England on or before Friday, 9th September, 2016.

6. Introduction/Background

- 6.1 Rotherham's BCF plan sets out key schemes, and how each of these will be measured and managed.
- 6.2 The BCF quarterly reporting template covers reporting on: income and expenditure, payment for performance, supporting metrics, integration measures, national conditions, income and expenditure.
- 6.3 Below is a summary of information included within the BCF submission:

7. Budget Arrangements

- 7.1 Confirmation that the BCF funds have been pooled by a Section 75 agreement signed by the Local Authority and the Clinical Commissioning Group.
- 7.2 Letter from Local Authority Chief Executive sent to NHS England on 2nd August, 2016, along with revised financial planning template, confirming that the CCG minimum contribution to social care has increased by 1.98%, which is above the required uplift of 1.5% for 2016/17.
- 7.3 The total spend on social care has increased to £9,380,269 for 2016/17.

8. National Conditions

Rotherham is fully meeting 7 out of the 8 national conditions as follows:

- 8.1 Plans are still jointly agreed between the Local Authority and the Clinical Commissioning Group.
- 8.2 Maintaining provision of social care services (not spending)
- 8.3 A joint approach to assessments and care planning are taking place and, where funding is being used for integrated packages of care, there is an accountable professional.

- 8.4 An agreement on the consequential impact of changes on the providers that are predicted to be substantially affected by the plans.
- 8.5 Agreement to invest in NHS commissioned out-of-hospital services.
- 8.6 Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan.
- 8.7 7 day services to support patients being discharged and prevents unnecessary admissions at weekends in place – we have now implemented a 7 day working hospital discharge pilot from 1st December, 2015, which will complete the intentions for 7 day working set out in the Rotherham BCF plan. However, we need to ensure that this becomes a permanent arrangement if we are to continue meeting this national condition. This will be reviewed as part of Phase 2 of the restructure of the adult social care workforce.

Rotherham is currently partly meeting 1 out of the 8 national conditions which comprises of two elements as follows:

- 8.8 The first element (which is fully met) includes better data sharing between health and social care, based on the NHS Number (NHSN). This is being used as primary identifier for health and social care services. Work now completed to ensure better sharing between health and social care. There are 5,495 adults who were in the scope of the NHSN matching project and all BCF records now have an NHS number assigned. Our new social care system will go "live" in December 2016 and this includes the facility to integrate with the NHS 'Patient Demographic Service' (PDS) – which will deliver the ability to quickly look up NHS numbers on the NHS spine. We will begin using the NHSN on our correspondence when the new Liquidlogic system is "live" (Liquidlogic includes the facility to add NHSN to correspondence with little extra work). Whilst we are waiting for PDS to go "live" we will add new NHSN's manually. Training materials have been issued which demonstrate to practitioners in adult social care how to use the NHSN field in the incumbent system. This includes mechanisms for maintaining the NHSN in the interest of ensuring that the field is always populated and that it should be captured as early as possible during the social care pathway.
- 8.9 The second element (which is partly met) around better data sharing includes whether we ensure that patients/service users have clarity about how data about them is used, who may have access and how they can exercise their legal rights. This second element of the national condition has recently been introduced since August 2016.

Significant progress is under way, with an expected full implementation date of 31st January, 2017, to ensure that we fully meet the national condition. The work carried out includes:

The Proposed Consent Model was fully approved at the Rotherham Interoperability Group on 31st August, 2016. The Model states that the ability to access a patient's information may be done via implied consent for direct care. The public must, however, be effectively informed that the data is in use and have the option to object to their records (from any organisation) being shared. Access of a record must be done on the explicit consent of the individual for each episode of care, wherever this is possible (and practical).

Where a patient requires emergency treatment and is unable to give consent, or when a record is being reviewed in response to a test result when the patient is not present, a professional clinical decision can be made considering whether the duty to share or implied consent may be justified. Such access without explicit consent should be documented. This should be fully auditable and monitored accordingly.

A Communications and Engagement plan has been drafted and information will be made available in a variety of formats covering:

- The system “Rotherham Health Record” (RHR) that we will be using to share data
- How it works
- What information will be shared within it (details such as name, address, medication)
- Who will have access to it
- Reassurance on the security of the RHR (both technical within the system and organisational in terms of duty of confidentiality)
- How to opt out
- Who to contact with any concerns/queries

9. Income and Expenditure

9.1 There is a total of £24,323,269 in the Better Care Fund for 2016/17.

9.2 There is a forecast expenditure of £6,080,817 per quarter for 2016/17.

10. Performance Data

The majority of the BCF metrics are on target as follows:

- 10.1 Non-elective hospital re-admissions are on track to meet target. This is subject to close monitoring as admissions to some specialties are above CCG contractual targets with providers.
- 10.2 Delayed Transfers of Care from hospital is on track to meet the target. Year to Date (Quarter 1) target is 769.4, against actual performance of 676.0.
- 10.3 Admissions to Residential Care – on track to meet target. Q1 figures show 50 admissions to residential care to date which equates to a rate of 102 per 100,000 population
- 10.4 Latest public information around the NHS Family and Friends Test shows a reduction of 123.08 to 115.9 in the rate of negative responses.
- 10.5 The proportion of older people still at home 91 days later after hospital discharge into rehabilitation - this is an annual measure and is reported at year end, with indicative data becoming available during January to March 2017.
- 10.6 Emergency re-admissions to hospital – Performance shows that this is currently off track and requires further investigation.

11. Additional Measures

- 11.1 Personal Health budgets, use and prevalence of multi-disciplinary and integrated care teams and use of integrated digital care records across and health and social care are additional measures that have been recently introduced. Rotherham can report favourably on the first two measures.
- 11.2 We are now providing Personal Health Budgets to 69 adults and 21 children in Rotherham during Quarter 1 of 2016/17. All assessed CHC or CCC individuals and/or representatives are offered information regarding requesting a PHB from Rotherham CCG. The CCG is considering the PHB ‘Local Offer’ which highlights the plans to rollout PHBs outside of CHC/CCC.

12. Service Reviews

- 12.1 We are now carrying out a series of individual "deep dive" service reviews on BCF schemes which will identify if there are any funding or performance issues or where there are concerns regarding strategic relevance.
- 12.2 Service reviews will take place between May and December 2016.

13. Conclusion/Next Steps

- 13.1 The quarterly format, and the timetable for submitting the quarterly and annual returns have been included within the new Section 75 Partnership Framework Agreement for the BCF for 2016/17, thus ensuring both the CCG and Local Authority are jointly responsible for compiling and submitting these reports to the HWB and NHS England.
- 13.2 The return has been completed and submitted to both the BCF Executive Group and Health and Wellbeing Board.

14. Background Papers

- 14.1 Appendix 1 - BCF Quarterly Data Collection Quarter 1 2016/17

Officer Contacts: Keely Firth, Chief Finance Officer, RCCG

E-mail: keely.firth@rotherhamccg.nhs.uk

Tel. No: 302025

Officer Contacts: Nathan Atkinson, Assistant Director of Commissioning, RMBC

E-mail: nathan.atkinson@rotherham.gov.uk

Tel. No: 822270

Quarterly Reporting Template - Guidance

Notes for Completion

The data collection template requires the Health & Wellbeing Board to track through the high level metrics and deliverables from the Health & Wellbeing Board Better Care Fund plan.

The completed return will require sign off by the Health & Wellbeing Board.

A completed return must be submitted to the Better Care Support Team inbox (england.bettercaresupport@nhs.net) by midday on 9th September 2016.

The BCF Q1 Data Collection

This Excel data collection template for Q1 2016-17 focuses on budget arrangements, the national conditions, income and expenditure to and from the fund, and performance on BCF metrics.

To accompany the quarterly data collection Health & Wellbeing Boards are required to provide a written narrative into the final tab to contextualise the information provided in this report and build on comments included elsewhere in the submission. This should include an overview of progress with your BCF plan, the wider integration of health and social care services, and a consideration of any variances against planned performance trajectories or milestones.

Cell Colour Key

Data needs inputting in the cell

Pre-populated cells

Question not relevant to you

Throughout this template cells requiring a numerical input are restricted to values between 0 and 100,000,000.

Content

The data collection template consists of 8 sheets:

Checklist - This contains a matrix of responses to questions within the data collection template.

1) Cover Sheet - this includes basic details and tracks question completion.

2) Budget arrangements - this tracks whether Section 75 agreements are in place for pooling funds.

3) National Conditions - checklist against the national conditions as set out in the BCF Policy Framework 16-17 and BCF planning guidance.

4) Income and Expenditure - this tracks income into, and expenditure from, pooled budgets over the course of the year.

5) Supporting Metrics - this tracks performance against the two national metrics, a DTOC metric, a Non-Elective Admissions metric, locally set metric and locally defined patient experience metric in BCF plans.

6) Additional Measures - additional questions on new metrics that are being developed to measure progress in developing integrated, coordinated, and person centred care.

7) Narrative - this allows space for the description of overall progress on BCF plan delivery and performance against key indicators.

Checklist

This sheet contains all the validations for each question in the relevant sections.

All validations have been coloured so that if a value does not pass the validation criteria the cell will be Red and contain the word "No" and if they pass validation they will be coloured Green and contain the word "Yes".

1) Cover Sheet

On the cover sheet please enter the following information:

The Health and Well Being Board

Who has completed the report, email and contact number in case any queries arise

Please detail who has signed off the report on behalf of the Health and Well Being Board

Question completion tracks the number of questions that have been completed, when all the questions in each section of the template have been completed the cell will turn green. Only when all 7 cells are green should the template be sent to england.bettercaresupport@nhs.net

2) Budget Arrangements

This section requires the Health & Wellbeing Board to confirm if funds have been pooled via a Section 75 agreement. Please answer as at the time of completion.

Have the funds been pooled via a s.75 pooled budget?

If the answer to the above is 'No' please indicate when this will happen

3) National Conditions

This section requires the Health & Wellbeing Board to confirm whether the eight national conditions detailed in the Better Care Fund Policy Framework 16/17 (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/490559/BCF_Policy_Framework_2016-17.pdf) and Better Care Fund Planning Guidance 16/17 (<http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/>) have been met through the delivery of your plan. Please answer as at the time of completion.

It sets out the eight conditions and requires the Health & Wellbeing Board to confirm 'Yes', 'No' or 'No - In Progress' that these have been met. Should 'No' or 'No - In Progress' be selected, please provide an estimated date when condition will be met, an explanation as to why the condition was not met within the year (in-line with signed off plan) and how this is being addressed.

Full details of the conditions are detailed at the bottom of the page.

4) Income and Expenditure

This tracks income into, and expenditure from, pooled budgets over the course of the year. This requires provision of the following information:

Planned income into the pooled fund for each quarter of the 2016-17 financial year

Forecasted income into the pooled fund for each quarter of the 2016-17 financial year

Actual income into the pooled fund in Q1 2016-17

Planned expenditure from the pooled fund for each quarter of the 2016-17 financial year

Forecasted expenditure from the pooled fund for each quarter of the 2016-17 financial year

Actual expenditure from the pooled fund in Q1 2016-17

Figures should reflect the position by the end of each quarter. It is expected that the total planned income and planned expenditure figures for 2016-17 should equal the total pooled budget for the Health and Wellbeing Board.

There is also an opportunity to provide a commentary on progress which should include reference to any deviation from plan or amendments to forecasts made since the previous quarter.

5) Supporting Metrics

This tab tracks performance against the two national supporting metrics, a Delayed Transfers of Care metric, a Non-Elective Admissions metric, the locally set metric, and the locally defined patient experience metric submitted in approved BCF plans. In all cases the metrics are set out as defined in the approved plan for the HWB and the following information is required for each metric:

An update on indicative progress against the six metrics for Q1 2016-17

Commentary on progress against each metric

If the information is not available to provide an indication of performance on a measure at this point in time then there is a drop-down option to indicate this. Should a patient experience metric not have been provided in the original BCF plan or previous data returns there is an opportunity to state the metric that you are now using.

6) Additional Measures

This tab includes a handful of new metrics designed with the intention of gathering some detailed intelligence on local progress against some key elements of person-centred, co-ordinated care. Following feedback from colleagues across the system these questions have been modified from those that appeared in the last BCF Quarterly Data Collection Template (Q2 /Q3/Q4 2015-16). Nonetheless, they are still in draft form, and the Department of Health are keen to receive feedback on how they could be improved / any complications caused by the way that they have been posed.

For the question on progress towards instillation of Open APIs, if an Open API is installed and live in a given setting, please state 'Live' in the 'Projected 'go-live' date field.

For the question on use and prevalence of Multi-Disciplinary/Integrated Care Teams please choose your answers based on the proportion of your localities within which Multi-Disciplinary/Integrated Care Teams are in use.

For the PHB metric, areas should include all age groups, as well as those PHBs that form part of a jointly-funded package of care which may be administered by the NHS or by a partner organisation on behalf of the NHS (e.g. local authority). Any jointly funded personal budgets that include NHS funding are automatically counted as a personal health budget. We have expanded this definition following feedback received during the Q3 reporting process, and to align with other existing PHB data collections.

7) Narrative

In this tab HWBs are asked to provide a brief narrative on overall progress, reflecting on performance in Q1 16/17.

Better Care Fund Template Q1 2016/17

Data Collection Question Completion Checklist

1. Cover

Health and Well Being Board	completed by:	e-mail:	contact number:	Who has signed off the report on behalf of the Health and Well Being Board:
Yes	Yes	Yes	Yes	Yes

2. Budget Arrangements

Have funds been pooled via a S.75 pooled budget? If no, date provided?
Yes

3. National Conditions

			7 day services		
	1) Are the plans still jointly agreed?	2) Maintain provision of social care services	3i) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate	3ii) Are support services, both in the hospital and in primary, community and mental health settings available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken (Standard 9)?	4i) Is the NHS Number being used as the consistent identifier for health and social care services?
Please Select (Yes, No or No - In Progress)	Yes	Yes	Yes	Yes	Yes
If the answer is "No" or "No - In Progress" please enter estimated date when condition will be met if not already in place (DD/MM/YYYY)	Yes	Yes	Yes	Yes	Yes
If the answer is "No" or "No - In Progress" please provide an explanation as to why the condition was not met within the quarter (in-line with signed off plan) and how this is being addressed?	Yes	Yes	Yes	Yes	Yes

4. I&E (2 parts)

		Q1 2016/17	Q2 2016/17	Q3 2016/17
Income to	Plan	Yes	Yes	Yes
	Forecast	Yes	Yes	Yes
	Actual	Yes		
	Please comment if there is a difference between the annual totals and the pooled fund	Yes		
Expenditure From	Plan	Yes	Yes	Yes
	Forecast	Yes	Yes	Yes
	Actual	Yes		
	Please comment if there is a difference between the annual totals and the pooled fund	Yes		
Commentary on progress against financial plan:		Yes		

5. Supporting Metrics

	Please provide an update on indicative progress against the metric?	Commentary on progress
NEA	Yes	Yes
	Please provide an update on indicative progress against the metric?	Commentary on progress
DTOC	Yes	Yes
	Please provide an update on indicative progress against the metric?	Commentary on progress
Local performance metric	Yes	Yes
	Please provide an update on indicative progress against the metric?	Commentary on progress
If no metric, please specify	Yes	Yes
Patient experience metric	Yes	Yes
	Please provide an update on indicative progress against the metric?	Commentary on progress
Admissions to residential care	Yes	Yes
	Please provide an update on indicative progress against the metric?	Commentary on progress
Reablement	Yes	Yes

6. Additional Measures

	GP	Hospital	Social Care	Community	Mental health
NHS Number is used as the consistent identifier on all relevant correspondence relating to the provision of health and care services to an individual	Yes	Yes	Yes	Yes	Yes
Staff in this setting can retrieve relevant information about a service user's care from their local system using the NHS Number	Yes	Yes	Yes	Yes	Yes
	To GP	To Hospital	To Social Care	To Community	To Mental health
From GP	Yes	Yes	Yes	Yes	Yes
From Hospital	Yes	Yes	Yes	Yes	Yes
From Social Care	Yes	Yes	Yes	Yes	Yes
From Community	Yes	Yes	Yes	Yes	Yes
From Mental Health	Yes	Yes	Yes	Yes	Yes
From Specialised Palliative	Yes	Yes	Yes	Yes	Yes
	GP	Hospital	Social Care	Community	Mental health
Progress status	Yes	Yes	Yes	Yes	Yes
Projected 'go-live' date (mm/yy)	Yes	Yes	Yes	Yes	Yes
Is there a Digital Integrated Care Record pilot currently underway in your Health and Wellbeing Board area?	Yes				
Total number of PHBs in place at the end of the quarter	Yes				
Number of new PHBs put in place during the quarter	Yes				
Number of existing PHBs stopped during the quarter	Yes				

Of all residents using PHBs at the end of the quarter, what proportion are in receipt of NHS Continuing Healthcare (%)	Yes
Are integrated care teams (any team comprising both health and social care staff) in place and operating in the non-acute setting?	Yes
Are integrated care teams (any team comprising both health and social care staff) in place and operating in the acute setting?	Yes
7. Narrative	
Brief Narrative	Yes

Data sharing			
4ii) Are you pursuing open APIs (i.e. systems that speak to each other)?	4iii) Are the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott Principles and guidance?	4iv) Have you ensured that people have clarity about how data about them is used, who may have access and how they can exercise their legal rights?	5) Is there a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional
Yes	Yes	Yes	Yes
Yes	Yes	Yes	Yes
Yes	Yes	Yes	Yes

Q4 2016/17
Yes
Yes

Yes
Yes

Specialised palliative
Yes
Yes

To Specialised palliative
Yes
Yes
Yes
Yes
Yes
Yes

Specialised palliative
Yes
Yes

Cover

Q1 2016/17

Health and Well Being Board

Rotherham

completed by:

Karen Smith

E-Mail:

karen-nas.smith@rotherham.gov.uk

Contact Number:

01709 254870

Who has signed off the report on behalf of the Health and Well Being Board:

Sharon Kemp and Chris Edwards

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercaresupport@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'

	No. of questions answered
1. Cover	5
2. Budget Arrangements	2
3. National Conditions	36
4. I&E	21
5. Supporting Metrics	13
6. Additional Measures	67
7. Narrative	1

Budget Arrangements

Selected Health and Well Being Board:

Rotherham

Have the funds been pooled via a s.75 pooled budget?	Yes
--	-----

If the answer to the above is 'No' please indicate when this will happen (DD/MM/YYYY)	
--	--

National Conditions

Selected Health and Well Being Board:

Rotherham

The BCF policy framework for 2016-17 and BCF planning guidance sets out eight national conditions for access to the Fund.

Please confirm by selecting 'Yes', 'No' or 'No - In Progress' against the relevant condition as to whether these have been met, as per your final BCF plan.

Further details on the conditions are specified below.

If 'No' or 'No - In Progress' is selected for any of the conditions please include an explanation as to why the condition was not met within this quarter (in-line with signed off plan) and how this is being addressed?

Condition (please refer to the detailed definition below)	Please Select ('Yes', 'No' or 'No - In Progress')	If the answer is "No" or "No - In Progress" please enter estimated date when condition will be met if not already in place (DD/MM/YYYY)	If the answer is "No" or "No - In Progress" please provide an explanation as to why the condition was not met within the quarter and how this is being addressed:
1) Plans to be jointly agreed	Yes		
2) Maintain provision of social care services	Yes		
3) In respect of 7 Day Services - please confirm:			
i) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate	Yes		
ii) Are support services, both in the hospital and in primary, community and mental health settings available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken (Standard 9)?	Yes		
4) In respect of Data Sharing - please confirm:			
i) Is the NHS Number being used as the consistent identifier for health and social care services?	Yes		
ii) Are you pursuing Open APIs (ie system that speak to each other)?	Yes		
iii) Are the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott Principles and guidance?	Yes		
iv) Have you ensured that people have clarity about how data about them is used, who may have access and how they can exercise their legal rights?	No - In Progress	31/01/17	A Proposed Consent Model was agreed at the Rotherham Interoperability Group on 31.8.16. The Consent Model states that the ability to access a patient's information may be done via implied consent for direct care. The public must however be effectively informed that the data is in use and have the option to object to their records (from any organisation) being shared. Access of a record must be done on the explicit consent of the individual for each episode of
5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	Yes		
6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans	Yes		
7) Agreement to invest in NHS commissioned out of hospital services, which may include a wide range of services including social care	Yes		
8) Agreement on a local target for Delayed Transfers of Care (DTC) and develop a joint local action plan	Yes		

National conditions - detailed definitions

The BCF policy framework for 2016-17 and BCF planning guidance sets out eight national conditions for access to the Fund:

1) Plans to be jointly agreed

The Better Care Fund Plan, covering a minimum of the pooled fund specified in the Spending Review, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area, should be signed off by the Health and Wellbeing Board itself, and by the constituent Councils and Clinical Commissioning Groups.

In agreeing the plan, Clinical Commissioning Groups and local authorities should engage with health and social care providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people. Furthermore, there should be joint agreement across commissioners and providers as to how the Better Care Fund will contribute to a longer term strategic plan. This should include an assessment of future capacity and workforce requirements across the system. The implications for local providers should be set out clearly for Health and Wellbeing Boards so that their agreement for the deployment of the fund includes recognition of the service change consequences. The Disabled Facilities Grant (DFG) will again be allocated through the Better Care Fund. Local housing authority representatives should therefore be involved in developing and agreeing the plan, in order to ensure a joined-up approach to improving outcomes across health, social care and housing.

2) Maintain provision of social care services

Local areas must include an explanation of how local adult social care services will continue to be supported within their plans in a manner consistent with 2015-16.

The definition of support should be agreed locally. As a minimum, it should maintain in real terms the level of protection as provided through the mandated minimum element of local Better Care Fund agreements of 2015-16. This reflects the real terms increase in the Better Care Fund.

In setting the level of protection for social care localities should be mindful to ensure that any change does not destabilise the local social and health care system as a whole. This will be assessed compared to 2015-16 figures through the regional assurance process.

It should also be consistent with 2012 Department of Health guidance to NHS England on the funding transfer from the NHS to social care in 2013-14:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf

3) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective (physical and mental health) admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate.

Local areas are asked to confirm how their plans will provide 7-day services (throughout the week, including weekends) across community, primary, mental health, and social care in order:

- To prevent unnecessary non-elective admissions (physical and mental health) through provision of an agreed level of infrastructure across out of hospital services 7 days a week;
- To support the timely discharge of patients, from acute physical and mental health settings, on every day of the week, where it is clinically appropriate to do so, avoiding unnecessary delayed discharges of care. If they are not able to provide such plans, they must explain why.

The 10 clinical standards developed by the NHS Services, Seven Days a Week Forum represent, as a whole, best practice for quality care on every day of the week and provide a useful reference for commissioners (<https://www.england.nhs.uk/wp-content/uploads/2013/12/clinical-standards1.pdf>).

By 2020 all hospital in-patients admitted through urgent and emergency routes in England will have access to services which comply with at least 4 of these standards on every day of the week, namely Standards 2, 5, 6 and 8. For the Better Care Fund, particular consideration should be given to whether progress is being made against Standard 9. This standard highlights the role of support services in the provision of the next steps in a person's care pathway following admission to hospital, as determined by the daily consultant-led review, and the importance of effective relationships between medical and other health and social care teams.

4) Better data sharing between health and social care, based on the NHS number

The appropriate and lawful sharing of data in the best interests of people who use care and support is essential to the provision of safe, seamless care. The use of the NHS number as a consistent identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of information. It is also vital that the right cultures, behaviours and leadership are demonstrated locally, fostering a culture of secure, lawful and appropriate sharing of data to support better care.

Local areas should:

- confirm that they are using the NHS Number as the consistent identifier for health and care services, and if they are not, when they plan to;
- confirm that they are pursuing interoperable Application Programming Interfaces (APIs) (i.e. systems that speak to each other) with the necessary security and controls (<https://www.england.nhs.uk/wp-content/uploads/2014/05/open-api-policy.pdf>); and
- ensure they have the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott principles and guidance made available by the Information Governance Alliance (IGA), and if not, when they plan for it to be in place.
- ensure that people have clarity about how data about them is used, who may have access and how they can exercise their legal rights. In line with the recommendations from the National Data Guardian review.

The Information Governance Alliance (IGA) is a group of national health and care organisations (including the Department of Health, NHS England, Public Health England and the Health and Social Care Information Centre) working together to provide a joined up and consistent approach to information governance and provide access to a central repository guidance on data access issues for the health and care system. See - <http://systems.hscic.gov.uk/infogov/iga>

5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional

Local areas should identify which proportion of their population will be receiving case management and named care coordinator, and which proportions will be receiving self-management help - following the principles of person-centred care planning. Dementia services will be a particularly important priority for better integrated health and social care services, supported by care coordinators, for example dementia advisors.

6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans

The impact of local plans should be agreed with relevant health and social care providers. Assurance will also be sought on public and patient and service user engagement in this planning, as well as plans for political buy-in. This should complement the planning guidance issued to NHS organisations.

There is agreement that there is much more to be done to ensure mental and physical health are considered equal and better integrated with one another, as well as with other services such as social care. Plans should therefore give due regard to this.

7) Agreement to invest in NHS commissioned out of hospital services, which may include a wide range of services including social care

Local areas should agree how they will use their share of the £1 billion that had previously been used to create the payment for performance fund.

This should be achieved in one of the following ways:

- To fund NHS commissioned out-of-hospital services, which may include a wide range of services including social care, as part of their agreed Better Care Fund plan; or

- Local areas can choose to put an appropriate proportion of their share of the £1bn into a local risk-sharing agreement as part of contingency planning in the event of excess activity, with the balance spent on NHS commissioned out-of-hospital services, which may include a wide range of services including social care (local areas should seek, as a minimum, to maintain provision of NHS commissioned out of hospital services in a manner consistent with 15-16);

This condition replaces the Payment for Performance scheme included in the 2015-16 Better Care Fund framework.

8) Agreement on local action plan to reduce delayed transfers of care (DTOC)

Given the unacceptable high levels of DTOC currently, the Government is exploring what further action should be taken to address the issue.

As part of this work, under the Better Care Fund, each local area is to develop a local action plan for managing DTOC, including a locally agreed target.

All local areas need to establish their own stretching local DTOC target - agreed between the CCG, Local Authority and relevant acute and community trusts. This target should be reflected in CCG operational plans. The metric for the target should be the same as the national performance metric (average delayed transfers of care (delayed days) per 100,000 population (attributable to either NHS, social care or both) per month.

As part of this plan, we want local areas to consider the use of local risk sharing agreements with respect to DTOC, with clear reference to existing guidance and flexibilities. This will be particularly relevant in areas where levels of DTOC are high and rising.

In agreeing the plan, Clinical Commissioning Groups and local authorities should engage with the relevant acute and community trusts and be able to demonstrate that the plan has been agreed with the providers given the need for close joint working on the DTOC issue.

We would expect plans to:

- Set out clear lines of responsibility, accountabilities, and measures of assurance and monitoring;
- Take account of national guidance, particularly the NHS High Impact Interventions for Urgent and Emergency Care, the NHS England Monthly Delayed Transfers of Care Situation Reports Definition and Guidance, and best practice with regards to reducing DTOC from LGA and ADASS;
- Demonstrate how activities across the whole patient pathway can support improved patient flow and DTOC performance, specifically around admissions avoidance;
- Demonstrate consideration to how all available community capacity within local geographies can be effectively utilised to support safe and effective discharge, with a shared approach to monitoring this capacity;
- Demonstrate how CCGs and Local Authorities are working collaboratively to support sustainable local provider markets, build the right capacity for the needs of the local population, and support the health and care workforce - ideally through joint commissioning and workforce strategies;
- Demonstrate engagement with the independent and voluntary sector providers.

Plan, forecast, and actual figures for total income into, and total expenditure from, the fund for each quarter to year end (in both cases the year-end figures should equal the total pooled fund)

Selected Health and Well Being Board:

Rotherham

Income

Q1 2016/17 Amended Data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Total BCF pooled budget for 2016-17 (Rounded)
Please provide, plan, forecast and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£6,080,817	£6,080,817	£6,080,817	£6,080,817	£24,323,268	£24,323,269
	Forecast	£6,080,817	£6,080,817	£6,080,817	£6,080,817	£24,323,268	
	Actual*	£6,080,817					

Please comment if one of the following applies: - There is a difference between the planned / forecasted annual totals and the pooled fund - The Q1 actual differs from the Q1 plan and / or Q1 forecast	There is no difference between the planned/forecasted annual totals and the pooled fund. The Q1 actual does not differ from the Q1 plan and/or Q1 forecast.
--	---

Expenditure

Q1 2016/17 Amended Data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Total BCF pooled budget for 2016-17 (Rounded)
Please provide, plan, forecast and actual of total expenditure from the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£6,080,817	£6,080,817	£6,080,817	£6,080,817	£24,323,268	£24,323,269
	Forecast	£6,080,817	£6,080,817	£6,080,817	£6,080,817	£24,323,268	
	Actual*	£6,080,817					

Please comment if one of the following applies: - There is a difference between the planned / forecasted annual totals and the pooled fund - The Q1 actual differs from the Q1 plan and / or Q1 forecast	There is no difference between the planned/forecasted annual totals and the pooled budget. The Q1 actual does not differ from the Q1 plan and/or Q1 forecast.
--	---

Commentary on progress against financial plan:	All schemes were in place and gained good traction in 2015/16 therefore all programmes of work in 2016/17 are well underway. The BCF is on plan to utilise the allotted fundin. A risk share agreement is in place and will utilise the risk pool funding.
--	--

Footnotes:

*Actual figures should be based on the best available information held by Health and Wellbeing Boards.

Source: For the pooled fund which is pre-populated, the data is from a quarterly collection previously filled in by the HWB and has been rounded to the nearest whole number.

National and locally defined metrics

Selected Health and Well Being Board:

Rotherham

Non-Elective Admissions	Reduction in non-elective admissions
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	Q1 number of admissions is below target. This is subject to close monitoring as admissions to some specialties are above CCG contractual targets with providers. These specialties are generally higher cost.
Delayed Transfers of Care	Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+)
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	Year to Date (Q1) target is 769.4. Performance is 676.0.
Local performance metric as described in your approved BCF plan	Emergency readmissions < 30 days of hospital discharge (all ages) PHOF4.11NHSOF3b - NB. local variation to national measure, using patients registered with a Rotherham GP, not LA population.
Please provide an update on indicative progress against the metric?	No improvement in performance
Commentary on progress:	Performance is currently off track and requires further investigation.
Local defined patient experience metric as described in your approved BCF plan	Inpatient Experience: The proportion of people reporting a poor patient experience of inpatient care. (Average number of negative responses per 100 patients)
If no local defined patient experience metric has been specified, please give details of the local defined patient experience metric now being used.	
Please provide an update on indicative progress against the metric?	Data not available to assess progress
Commentary on progress:	Data not yet published nationally
Admissions to residential care	Rate of permanent admissions to residential care per 100,000 population (65+)
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	Qtr 1 figures show 50 admissions to date which equates to a rate of 102 per 100,000 population which whilst acknowledging some time lag in qtr 1 recording we assess the measure to be within target profile.

Additional Measures

Selected Health and Well Being Board:

Rotherham

Improving Data Sharing: (Measures 1-3)

1. Proposed Measure: Use of NHS number as primary identifier across care settings

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
NHS Number is used as the consistent identifier on all relevant correspondence relating to the provision of health and care services to an individual	Yes	Yes	No	Yes	Yes	Yes
Staff in this setting can retrieve relevant information about a service user's care from their local system using the NHS Number	Yes	Yes	Yes	Yes	Yes	Yes

2. Proposed Measure: Availability of Open APIs across care settings

Please indicate across which settings relevant service-user information is currently being shared digitally (via Open APIs or interim solutions)

	To GP	To Hospital	To Social Care	To Community	To Mental health	To Specialised palliative
From GP	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Shared via interim solution	Not currently shared digitally	Shared via interim solution
From Hospital	Shared via interim solution	Shared via interim solution	Not currently shared digitally	Shared via interim solution	Not currently shared digitally	Not currently shared digitally
From Social Care	Not currently shared digitally	Not currently shared digitally	Shared via Open API	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally
From Community	Shared via interim solution	Shared via interim solution	Not currently shared digitally	Shared via interim solution	Not currently shared digitally	Shared via interim solution
From Mental Health	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally
From Specialised Palliative	Shared via interim solution	Not currently shared digitally	Not currently shared digitally	Shared via interim solution	Not currently shared digitally	Shared via interim solution

In each of the following settings, please indicate progress towards instillation of Open APIs to enable information to be shared with other organisations

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
Progress status	Installed (not live)	In development	In development	In development	Unavailable	In development
Projected 'go-live' date (dd/mm/yy)	31/01/17	31/01/17	31/01/17	31/01/17	31/01/18	31/01/17

3. Proposed Measure: Is there a Digital Integrated Care Record pilot currently underway?

Is there a Digital Integrated Care Record pilot currently underway in your Health and Wellbeing Board area?	Pilot currently underway
---	--------------------------

Other Measures: Measures (4-5)**4. Proposed Measure: Number of Personal Health Budgets per 100,000 population**

Total number of PHBs in place at the end of the quarter	90
Rate per 100,000 population	34

Number of new PHBs put in place during the quarter	0
Number of existing PHBs stopped during the quarter	0
Of all residents using PHBs at the end of the quarter, what proportion are in receipt of NHS Continuing Healthcare (%)	100%

Population (Mid 2016)	261,412
-----------------------	---------

5. Proposed Measure: Use and prevalence of Multi-Disciplinary/Integrated Care Teams

Are integrated care teams (any team comprising both health and social care staff) in place and operating in the non-acute setting?	Yes - in some parts of Health and Wellbeing Board area
Are integrated care teams (any team comprising both health and social care staff) in place and operating in the acute setting?	Yes - in some parts of Health and Wellbeing Board area

Footnotes:

Population projections are based on Subnational Population Projections, Interim 2014-based (published May 2016).
<http://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/localauthoritiesinenglandz1>
 Q4 15/16 population figures onwards have been updated to the mid-year 2016 estimates as we have moved into the new calendar year.

Narrative

Selected Health and Well Being Board:

Rotherham

Remaining Characters

29,191

Please provide a brief narrative on overall progress, reflecting on performance in Q1 16/17. Please also make reference to performance across any other relevant areas that are not directly reported on within this template.

BCF Governance continues to closely monitor specific full and accelerated implementation of the two projects linked to the BCF national conditions within agreed timescales. These are:

National Condition 3 - 7 day services to support patients being discharged at weekends has now been established and fully operational since 1.12.15. A review has now been carried out in 2016/17 to measure success and outcomes of this project. It has been agreed that the pilot will continue, pending Phase 2 of the adult social care restructure, when this will become a permanent arrangement in September 2016. A further review will look at whether there needs to be changes in working patterns to improve effectiveness.

National Condition 4 - NHS Number being used as primary identifier for health and social care services Work now completed to ensure better sharing between health and social care. There are 5,495 adults who were in the scope of the NHS number matching project and all BCF records now have an NHS number assigned. Our new social care system will go "live" in December 2016 and this includes the facility to integrate with the NHS 'Patient Demographic Service' (PDS) – which will deliver the ability to quickly look up NHS numbers on the NHS spine. We will begin using the NHS number on our correspondence when the new Liquidlogic system is "live" (Liquidlogic includes the facility to add NHS numbers to correspondence with little extra work). Whilst we are waiting for PDS to go "live" we will add new NHS numbers manually. Training materials have been issued which demonstrate to practitioners in adult social care how to use the NHS number field in the incumbent system. This includes mechanisms for maintaining the NHSN in the interest of ensuring that the field is always populated and that it should be captured as early as possible during the social care pathway.

The BCF Programme Board continues to take a lead in developing proposals for integration, which is part of our local STP Plan and BCF Plan. The BCF Plan for 2016/17 has now been agreed by Health and Wellbeing Board members on 28.4.16, which details our key achievements, key priorities for 2016-2019, risk assessment, contingency planning and patient engagement. A new Section 75 agreement has been developed which was approved at the Health and Wellbeing Board on 1.6.16.

We are now carrying out a series of individual "deep dive" service reviews on BCF schemes which will identify if there are any funding or performance issues or where there are concerns regarding strategic relevance. Service reviews will take place between May and December 2016.

Delayed Transfers of Care (DTOC) - Q1 2016/17 performance is positive and below trajectory. A DTOC multi agency plan is in place and weekly meetings take place on a multi agency basis to address delayed transfers of care.

Personal Health Budgets - there are a total of 69 adults and 21 children in receipt of a PHB during Quarter 1 of 2016/17. All assessed CHC or CCC

Individuals and/or representatives are offered information regarding requesting a PHB from Rotherham GCG. The GCG has recently agreed the PHB (form

Health & Wellbeing Board – Wednesday 21 September 2016

Rotherham Place Plan

Chief Officer: Rotherham CCG	Chris Edwards
Chief Executive: The Rotherham Foundation Trust	Louise Barnett
Chief Executive: Rotherham MBC	Sharon Kemp

Purpose:

To update the Health and Wellbeing Board on the development of the latest iteration of the Rotherham's Integrated Health and Social Care Place Plan. This forms part of the wider South Yorkshire & Bassetlaw Sustainability & Transformation Plan (STP).

Background:

The NHS Shared Planning Guidance asked every local health and care system in England to come together to create its own ambitious local plan for accelerating implementation of the Five Year Forward View (5YFV). These blueprints, called Sustainability and Transformation Plans (STPs), will be place-based, multi-year plans built around the needs of local populations.

Rotherham sits within the South Yorkshire and Bassetlaw footprint which is led by Sir Andrew Cash (Chief Executive of Sheffield Teaching Hospitals).

The Rotherham Integrated Health and Social Care Place Plan summarises local ambitions for the STP and is jointly produced by the Rotherham Clinical Commissioning Group (RCCG), Rotherham Metropolitan Borough Council (RMBC), The Rotherham NHS Foundation Trust, (TRFT), Rotherham, Doncaster & South Humber NHS Foundation Trust, (RDASH) and Voluntary Action Rotherham (VAR).

This latest version of the Plan attached to this cover note demonstrates the commitment across the STP partners in Rotherham to the direction of travel for Rotherham. The Plan provides for the continuation of collaborative and transformational activity across the whole health and care system. Additional transformation funding from the STP will enable the proposed priority areas to go further and faster.

The Rotherham Integrated Health and Social Care Place Plan will form part of the South Yorkshire & Bassetlaw Sustainability & Transformation Plan (STP) be submitted to NHS England In October 2016.

Financial Implications:

NHS England has indicated that transformation funding will be made available plans which meet their criteria. However, the level of funding and the proposed allocation for Rotherham is unknown at this juncture.

Recommendations:

The Health and Well Being Board are asked to note progress and delegate responsibility to individual organisations to sign off the October submission.

Note that it is proposed to bring the October submission to a future meeting.

Rotherham's Integrated Health and Social Care Place Plan

DRAFT

08 September 2016



1	INTRODUCTION	3
1.1	PURPOSE AND POSITIONING OF THIS DOCUMENT	3
1.2	OUR PLACE PLAN ON A PAGE	3
2	CONTEXT	5
2.1	HOW THIS PLACE PLAN WAS DEVELOPED	5
2.2	A SNAPSHOT OF ROTHERHAM	6
3	CASE FOR CHANGE	7
4	TRANSFORMATION APPROACH.....	8
4.1	PREVENTION, SELF-MANAGEMENT, EDUCATION AND EARLY INTERVENTION	9
4.2	ROLL OUT OUR INTEGRATED LOCALITY MODEL – ‘THE VILLAGE’ PILOT	13
4.3	URGENT AND EMERGENCY CARE CENTRE	15
4.4	DEVELOPMENT OF ROTHERHAM 24/7 CARE COORDINATION CENTRE (CCC)	17
4.5	BUILDING A SPECIALIST RE-ABLEMENT CENTRE	18
5	ENABLERS.....	19
5.1	ACCOUNTABLE CARE	19
5.2	ONE PUBLIC ESTATE APPROACH	19
5.3	ASSET-BASED APPROACH	20
5.4	INTEGRATED IT	20
5.5	EMERGING TECHNOLOGY AND THE ‘INTERNET OF THINGS’	21
5.6	GOVERNANCE STRUCTURE.....	22
6	EXPECTED BENEFITS AND INVESTMENT REQUIRED	23
6.1	KEY PERFORMANCE INDICATORS	25
7	OVERVIEW OF IMPLEMENTATION	26

Our commitments

Over the next 5 years, we will focus on:

Improving the health and wellbeing gap through:

- Prevention, self-management, education & early intervention

Driving transformation to close the care and quality gap through:

- Rolling out our integrated locality model – ‘The Village’ pilot
- Opening an integrated Urgent and Emergency Care Centre
- Development of a 24/7 Care Coordination Centre
- Building a Specialist Re-ablement Centre

These initiatives will contribute to closing the finance and efficiency gap.

1 Introduction

Rotherham's Health and Social Care Community has been working in a collaborative way for the past several years to transform the way it cares for its population of 261,000. Our track record in developing and delivering new solutions makes Rotherham the perfect test bed for new innovations. We are passionate about providing the best possible services and outcomes for our population and are committed to a whole system partnership approach, as we recognise that it is only through working together that we can provide sustainable services over the long term.

Our common vision is:

Supporting people and families to live independently in the community, with prevention and self-management at the heart of our delivery.

Our ambition is to champion prevention and integration and establish a range of initiatives in Rotherham to serve as a proof of concept that can then be rolled out further across South Yorkshire and Bassetlaw.

1.1 Purpose and positioning of this document

This document, *Rotherham's Integrated Health and Social Care Place Plan* (the Place Plan), details our joined up approach to delivering five key initiatives that will help us achieve our Health and Wellbeing Strategic Aims¹ and meet the region's Sustainability and Transformation Plan (STP) objectives². Planning and delivery at an overarching STP level must be coordinated with planning and delivery at a local (Rotherham) level, as they represent different elements of the same system.

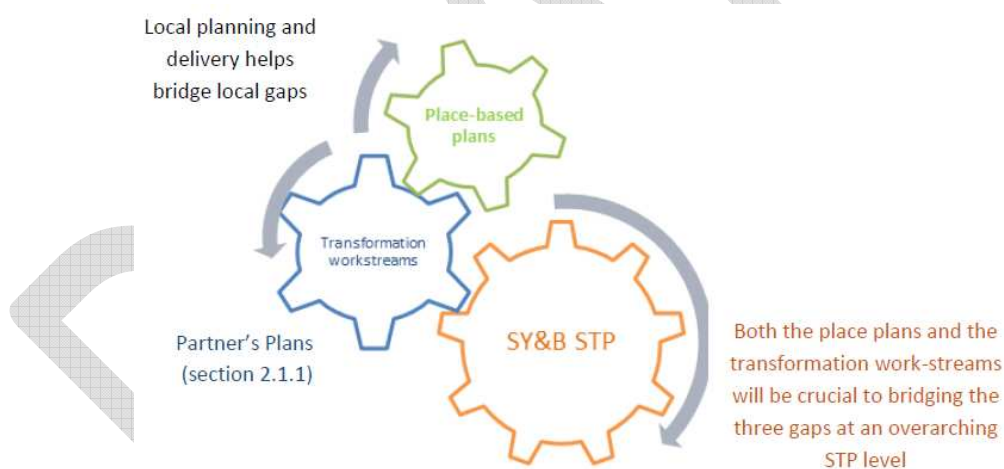


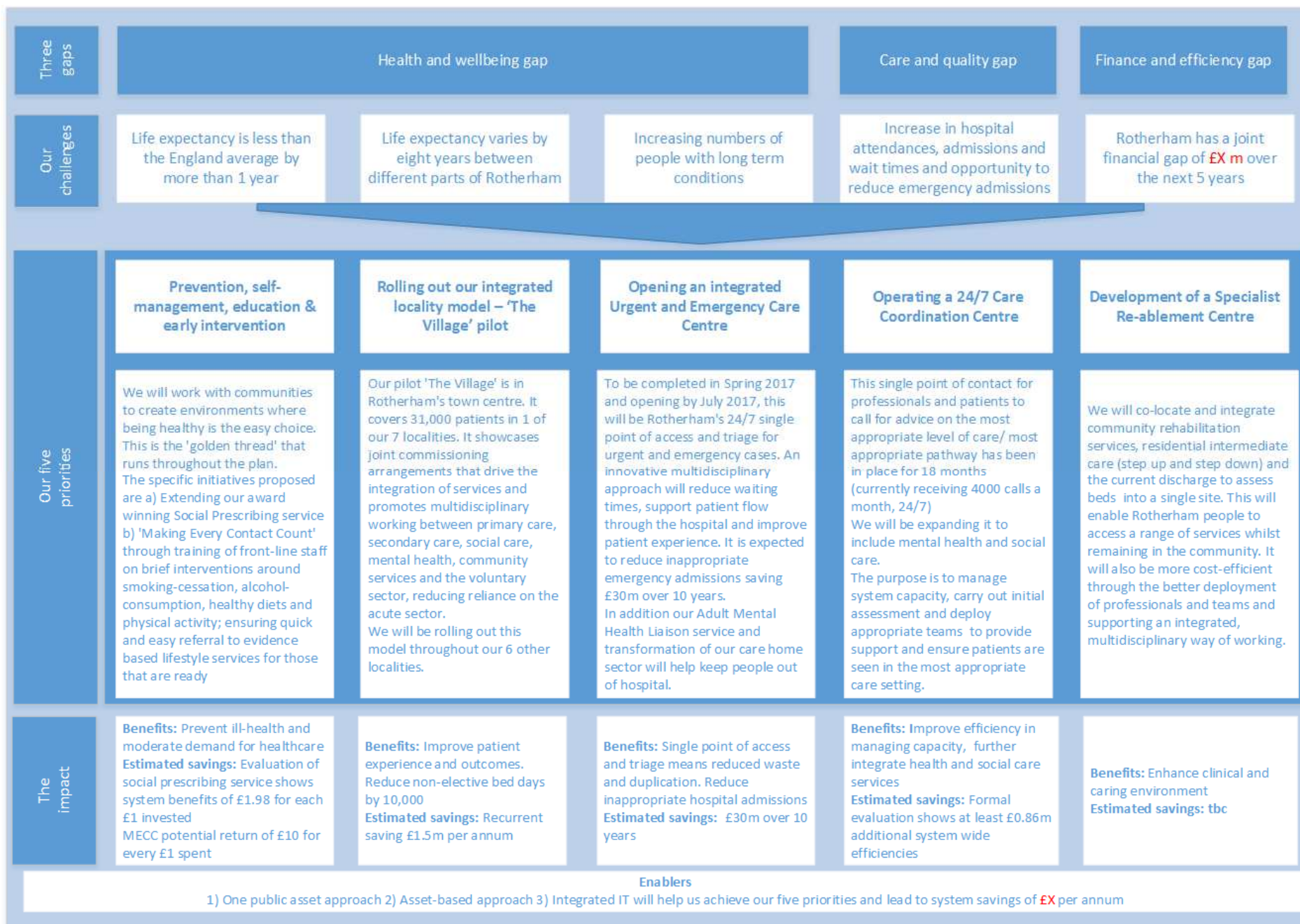
Figure 1 The Place Plan, Transformation Work-Streams and STP all represent different parts of same system

1.2 Our Place Plan on a page

We note that our Place Plan shows how our joint initiatives will help us address Rotherham's challenges and achieve our aims, as illustrated in the diagram below. We have identified **£X net savings** from our joint initiatives and we have worked very closely as partners to ensure there is no double-counting of the estimated benefits and savings from each partner's own transformation work-streams. What we present here is over and above the partners' contributions to creating savings in the system. Some projects are difficult to quantify (e.g. prevention and education) but we expect they will result further savings.

¹ Rotherham Borough Joint Health and Wellbeing Strategy 2015-18. Available online: http://rotherhamhealthandwellbeing.org.uk/hwp/downloads/file/4/rotherham_borough_joint_health_and_wellbeing_strategy_2015-18

² STP currently in draft



2 Context

2.1 How this place plan was developed

The development of the Place Plan is a joint collaboration with representatives from key stakeholders across Rotherham's health and social care services, as depicted in the diagram below.

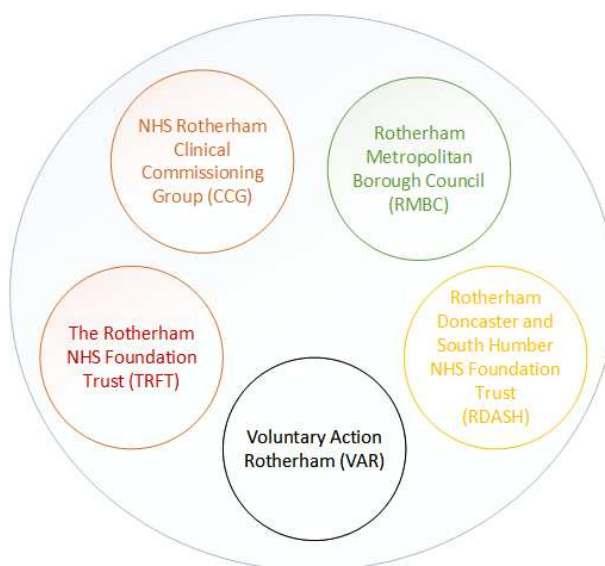


Figure 2 Partner Organisations involved in developing the Place Plan

The partners will continue working closely together to ensure that the initiatives in this Plan are implemented. The Place Plan and its implementation will be further refined with the Rotherham Together Partnership, to include South Yorkshire Police, South Yorkshire Fire and Rescue Service and Yorkshire Ambulance Service in its next iteration.

We have a strong record of delivery and evaluation of our innovative projects and to continue this, we have partnered with Sheffield Hallam University to evaluate our key projects in order to gather evidence and inform our investment decisions. Where we do not have local evidence, we will use evidence of cost benefit analysis from other areas.

2.1.1 Relevant documents

The Place Plan does not replace the partners' individual plans but rather builds upon them by taking a common lens and identifying key areas of collaboration. This document is aligned with the following relevant documents:

- The **Sustainability and Transformation Plan** (July 2016) 'shows how local services will evolve and become sustainable over the next five years – ultimately delivering the Five Year Forward View vision of better health, better patient care and improved NHS efficiency'. We note that our Place Plan does not describe how we will locally address all STP workstreams– instead we focus on our joint priorities as a Health and Social Care community. The CCG's Commissioning Plan (below) covers all STP workstreams. We anticipate the yet to be developed Operational Plan will detail how changes developed through the STP process will be delivered on the ground.
- **NHS Rotherham's CCG Commissioning Plan 2016 – 2020**³ (v July 2016) 'set(s) a clear strategic direction and long term (5 years) commissioning vision'. The document describes in detail how Rotherham CCG

³ NHS Rotherham CCG Commissioning Plan 2016- 2020

<http://www.rotherhamccg.nhs.uk/Downloads/our%20plan/Rotherham%20CCG%20Commissioning%20Plan%202016-17%20Part%201%20and%202%20-%20final%20July%202016.pdf>

will deliver the *Five Year Forward View* locally and the nine 'must dos'/ key system priorities for 2016/17 within our local health economy.

- **Rotherham MBC's Corporate Plan for 2016-17⁴**, which sets out the council's strategic vision for the future and how, through a range of headline priorities, its services will support better outcomes for the borough. A key element of this is a commitment to work with partners to integrate health and care commissioning and delivery, to reduce duplication and provide single points of access in the interests of the customer.
- **Rotherham Improvement Plan 2015⁵** - draws together the actions required to ensure the Council becomes the well-run, high-performing authority which local people deserve. This is in addition to wider changes to ensure effective management and leadership, ensure we are a "child-centred" borough and have excellent working relationships with our partner organisations.
- **The Rotherham Foundation Trust (TRFT) Annual Plan 2015/16⁶**
- **Health and Wellbeing Strategy 2015 – 18**, sets the strategic priorities of the Health and Wellbeing Board, based on intelligence from the local joint strategic needs assessment. The strategy enables commissioners to plan and commission integrated services to achieve better health and wellbeing outcomes for local people. Crucially, the strategy is about working as an effective partnership with service providers, commissioners and local voluntary and community organisations all of whom have an important role to play in identifying and acting upon local priorities.

2.2 A snapshot of Rotherham

Below we provide a snapshot of Rotherham's population⁷.

- **Population 260,800** (2015) and forecasted to grow to 269,100 by 2025 (3.5%)
- In line with the rest of the country, the most significant demographic change occurring in Rotherham is the **growth in the number of older people**. The number of older people (65+) is projected to rise by 8,800 (18%) between 2015 and 2025 and the number aged 85+ is projected to rise by 2,300 (40%) by 2025. This will mean an increase in the number of people with long term conditions such as heart disease, diabetes, dementia and cancer. As at 2014/15 there were almost 13,900 people in Rotherham with diabetes, and nearly 5,400 on GP stroke registers. By 2025 we project that there will be nearly 4,500 people in Rotherham living with dementia⁸.
- **Life expectancy** at birth is 78.1 years for men and 81.3 years for women for 2012-14. This is below the national average by 1.4 years for males and 1.9 years for females⁹.
- Rotherham people live longer with **ill-health and/or disability** than England average - men live 21 years and women 22 years in poor health¹⁰.
- Rotherham is becoming **more ethnically diverse** with the Black and Minority Ethnic (BME) population doubling in size between the 2001 and 2011 Censuses, and continues to grow¹¹.
- Significantly **higher than average deprivation**, unemployment and long term unemployment. 50,370 Rotherham residents (19.5%) live in the most deprived 10% of England. Rotherham has 8,640 residents (3.3%) living in the most deprived 1% of England¹².

⁴ Available online: http://www.rotherham.gov.uk/downloads/file/1491/corporate_plan_2013-16

⁵ Available online: <http://www.rotherham.gov.uk/improvementplan>

⁶ Available online: http://www.therotherhamft.nhs.uk/key_documents/

⁷ Office for National Statistics: 2015, Mid-year estimate 2014 – based population projections, life expectancy at birth 2012-2014, 2001 census, 2011 census.

⁸ Health and Social Care Information Centre: Quality and Outcomes Framework 2014/15

⁹ Public Health England: <http://www.phoutcomes.info/public-health>

¹⁰ outcomesframework#page/1/gid/1000049/pat/6/par/E12000003/ati/102/are/E08000018/iid/22303/age/164/sex/4

¹¹ Source: (2012-14 Healthy Life Expectancy at birth (PHOF)

¹² ONS:2001 Census and 2011 Census

¹² Department for Communities and Local Government and Local Government: Indices of Deprivation 2015

3 Case for change

The health of the Rotherham population is generally poorer than the English average. We have a growing population, but notably, we will see a significant increase in the 85+ population. This leads to growing pressures on our health services, social care, informal care, supported housing and other services. Life expectancy, although lower than average, has been increasing. However, the average time spent in ill-health has also been increasing as people are living longer in poor health, resulting in a growing number of people with high levels of need.

Our key challenges are described in the diagram below.

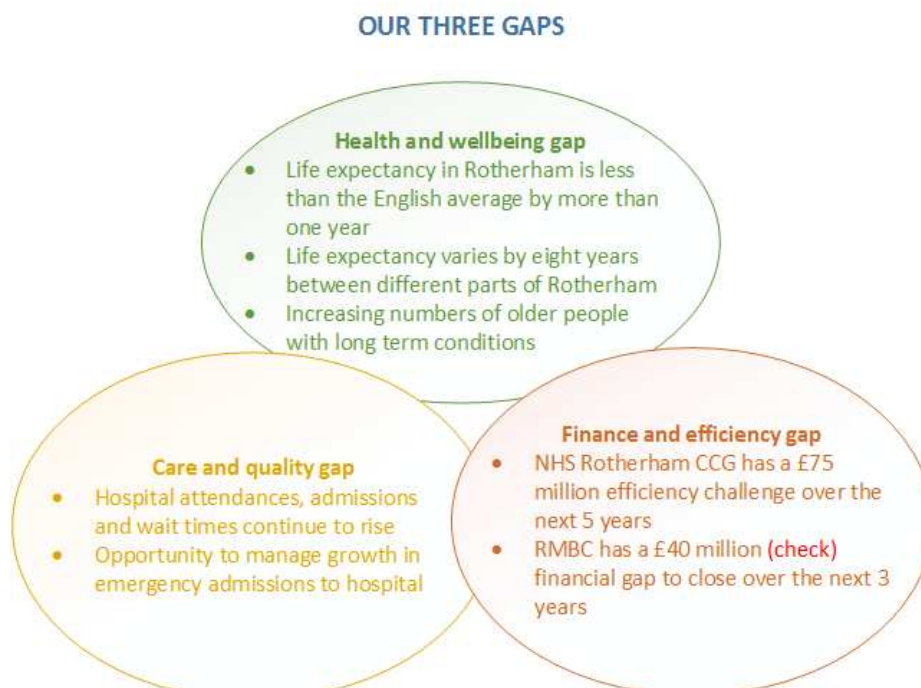


Figure 3 Rotherham's three gaps

<Note, we will add TRFT figures to the efficiency gap when we know then and link to the figure in red in the plan on a page>

We have already made significant progress on delivery of the key enablers to tackle our local gaps. As a Health and Care Community with the additional support of transformational funding at a local place level, we know that we can move further and faster to deliver the required transformation to support system sustainability. We believe our strong track record of patient level evaluation would also allow the wider system to learn from our innovations.

4 Transformation approach

We have identified **five priorities** to maximise the value of our collective action and transform our health and care system so that we can reduce demand for acute services and achieve clinical and financial sustainability. We note that even though the priorities are presented as separate initiatives, they are all very closely interlinked.

1. Prevention, self-management, education & early intervention

- We will work with communities to create environments where being healthy is the easy choice. We will also focus on information, prevention, enablement, rather than on-going support which increases dependence and reliance on health and social care services. This is the 'golden thread' that runs throughout the plan. The specific initiatives proposed are a) Extending our award winning **Social Prescribing service** b) **'Making Every Contact Count'** through training of front-line staff on brief interventions around smoking-cessation, alcohol-consumption, healthy diets and physical activity; ensuring quick and easy referral to evidence based lifestyle services for those that are ready

2. Rolling out our integrated locality model – 'The Village' pilot

- Our pilot 'The Village' is in Rotherham's town centre. It covers 31,000 patients in 1 of our 7 localities. It showcases joint commissioning arrangements that drive the integration of services and promotes multidisciplinary working between primary care, secondary care, social care, mental health, community services and the voluntary sector, reducing reliance on the acute sector.
- We will be rolling out this model throughout our 6 other localities.

3. Opening an integrated Urgent and Emergency Care Centre

- To be completed in Spring 2017 and opening by July 2017, this will be Rotherham's 24/7 single point of access and triage for urgent cases. An innovative multidisciplinary approach will reduce waiting times, support patient flow through the hospital and improve patient experience. It is expected to reduce emergency admissions saving £30m over 10 years.
- In addition our Adult Mental Health Liaison service and transformation of our care home sector will help keep people out of hospital.

4. Further Development of a 24/7 Care Coordination Centre

- This single point of contact for professionals and patients to call for advice on the most appropriate level of care/ most appropriate pathway has been in place for 18 months (currently receiving 4000 calls a month, 24/7)
- We will be expanding it to include mental health and social care.
- The purpose is to manage system capacity, carry out initial assessment and deploy appropriate teams to provide support, avoid potential hospital admissions and ensure people are in the most appropriate care setting.

5. Building a Specialist Re-ablement Centre

- We will colocate and integrate community rehabilitation services, residential intermediate care (step up and step down) and the current discharge to assess beds into a single site. This will enable Rotherham people to access a range of services while remaining in the community. It will also be more cost-efficient through better deployment of professionals and teams and supporting integrated multi-disciplinary way of working.

These initiatives, supported by our locally agreed Better Care Fund¹³, provide a real opportunity to improve the lives of the Rotherham population and some of the most vulnerable people in our society- giving them control, placing them at the centre of their own care and support, and in doing so, providing them with a better service and better quality of life.

Our approach to transformation is based on a multi-agency strategy of **prevention** and early intervention and **integration** of health and social care services. We also recognise the importance of addressing the **wider determinants of health**. Economic growth and getting people into employment remains a priority for the Borough. The links between poverty and ill health are well established and the pace of improvement in health is likely to be threatened if unemployment remains high or employment opportunities are low paid

¹³ Rotherham Better Care Fund Plan. Available online: <http://www.rotherhamccg.nhs.uk/better-care-fund.htm>

or insecure. The emphasis on narrowing inequalities, targeting resources towards areas of greatest need and poverty reduction are focuses for the Joint Health and Well-being Strategy. The quality of housing also has a direct impact on our health and wellbeing. Rotherham is aiming to build future proof housing and develop:

- Different housing solutions for people with long-term conditions
- Community environments where being healthy is the easy choice, e.g. healthy food in schools and in staff canteens.
- More extra-care facilities¹⁴- there are 2,460 in-house and 370 independently provided sheltered housing units and 236 accommodation based support units for older people. Generally all the schemes run at full capacity. It is anticipated that demand may reduce in the future as more people are supported to remain at home, but it is possible that capacity will be filled with people who would otherwise have been placed in residential care.

The remainder of this section describes our five priorities and their associated initiatives in more detail.

4.1 Prevention, self-management, education and early intervention

We want health and care to be managed long before someone needs to have hospital treatment or experiences problems in their life. We want to do this in a way that is right for them, whether this is through providing information and advice, or through more active management. The diagram below presents Rotherham's wider prevention and early intervention programme of work, organised by the scale of coverage of the interventions. It also highlights the initiatives this Place Plan focuses on as part of our priorities.

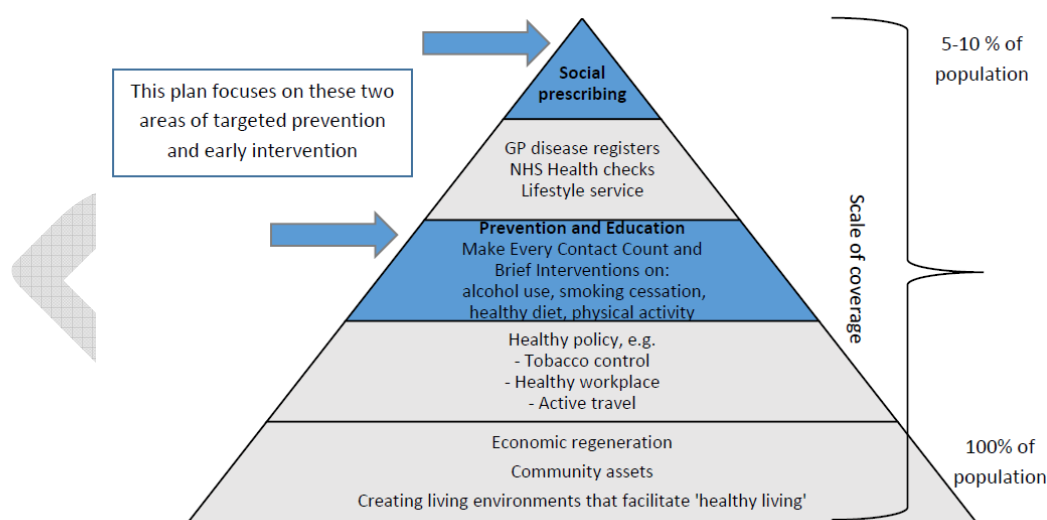


Figure 4 Rotherham's wider prevention and intervention programme

We will better meet the needs of local people by targeting individuals that can gain most benefit through:

- Expanding our award-winning **Social Prescribing** service both for those at risk of hospitalisation and for mental health clients.
- Expanding systematic use of **Healthy Conversations** (brief interventions) and advice by ensuring every statutory organisation signs up to **Making Every Contact Count** (MECC) and by training front-line staff to talk about sensitive issues such as alcohol use, healthy eating habits, increasing

¹⁴ Property that can be purchased or rented, usually in the form of a self-contained flat, apartment or bungalow, where people can be looked after by support and / or care staff

physical activity and quitting smoking. We will also ensure quick and easy referral to evidence based lifestyle services (e.g. smoking cessation) to support those that are ready to change and in a way that is right for them.

These initiatives will increase capacity across the health and social care system, allowing us to better support individuals to make positive, sustained lifestyle changes by adopting a person-centred and a whole community approach to improving health and well-being. We discuss these initiatives in the remainder of this section.

4.1.1 Social prescribing

Our national award winning Social Prescribing service was highlighted in the *Five Year Forward View* as exceptional practice, saving money and improving outcomes. There are two aspects to this service:

1. **Targeting people at risk of hospitalisation.** We already target the top 5% of people at risk of hospitalisation using admission risk stratification and GP judgement and we intend to expand this to target the top 10% at risk people as our patient level evaluation¹⁵ has shown this cohort will benefit from the service.
2. **Extend our social prescribing service to cover mental health clients.** This is a model of partnership working between primary care and the voluntary sector. We have piloted this approach for almost two years and the initial findings are positive¹⁶. Mental health clients could be part of the targeted 10% of people at risk of hospitalisation.

Figure 5 How Social Prescribing for those suffering mental health problems can make a difference to someone's life

Without social prescribing	With Social Prescribing
Helen gave birth to a severely disabled daughter at the age of 16. She cared for her 24/7 for 20 years until she had no choice but to put her in to care.	Helen gave birth to a severely disabled daughter at the age of 16. She cared for her 24/7 for 20 years until she had no choice but to put her in to care.
Having struggled with her mood throughout – this decision plunged her further in to despair.	Having struggled with her mood throughout – this decision plunged her further in to despair.
For years she has taken multiple medications. Her house has been repossessed because her husband is a gambling addict. Her self-esteem is non-existent and she is overwhelmed by guilt.	For years she has taken multiple medications. Her house has been repossessed because her husband is a gambling addict. Her self-esteem is non-existent and she is overwhelmed by guilt.
Helen goes to the GP to fill her prescriptions. She spends a couple of months sleeping on friends' sofas but eventually she finds herself homeless and alone. She doesn't know who she can go to for help. After some time braving the cold, a chest infection deteriorates into pneumonia and she goes to ED.	Helen goes to the GP to fill her prescriptions and the GP persuades her that it is time to invest in herself. Helen reluctantly accepts the referral and attends 'Radiance and Relaxation' groups organised by a volunteer organisation. "I was terrified about going back on my own – but I had loved it, so I had to go. There are steps up to the building, by the time I got to the top I was so anxious that I couldn't feel my legs - but I did it, and I've kept going "
	Helen got her confidence back, found a job and was able to afford a place for herself again.

¹⁵ Centre for Regional Economic and Social Research, Sheffield Hallam University. *Evaluation of the Rotherham Mental Health Social Prescribing Pilot*. August 2016 draft. Available upon request.

¹⁶ Centre for Regional Economic and Social Research, Sheffield Hallam University. *Evaluation of the Rotherham Mental Health Social Prescribing Pilot*. August 2016 draft. Available upon request.

4.1.2 Making Every Contact Count (MECC) and Healthy Conversations

We want to make every contact count, maximising opportunities to create positive change by encouraging small, sustained, lifestyle changes to improve outcomes. The MECC approach empowers front-line staff to recognise the role they have in promoting healthy lifestyles, supporting behaviour change and contributing to reducing the risk of chronic disease. This will involve initiating undertaking simple brief intervention or *healthy conversations* with a person as part of a routine appointment or consultation, and where appropriate, signposting them to sources of further information and to local services. We will ensure quick and easy referral to evidence based lifestyle support services (e.g. smoking cessation) for those that are ready to change and in a way that is right for them.

Part of our MECC approach is considering the health and wellbeing of our staff. We will promote healthy working environments and ensure organisations sign up to the Workplace Wellbeing Charter¹⁷.

There is a very large body of research evidence supporting Brief Interventions in primary care including at least 56 controlled trials^{18 19}. For every eight people who receive simple alcohol advice, one will reduce their drinking to within lower-risk levels²⁰. This compares favourably with smoking where only one in twenty will act on the advice given²¹. This improves to one in ten with nicotine replacement therapy. The following table summarises evidence from NICE (2014), showing brief interventions can be effective for reducing alcohol consumption, increasing physical activity, reducing diabetes risk and aiding smoking cessation attempts.

Brief intervention	Evidence from NICE 2014 ²²
Alcohol	The most effective interventions for reducing alcohol consumption in adults and vulnerable young people appear to be brief counselling interventions and extended brief interventions. For people classed as problem drinkers there is evidence from multiple systematic reviews supporting the effectiveness of brief interventions delivered in primary care with a range of underlying behavioural change components.
Physical activity and healthy diet	Brief interventions in primary care can be effective in producing moderate increases in physical activity in middle aged and older populations in the short term (6–12 weeks), longer term (more than 12 weeks) or very long term (more than 1 year). For the effect to be sustained at 1 year, the evidence suggested that several follow-up sessions over a period of 3–6 months are needed after the initial consultation episode. There is evidence that lifestyle interventions combining physical activity and diet are more effective at reducing diabetes risk than those of diet or physical activity alone based on a meta-analysis of 12 RCTs.
Smoking	Strong evidence from 7 trials suggests that multi-session smoking interventions can be effective at aiding cessation attempts among smokers who are motivated to quit or report intending to quit within 6 months.

¹⁷ <http://www.wellbeingcharter.org.uk/index.php>

¹⁸ Moyer, A., Finney, J., Swearingen, C. and Vergun, P. (2002) Brief Interventions for alcohol problems: a meta-analytic review of controlled investigations in treatment -seeking and non-treatment seeking populations. *Addiction*, 97, 279-292. Abstract available at <http://www.ncbi.nlm.nih.gov/pubmed/11964101>

¹⁹ Kaner et al., 2007

²⁰ Moyer, A., Finney, J., Swearingen, C. and Vergun, P. (2002) Brief Interventions for alcohol problems: a meta-analytic review of controlled investigations in treatment -seeking and non-treatment seeking populations. *Addiction*, 97, 279-292. Abstract available at <http://www.ncbi.nlm.nih.gov/pubmed/11964101>

²¹ Silagy, C. and Stead, L.F. (2003) Physician advice for smoking cessation (Cochrane Review). Most recent version of this review (2013) available at <http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD000165.pub4/full>

²² <https://www.nice.org.uk/guidance/ph49/evidence/evidence-statements-69192109>

Making Every Contact Count and Referral to Lifestyle Service

Robert was referred to a Health Trainer in April 2015 as he wasn't happy with his weight and current lifestyle. He felt that he was lacking in confidence and had little motivation to do anything. Robert was very unhappy, did not feel very positive or see himself in a good light. He has high blood pressure and takes medications to manage it.

At first Robert found the idea of setting goals quite daunting, but over the next few weeks Joe (Health Trainer) worked with Robert on helping him to set small realistic goals that would, over time, help him to achieve his bigger goals. Together they looked at better portion control, healthier food choices and increasing physical activity. Robert joined a local exercise class and is now walking more than he ever thought he could. He has started growing his own fruit and veg in a small plot that he and his partner have built in their back garden and now shares the knowledge he has acquired by passing on tips to help his family and friends. Although Robert found things difficult at first, he now feels that he has adjusted to his new lifestyle and feels much more positive about himself. Family and friends have all noticed the positive changes in Robert and his levels of self-confidence are much higher. He has lost 31lbs over 13 weeks and his blood pressure has reduced. As a result, he has also been able to reduce the amount of blood pressure medication that he takes.

Our **volunteers and carers** will help us achieve our prevention priorities. Access to voluntary services can be prescribed as an alternative to a traditional medical response and given the size of our volunteer services base, we have ample opportunity to expand our offering of social prescribing services.

Rotherham has a strong and vibrant voluntary, community and social enterprise sector. There are approximately 1,382 Voluntary and Community Groups in Rotherham of varying sizes and supporting a range of activity – over 55% of which are directly involved in health, welfare and social care²³. Volunteers and carers are a core part of Rotherham's social and economic offer and an important component of this Plan. In many instances impartial voluntary sector organisations can have more positive impact on encouraging and delivering behaviour change messages to support residents to self-manage than statutory partners. Further, this often offers better value for money. Voluntary Action Rotherham (VAR) have developed a public on line 'platform' for voluntary, community groups (VCS) and social enterprises in Rotherham. Rotherham GISMO (**Group Information Services Maintained Online**) is unique, in that it is the single, most comprehensive and largest directory of VCS groups and organisations publicly available and easily accessible. 700 groups are members of GISMO. VAR aims to further develop the directory of groups on the Rotherham GISMO website. The aim is to make it more detailed, interactive and more widely used by groups, the general public and support staff in partner agencies. The particular focus will be on promoting self-management and prevention, linked to the wider community assets and social prescribing agendas.

VAR also run a **Community Health Champions** scheme supported by volunteer health ambassadors who spread the 'Right Care Right Time' message, use of Pharmacy First and Prescription Waste Management. This approach has effectively targeted communities where there has been a high incidence of attendance to A&E and we are seeking to further develop the model and expand it into other deprived communities in Rotherham.

²³ Rotherham State of the Sector of the Voluntary and Community Sector 2015, Rotherham Social Prescribing Service for People with Long Term Conditions Jan 2016 both by Sheffield Hallam University Centre for Regional Economic & Social Research

4.2 Roll out our integrated locality model – ‘The Village’ pilot

Why develop an integrated team?

- The capacity at Rotherham Hospital is frequently close to full
- People prefer care at home and we know being at home is better for our wellbeing
- Health and Social Care teams deliver excellent care, but often this is poorly coordinated with others. This can lead to ‘silo working’, which does not benefit the client.
- There is frequent duplication of information gathering from the client. This is especially so when different teams initially assess client need, often asking the same type of questions.
- Funding is struggling to maintain resources in order to meet growing demand.

The integrated locality model is in its third year of development and ‘The Village’ pilot was established in July 2016 to develop and test the model’s concept of a multi-professional team delivering health and social care to a General Practice population in a single, seamless pathway. It is located in Rotherham’s town centre and covers 31,000 people in one of our seven localities.

The team aims to provide seamless care to the designated General Practice cluster population (using the same GP register list), ensuring the client receives coordinated care from a single case management plan and lead professional. Resources are pooled from the Rotherham NHS Foundation Trust, Rotherham Borough Council and others to deliver quality care closer to people's homes. The integration of care is supported through the alignment of resources, single line management arrangements, and the sharing of information for a designated practice population through an innovative, secure technology portal. The model will overtime move towards including closer alignment with the care homes within the locality and the co-location of other support services, all around a common vision and purpose: a more efficient and effective way of working, with reduced duplication of assessments and avoidance of multiple referrals leading to individuals being transferred between services. The approach allows the team to be more proactive and less reactive in caring for the population and by working with individuals, families and communities we aim to reduce dependence, promote self-management and increase overall systems resilience. The majority of the population who are benefiting are older people and as such are the pilot’s initial focus. However, younger people, children and families are also expected to benefit from the integrated approach. The difference in approach to care is shown schematically below:

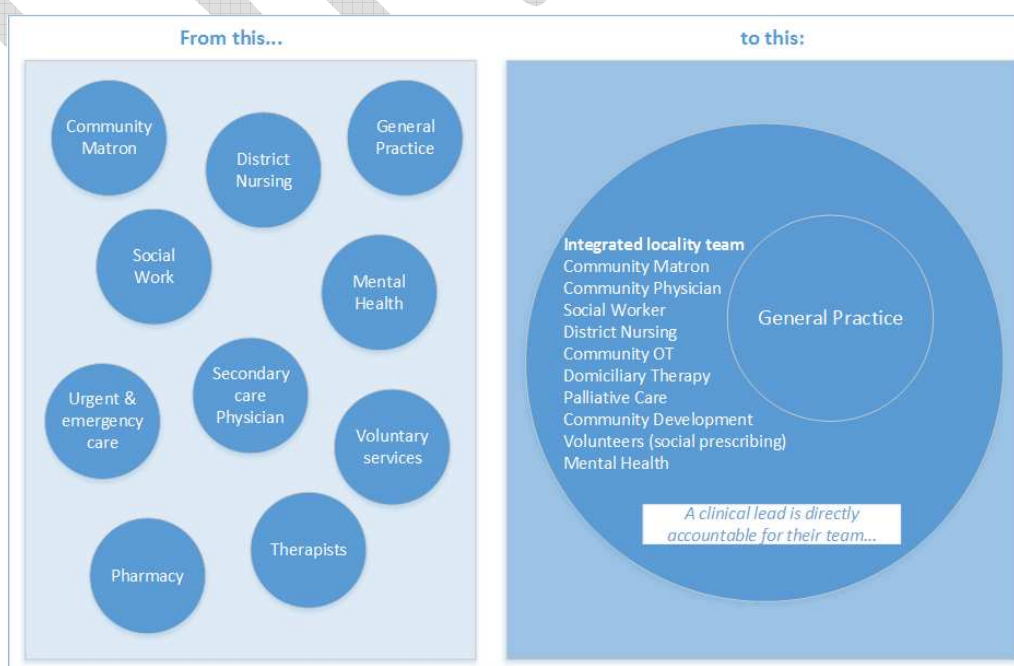


Figure 6 From fragmentation to integration

A key component of the model is the interface between secondary and primary care with hospital and community physician's being able to manage and run advanced virtual wards (and deploying interactive virtual ward rounds), enabling people to stay closer to home, in the community.

We are planning on rolling out the model to all seven localities taking into account any lessons learned from the ongoing evaluation (with the pilot due to conclude in July 2017). Joint care planning and support will address both the psychological and physical needs of the individual, recognising the huge overlap between mental and physical well-being. Service integration therefore becomes a vehicle to deliver "parity of esteem". The team also seeks to incorporate other key players in the community: South York Police, South Yorkshire Fire and Rescue Service and Yorkshire Ambulance Service to supplement the care provided.

Locality teams will also champion and support the Making Every Contact Count (MECC) approach as a part of their daily delivery of care.

Case study on integrated locality model

Grant has severe depression and diabetes. His GP referred him to a social worker specialising in mental health and to a district nurse who helped him to better understand and manage his diabetes. They both met with Grant together and drew up a care plan. The GP also has access to this same care plan. Through the social worker, Graham was referred to talking therapy and put in touch with a peer support worker. This has helped him regain his hope for the future.

The partners are committed to working together to achieve the following objectives²⁴ for the whole of Rotherham:

1. An integrated health and social care delivery system which promotes joint working
2. An integrated commissioning framework with joint outcomes and service specifications
3. More care and support provided in people's homes
4. Integrated care planning that addresses physical and psychological wellbeing
5. Individuals and families taking more control of their health and care
6. Accurate identification and active case management of people at high risk of admission
7. Broader use of new technology to support care at home
8. A financially sustainable model that targets resources where there is greatest impact
9. Prevention, self-care and empowering citizens, communities and frontline staff will be at the heart of everything we do.

4.2.1 Transformation of the care home sector

An important part of our new integrated locality model of care and of ensuring there are appropriate care solutions in the community, is the transformation of our care home sector. Approximately 15% to 18% of emergency admissions into the hospital are from care homes and the length of stay for these people tends to be higher than for average admissions. Most people want to be cared for in their own homes and we know that this is best for their wellbeing. Partnership with the care home sector is therefore critical to reducing demand for acute services. Our aim is for:

- Fewer admissions from care homes into hospital
- Patient length of stay to be more proactively managed through technology (e.g. automated systems from providers to case management systems to alert on bed availability)
- Less people to be automatically placed in care homes when they could stay in their own home and be supported within their community

²⁴ Aligned with the outcomes set out in Rotherham's Health and Well Being and Rotherham CCG's Commissioning Plan.

To help us achieve this, we will further develop our **care home liaison service** linking medical staff into care homes and also linking in with mental health liaison services (described in Section 4.3.1 below) and with the integrated locality team. Currently physiotherapy assessment is carried out in the hospital ward and then another one upon admission to the intermediate care beds. We plan to introduce a 'Trusted Assessor' model to streamline the assessment - with one person/team appointed to undertake health and social care assessments on behalf of multiple teams, using agreed criteria and protocols.

We are also aware that a number of care home staff remain uncomfortable in managing a care home resident who is frail and experiencing deterioration in their health due to an infection or dehydration. Whilst advance care plans can help inform decision-making, there is an important need to upskill staff in this sector with the assessment and practical skills to manage residents with higher acuity medical problems. We would like to develop a syllabus to help **upskill staff in some of our care homes** and for them to develop a subspecialty interest in higher acuity patients in order to reduce transfers to different levels of care and also to facilitate earlier discharge from hospital. One option being considered is to increase opportunities for care home staff to work within the hospital and develop the necessary skills to take back within the care home setting.

4.3 Urgent and Emergency Care Centre



Figure 7 Front of Urgent and Emergency Care Centre (at the front of the hospital)

The pressures that our health and social care system are facing are greater than elsewhere in the country – we are not only growing in numbers (3.5%); our older population, particularly those 85+ will see significant growth (40%) by 2025. The resulting changes in size and complexity means that despite our Hospital performing better than most²⁵, there are still opportunities to *manage growth* in emergency admissions to hospital and to *reduce growth* in hospital attendances and admissions.

Attendances to ED and onward admission into hospital continue to grow year on year. Admission rates from ED, whilst below the national average, can vary and sometimes be linked to the seniority of the clinician within the department at the time. Analysis undertaken shows we could potentially avoid 1,800 admissions per year through more consistent senior clinical review, which would also improve outcomes

²⁵ Right Care Analysis. Available online: <https://www.england.nhs.uk/wp-content/uploads/2016/03/rotherham-ccg-cfv.pdf>

for patients. The alternative, is that if we do nothing to mitigate the rising demand for urgent and emergency care, we estimate £11m additional expenditure would be required in 10 years²⁶.

We therefore have ambitious plans to contain growth in emergency admissions and assessments and the new Urgent and Emergency Care Centre is one of our primary initiatives to tackle this challenge. The Centre will be fully operational by Summer 2017 and will ensure improved co-ordination and delivery of urgent care provision across Rotherham by creating a single point of access and triage for patients.

The Centre will house a team of specialists 24/7 so patients can be seen straight away by the right support. The aim is for patients to be assessed and possibly treated as early as possible and we will pioneer an innovative 'next available clinician staffing model' which integrates GPs, ED consultants and highly trained nurses. This will also reduce reliance on middle grade medical staff, for which there is anticipated to be an ongoing national shortage. It will also accommodate social workers, mental health teams and care coordination teams. The diagram below illustrates the key aspects of the Centre's innovative model:

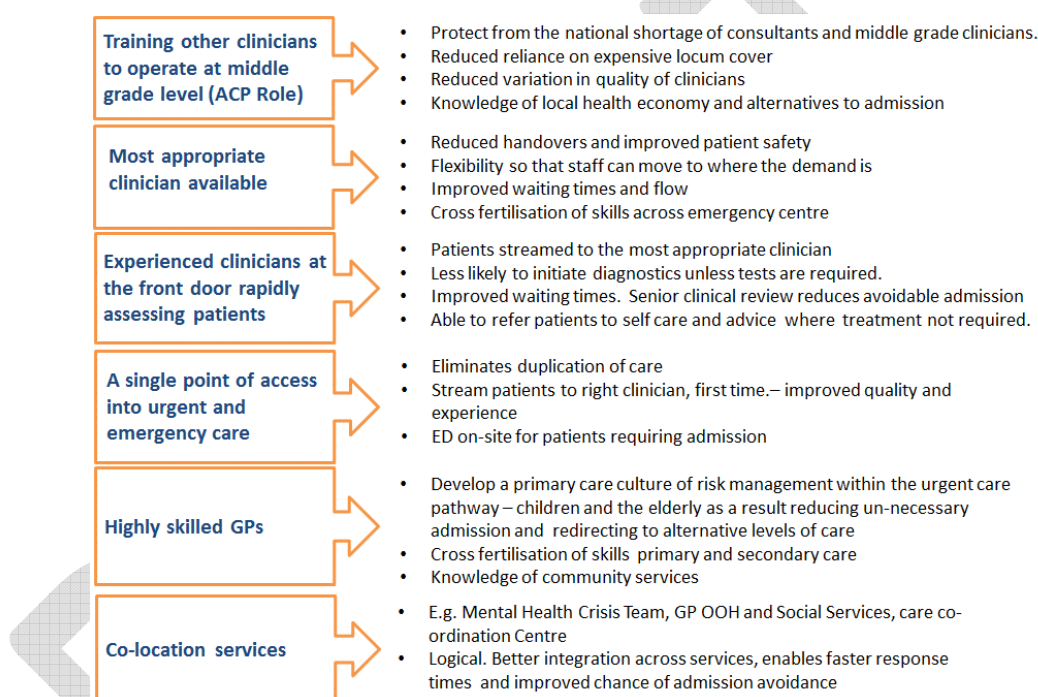


Figure 8 Key Aspects of our Urgent and Emergency Care Centre Model

4.3.1 Expanding access to the Adult Mental Health Liaison Service

Physical and mental health are inextricably intertwined. Long-term conditions (LTCs), such as diabetes, are associated with high rates of mental illness. Some 70% of NHS spend goes on the treatment of LTCs, a great deal of which currently involves treatment in acute hospitals²⁷. To optimise the physical health care of patients, it is essential that their mental health and wellbeing are addressed at the same time. Guidance for Commissioners is that liaison services should be provided throughout the acute hospital, including in A&E departments; and that a liaison service should be an integral part of the services provided by acute hospital trusts, as trusts that have incorporated a liaison service have demonstrated much better cost effectiveness.

²⁶ NHS Rotherham CCG, The Rotherham NHS Foundation Trust, Care. *Business Case for Emergency Centre: Right Care, First Time*. 2015. Available upon request.

²⁷ Joint Commissioning Panel for Mental Health (2013) *Guidance for Commissioners of Liaison Mental Health Services to Acute Hospitals*. <http://www.jcpmh.info/wp-content/uploads/jcpmh-liaison-guide.pdf>

As part of our wider Mental Health services transformation plan, we launched the Rotherham Mental Health Liaison Service (April 2015) to provide round the clock mental health care (assessment, treatment and management) to patients who attend Rotherham Hospital. The two year pilot is currently being externally evaluated by Sheffield Hallam University who are due to report in Autumn 2016. This is part of the CCG's plan to move toward the national 2020/21 expectation that local acute hospitals should meet or aim for the 'Core 24' standards for mental health liaison as a minimum.

Case study on adult mental health liaison service

Agnes is an 80 year old retired accountant. She has been a widow for 13 years and lives with one of her six adult grandchildren. One day, her daughter finds her on the floor at home and calls an ambulance.

A&E treat Agnes for opiate overdose. The mental health liaison team assesses her and finds that although she is in relatively good health, she has some chronic pain issues that have not been addressed and she also admits to feeling increasingly low in mood, eventually leading to her overdose. She is afraid of losing her independence and being a burden on her family.

The team provide her with support while she's in the ward. They discuss her feelings and concerns and a psychiatrist prescribes her medication for her depression and anxiety. Agnes and the team agree a care plan and she is able to return home that same day. She and her family know that she will be followed up at home by community staff who will provide on-going risk assessment and care planning.

Agnes feels 'listened to' and further admission to mental health inpatient facility or a longer stay in hospital is avoided.

Working with partners from across Rotherham the service has also developed:

- A new adult mental health emergency centre pathway as part of the CCG's Urgent Care Programme of work.
- Close working partnerships with both the Acute Hospital Lead Alcohol Liaison service and the new implemented Children and Adolescent Mental Health Services (CAMHS) Liaison service based in the acute hospital.

We aim to expand access to this service to improve the outcomes and experience of people experiencing a mental health crisis and to achieve the following benefits:

- improved access to mental health care for a population with high morbidity
- reduced emergency department waiting times for people with mental illness
- reduced admissions, re-admissions and lengths of stay
- reduced use of acute beds by patients with dementia
- reduced risk of adverse events
- enhanced knowledge and skills of acute hospital clinicians
- improved compliance of acute trusts with legal requirements under the Mental Health Act (2007) and Mental Capacity Act (2005)

4.4 Development of Rotherham 24/7 Care Coordination Centre (CCC)

The CCC has been in place for 18 months and currently takes 4000 calls a month, 24/7. Its aim is to act as a central point of access for health professionals and people into community and hospital based urgent care services. Our aim is to expand the scope of the CCC to include mental health, voluntary and social care sector services, improving access through a comprehensive directory of services, driving efficiency and cutting down waste.

Through managing system capacity, carrying out an initial assessment (currently done by specially trained senior nurses but in future this might be by other professionals) on the most appropriate level of care

needed, and deploying the right teams (e.g. integrated rapid response team), the CCC has assisted in meeting targets for emergency admissions, reducing the number of avoidable admissions and ensuring full and appropriate utilisation of community services²⁸. It also relieves pressure on GPs by streamlining the referral process into urgent care services and ensuring that GPs are able to make informed choices about the most appropriate level of care for people. The CCC is crucial to The Rotherham Foundation Trust (TRFT) vision of developing a whole system integrated service approach where people receive the appropriate care at the appropriate time in the appropriate place provided by the appropriate professional.

Over the next two or three years we expect our CCC to allow our health and social care services to:

- Develop information sharing among all health and social care professionals to quickly identify individuals at risk and where a needs assessment can be made
- Develop and maintain a register of patients who are medically fit for discharge and ensure that they are placed on the correct care pathway
- In addition to being the single point of access for community nursing referrals, the CCC will also start to support GPs in the case management of people with long term conditions

New technology will also be deployed which will provide access to single care records and also allow the CCC to see people in the various care settings throughout the health and social care community. The CCC will also help support the integrated locality teams in providing advice and support around pathways and to also act as a trigger when people from the locality (case managed by the locality team) access hospital services.

4.5 Building a Specialist Re-ablement Centre

We want to develop a more integrated approach to the provision of intermediate care services for those patients who cannot be treated at home, but who do not need to be treated in a hospital setting. Our aspiration is to locate all rehabilitation services on a single, co-located, non-acute setting to create an environment that support integrated working, with a combination of health and social care professionals working as part of a multi-disciplinary team.



This ambitious transformation of services will support our joint priorities of promoting independence, prevention of avoidable hospital admission and discharges. Building the right capacity and capability for an integrated intermediate care service is a key element in driving this forward. A fully integrated team of health and social care professionals will provide a mix of community rehabilitation services, residential intermediate care (with a focus on stepping down), and the current discharge to assess beds for people living in the community, and for people leaving a hospital setting. This model will allow Rotherham people to remain in their community longer than would otherwise be possible.

We anticipate the Re-ablement Centre will deliver quality and drive efficiencies through creating economies of scale, a single point of access, shorter travel times, reduced duplication and lower running costs. We recognise there is a limited evidence based and for this reason we are building a robust performance framework and audits which will allow us to monitor the success of this initiative. We will allow enough flexibility so we can respond promptly to any changes required.

²⁸ London School of Economics. Economic Evaluation of Liaison Psychiatry Services. Available online: <http://www.bsmhft.nhs.uk/our-services/urgent-care/rapid-assessment-interface-and-discharge-raid/lse-report-on-raid/>

“Re-ablement is one of council’s main tools in managing the costs of service provision for an ageing population and has proved an important area where joint integration commissioning can make savings, when faced with the necessity of streamlining budgets” – *Plymouth Pilot Review*

To enhance our current provision we will work in partnership with an independent provider to deliver the capital solution, considering the most advantageous geographical location to meet local need, whilst offering opportunities for joint provision across the wider STP footprint.

5 Enablers

This section outlines the enablers that will support our five priority initiatives.

5.1 Accountable Care

We view ourselves as collectively accountable for the health and wellbeing of our population and consider this plan to be our framework for jointly providing Acute, Community and Emergency Primary Care Services. Our new governance arrangement (Section 5.6) enables us to become an accountable care system. We will be considering options for exploring moving towards an Accountable Care Organisation arrangement.

5.2 One public estate approach

One public estate partnerships across the country have shown the value of working together across the public sector and taking a strategic approach to asset management. At its heart, the programme is about getting more from our collective assets – whether that’s catalysing major service transformation such as health and social care integration and benefits reform, unlocking land for new homes and commercial space, or creating new opportunities to save on running costs or generate income.

This is encompassed in four core objectives²⁹:

1. creating economic growth (new homes and jobs)
2. more integrated, customer-focused services
3. generating capital receipts
4. reducing running costs.

In alignment with these national programme objectives, we aim to:

- Adopt a ‘common sense’ sharing of Rotherham’s resources.
- Use our public buildings more efficiently
- Site services in locations which make them easier to access
- Release surplus sites to support growth or for community care

There are emerging opportunities arising from closer linkages with the Sheffield City Region, including the Joint Assets Board which is leading on the One Public Estate approach on behalf of public sector partners locally. This alignment could include access to revenue funding (£0.5m) to support the realisation of ambitious plans and focus on a transformational asset based approach. Rotherham is conducting a review of estate across health and social care, and RMBC is also leading a wider review across the Sheffield City Region ensures that the most efficient use is made of the public estate and that surplus sites are released to support growth.

²⁹ Cabinet Office and Local Government Association. One Public Estate Invitation to Apply (April 2016)
http://www.local.gov.uk/documents/10180/7632544/L16-57+OPE+Phase+4+prospectus_v05.pdf/1bdec934-9819-425d-8ff3-01c22c5f4e97

5.3 Asset-based approach

The diagram below illustrates that by ‘assets’ we mean more than just buildings.

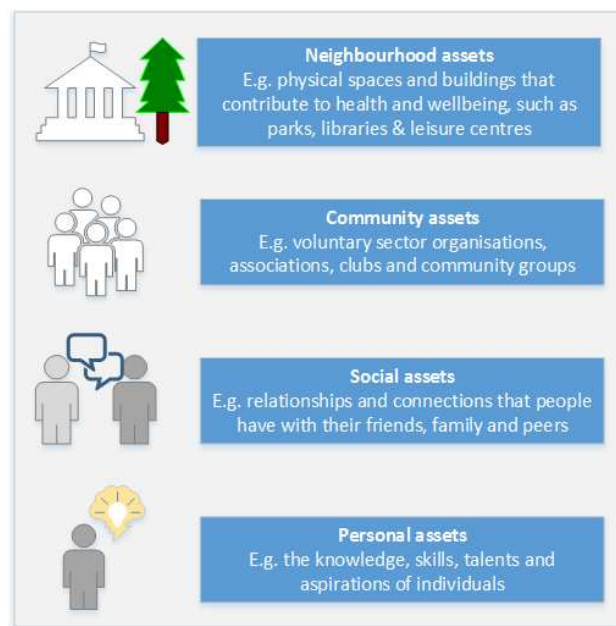


Figure 9 What do we mean by assets?

We recognise the crucial role that individuals, families and our communities can play in helping us improve our health and wellbeing. The diagram below summarises how we see this working in practice:



Figure 10 Our asset-based approach (based on Greater Manchester Public Health Network/ Innovation Unit)

This approach embeds an owned culture of wellbeing and prevention across communities as well as within statutory services in addition to shifting demand with clear fiscal benefits. An evidence base to inform a more detailed investable proposition for Rotherham linked to wider asset based approaches will need to be developed. For now, we provide evidence from Wigan Council in section 6.

5.4 Integrated IT

Linking up Health, Social Care and Care Home records is a must do and we have already made good progress with over 5000 records being integrated through our *Better Care Fund Plan*, with the Rotherham

Clinical Portal connecting disparate health systems and the population of Social Care systems with NHS Numbers in preparation for further connectivity. Our model of one provider for Health IT has facilitated a coordinated approach.

We plan to further integrate systems by engaging suppliers to use national technical standards across Health and Social Care and using the Rotherham Clinical Portal as a secure “window” into organisational systems, and to support our self-care agenda, people will be able to view and add their own data and interact with Health and Social care professionals using modern technology. We are also planning to ensure we share and exchange information with other providers outside of Rotherham.

Integrated digital care records across Health, Social Care and Care Home requires significant multi-year investment to move organisational processes from traditional paper based systems to electronic systems with a robust shared infrastructure platform. This is estimated in section 6 below.

5.5 Emerging technology and the ‘internet of things’

We are exploring options for expanding the use of emerging technology to encourage and support people as part of their approach to self-management. Examples of this includes:

- Attainment of self-determined goals to be captured in smart phone apps, e.g. to walk 5,000 steps per day or to take a daily blood pressure reading would be reinforced through a strengths based approach from community health champions and social prescribing services. People would be encouraged to record their progress and to electronically feed information into a single contact point. The access point would collate real time data and this would assist in more detailed risk stratification exercises and in determining where to target future interventions.
- The ‘Internet of Things’ approach would be applied to support people within their home environment to promote positive behaviours to alleviate harm e.g. through the use of talking fridges to ensure people eat regularly, pill dispensers to prompt medication and door sensors to alert if people are leaving the property at unusual times. The internet link would enable predetermined automated scenario based access to professionals, family members or friends should the alerts not trigger the necessary behaviours, thereby preventing escalation and ultimately A&E admission.

5.6 Governance structure

<to be included>

DRAFT

6 Expected benefits and investment required

As a Health and Care Community we are committed to these initiatives over the next 5 years, but with the additional support of transformational funding at a local place level, we know that we can move further and faster to deliver the required transformation to support system sustainability. This section summarises the benefits we expect from our initiatives and an estimate of transformation funding we require for each. <Table to be updated with most recent financial analysis>

Initiative	Benefits	Investment required
1.Prevention & self management		
Making Every Contact Count and brief interventions	Prevent ill-health and moderate demand for healthcare: <ul style="list-style-type: none"> estimate 80% of heart disease, stroke and type 2 diabetes cases & 40% of cancer cases could be avoided if common lifestyle risk factors were eliminated 1:8 individuals will change their alcohol consumption behavior as a result of brief intervention and 1:20 individuals will change their smoking behavior as a result of brief intervention³⁰ Every 5,000 patients screened in primary care may prevent 67 A&E visits and 61 hospital admissions. Costs £25,000, Saves £90,000³¹ Every £1 spent smoking prevention programmes in schools can return as much as £15³² Every £1 spent on physical activity initiatives returned an estimated £23 in quality of life, reduced NHS use and other gains³³ Making Every Contact Count could show a return of £10 for each £1 spent and would be expected to save households and employers some £28 for each £1 spent, by reducing spending on cigarettes, alcohol and care and improving employment and income³⁴. 	£1.8m per annum
Social prescribing Increase target from 5% to 10% of people at risk of hospitalisation Expand service to cover mental health clients	Savings & improved outcomes from social prescribing targeting people at risk of hospital admission <ul style="list-style-type: none"> Evaluation shows system benefits of £1.98 for each £1 invested 	£1.1 million per annum £45k for VAR website offer, £25k for VAR Health Champions

³⁰ Identification and Brief Advice (IBA) - Provide more help to encourage people to drink less. Available online: <http://www.alcohollearningcentre.org.uk/Topics/Browse/HIC/IBA/>

³¹ PHE publications gateway number: 2013-190 <http://www.nta.nhs.uk/uploads/alcoholanddrugswhyinvest2015.pdf>

³² Making the case for Public Health interventions, Kings' Fund and LGA, 2014

³³ Making the case for Public Health interventions, Kings' Fund and LGA, 2014

³⁴ Making Every Contact Count: Value for Money, MECC Advisory Group

2. Integrated Locality Model		
	Improved patient outcomes Reduced utilisation of secondary services through proactive management of patients Reduction in non-elective bed days by 10,000 (estimated saving £1.5m per annum)	One off funding of £1.5m £1.25m per annum to trial new staffing models in primary care & to fund transformational support
Transformation of Care Homes		£0.6 funding would provide appropriate equipment and training to revitalise the care home sector to manage high acuity patients out of hospital ³⁵
3. Urgent & Emergency Care Centre		
Urgent and Emergency Care Centre	Investment would mean we can go further & faster in developing the model and help us realise system savings of £30m over 10 years ³⁶	New capital build and transformation investment of £0.45m
Adult Mental Health Liaison Service	The recent evaluation of the RAID service in Birmingham has provided compelling evidence of the cost effectiveness of an integrated liaison psychiatry service for people with dementia showing a return for investment of £4 for every £1 invested. ³⁷	
4. Care Coordination Centre		
	Formal evaluation shows at least £0.86m additional system wide efficiencies and also improve the efficiency, and further integrate health and social care services	Non recurrent infrastructure cost: £0.46m
5. Re-ablement Centre		
	Allow transition to new staffing and skill mix models of care Enhance clinical and caring environment Allow transition of long stay residents from existing provision into new care home provision Plymouth reviewed its Re-ablement Service in 2014 and found that it achieved the financial objectives stated in the Council's business case of £500k in savings in the first year of delivering these services.	£3m per annum

³⁵ Based on TRFT estimated based on current cost of a hospital bed versus benchmarked equivalent care beds in the independent sector.

³⁶ The Emergency Care Centre Business Case sets out the savings in non-elective admissions (pg 19) – the assumption is that by doing nothing, activity growth will be 3% per annum. Implementing the new emergency centre will save 5 admissions per day against the do nothing scenario.

³⁷ NHS Confederation (2011) With money in mind: the benefits of liaison psychiatry. London: NHS confederation.

NHS Confederation (2009). Healthy mind, healthy body: how liaison psychiatry services can transform quality and productivity in acute settings. London: NHS Confederation

Parsonage, M. and Fossey, M. (2011) Economic evaluation of a liaison psychiatry service. London: Centre for Mental Health.

It also estimated that the re-ablement of 528 service users reflects a possible saving of £3.8m (when compared to 12 months domiciliary care provision as an alternative)³⁸

Enablers		
One Public Estate Approach Asset Based Approach	This requires more scoping work to estimate The Wigan Council, through its <i>Wigan Deal</i> Programme ³⁹ has demonstrated that for every £1 invested in community assets generates benefits of £1.95 per person over a five year period	This requires more scoping work to estimate
Integrated IT	Potential cash and non-cash benefits would be circa £0.96m	Non-recurrent cost estimates suggest approx. £15m over 5 years to meet full regional digital STP aspirations with a further £0.4m in the next two years to further integrate the Rotherham Clinical portal between Health and Social care.
Emerging technology	This requires more scoping work to estimate	This requires more scoping work to estimate

6.1 Key Performance Indicators

We will measure our success by:

- A reduction in the number of unscheduled hospital attendances and admissions
- A reduction in the length of stay in an acute hospital setting for locality residents
- A reduction in the number of A&E attendances and hospital admissions from care homes
- A reduction in the length of stay in an acute hospital bed for care home residents
- A reduction in the number of residents requiring home care packages
- A reduction in the cost of providing home care packages
- A reduction in the number of patients requiring alternative levels of care (either on an intermediate or permanent basis)

³⁸ Human Support Group. *Reablement – Standing at the Junction of Health and Social Care*. Plymouth Review. (2014) Available online: <http://www.humansupportgroup.co.uk/wp-content/uploads/2015/10/Reablement-brochure.pdf>

³⁹ The Deal for the Future. Wigan Council 2020. <https://www.wigan.gov.uk/Docs/PDF/Council/Strategies-Plans-and-Policies/Corporate/Deal-for-future/The-plan.pdf>

7 Overview of implementation

Below we present a high level overview of our activity to 2020. We have included an asterisk (*) next to those activities that are particularly dependent on transformational funding.

<consider adding a column with the estimated required investment for some of these activities>

	FY 16/17				FY 17/18				FY 18/19				FY 19/20			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
1. Prevention, self-management, education & early intervention																
Social Prescribing																
Mental Health Social Prescribing 2 year pilot																
Evaluation of the Mental Health Social Prescribing pilot																
*Expand cover to mental health clients/ increase referrals to 2000 per year																
*Increase target from current 5% to 10% (patients at risk of hospitalisation)																
Making Every Contact Count and Healthy Conversations																
All key statutory organisations signed up to MECC																
*Frontline staff cohort trained																
Introduction of small grants process to pump prime VCS sector																
*Develop robust Community Health Champions Scheme																
2. Integrated locality model																
Implementation of the integrated locality team pilot																
Final evaluation of the pilot 'The Village'																
Roll out of the integrated locality teams across the Borough																
*Care home transformation (timeframes to be confirmed)																
3. 24/7 Care Coordination Centre																
Scoping and planning expansion to other health and social care services																
*Expansion to involve other Health and Social Care services																
Evaluation of upscaled service																
4. Urgent and Emergency Care Centre																
Redesigned structure of acute intake/ walk-in centre/ new workforce model																
Urgent and Emergency Care Centre IT Solution implemented																
Completion of the capital Build for the Emergency Care Centre																
Full implementation of the Emergency Centre Model																
Adult Mental Health Liaison																
External evaluation Adult Mental Health Liaison service pilot																
Determine future commissioning intentions for Adult Mental Health Liaison																
5. Re-ablement Centre																
*Full implementation of the Integrated Rapid Response service																
Review of the current intermediate care service model																
Undertake full review of acute and community respiratory pathways																
*Development of the re-ablement hub																

Health and Well Being Board 21 September 2016

Community Transformation – Progress Report

Lead Officers:	Dominic Blaydon:	Head of LTC and UC	Rotherham CCG
----------------	------------------	--------------------	---------------

Purpose:

The purpose of this paper is to provide a progress report on the Community Transformation Programme

Background:

The Community Transformation Programme was set up in 2013 to facilitate the transfer of care from hospital to the community. The priorities reflect many of those already identified in the Better Care Fund Plan. The programme is overseen by a multi-agency Transformation Board. This Board is focusing on the following key workstreams.

1 Integrated Health and Social Care Teams

Evidence suggests that integrated health and social care teams are likely to achieve better results than those that operate within strict organisational boundaries. The Kings Fund identifies some of the key characteristics of a successfully integrated team.

- Community-based multi-professional teams based potentially around practice populations
- A focus on intermediate care, case management and support to home-based care
- Joint care planning and co-ordinated assessments of care needs
- Named care coordinators who retain responsibility throughout the patient journey
- Clinical records that are shared across the multi-professional team.

The Community Transformation Programme is leading the development of a fully integrated health and social care team to support the Health Village. The team is now co-located and supporting people who are registered with the GP practice population. The team are about to introduce a single line management structure and joint service specification. The integrated health and social care team includes community nurses, a community matron, social workers and allied health professionals. It will have a single point of access for all referrals. As well as focusing on structure, the process of integration will include a programme of relational transformation aimed at enhancing interpersonal relationships and breaking down cultural/ organisational barriers.

The team will incorporate named care coordinators responsible for supporting people with complex needs. Rotherham FT is developing an IT portal that can be used for integrated care planning and provide visibility of the services that people are receiving. The team has a combined outcome framework which supports the strategic objectives of both the local authority and the CCG.

2. *A Reablement Hub Incorporating Intermediate Care*

With an ageing population, people living longer with more long term conditions and a significant efficiency challenge we want to develop a more integrated approach to the provision of intermediate care services. This ambitious transformation of services will support our joint priorities of promoting independence, prevention of avoidable hospital admission and delayed discharges. The aim is to support recovery in a non-acute setting, enabling people to achieve optimum levels of independence. Building the right capacity and capability for an integrated intermediate care service is a key element in driving this forward.

The Transformation Board is working across health and social care to develop a fully integrated intermediate care offer, with the right number of beds to meet demand, more flexible eligibility criteria, increased provision of services and more choice of housing. The intention is to build on our current intermediate service, offering support to remain at home without having to rely on statutory services.

The Transformation Board is working closely with the BCF programme to develop a business case that will focus on the following issues

- Identification of an appropriate site
- Description of the service model
- Timescales for development
- Financial requirements and potential for recurrent savings
- Eligibility criteria
- Outcomes and performance management framework

3. *A Multi-Disciplinary Integrated Rapid Response Service (IRR)*

Over the last year the Transformation Board has combined a range of community health teams which provide reactive health care interventions. The service incorporates the following legacy services:

- Care Home Support Advance Nurse Practitioners
- The Fast Response Service
- The District Nursing Twilight Service, Evening Service and Night Sister

The IRR service now supports patients who are medically for discharge, can be cared for at home but are waiting for the appropriate health or social care package to be assessed and put in place. It also supports patients who are at immediate risk of hospital admission. The service is accessed through the Care Coordination Centre. The main interventions carried out by the IRR service include;

- Rapid MDT assessment and care planning
- Nursing intervention , including IV therapy if capacity allows
- Falls risk assessment
- Intensive rehabilitation services, including physiotherapy, occupational therapy and reablement
- Respite care e.g. due to carer breakdown
- Co-ordinating alternative levels of care

In line with the BCF Plan, the Transformation Board is now working on extending the IRR Service so that it incorporates social care. If successful the new service will be able to support people with an urgent health and social care need. There will be a significantly stronger link between the out-of-hours social care services with additional enablement support.

4. *A Single Health and Social Care Plan for People with Long Term Conditions*

When done well, care planning can be effective in improving the quality of life of people with long term conditions. Over the next two decades, shifts in demographics and disease management will result in a greater proportion of people than ever before, living well into their eighth and ninth decades of life. The majority of these people will also be living with at least one long term condition. Ensuring their care is well managed over the long term, including the approach to the end of their lives, will become an increasing challenge for the CCG and the local authority.

One major barrier to supporting this cohort of is the fragmented approach to care planning. Health and social care still have separate systems for preparing care plans. Although communication and connectivity has improved between health and social care professionals, they are hampered by a requirement to have separate care plans.

The Transformation Board is developing integrated health and social care plans for people on the long term case management programme. Now that social care and health records can be matched using the NHS number there is an opportunity to develop single care records and care plans. Using integrated care planning we can avoid duplication and multiple monitoring regimes.

5. *A Joint Approach to Care Home Support*

There are presently around 1,800 older people living in residential and nursing care homes in Rotherham. The number of residents is predicted to increase to 2,100 by 2020. This figure includes those residents that are financially supported by the Local Authority, self-funders and out-of-authority placements. Around 400 older people are admitted to residential care each year with complex needs.

Rotherham has a Care Home Support Service, funded through the Better Care Fund. The main aims of the Care Home Support Service are to:

- Ensure that the appropriate quality of care is provided in our residential and nursing homes
- Reduce A&E referrals, ambulance journeys and hospital admissions from care homes
- Meet the mental health needs of residents (via agreed Mental Health pathways)
- Develop personalised care plans for residents at high risk of hospital admission
- Address health training needs of care home staff
- Ensure appropriate access to falls prevention services
- Promote healthy living initiatives

The Transformation Board has realigned the service specification so that residents at high risk of hospital admission are allocated a care co-ordinator from within the Care Home Support Service. The care co-ordinator combines advanced clinical nursing and therapy practice with the co-ordination of integrated care plans.

In line with the BCF Plan the Transformation Board will support residential and nursing homes in meeting the needs of residents with organic and functional mental health problems. The intention is to conduct an annual mental health assessment of all care homes. The assessment will identify residents with depression and dementia. We will monitor these residents, ensuring that they are sign-posted to appropriate health and adult social care services for support. We will identify residents who have memory problems and ensure that they are referred to the Rotherham Memory Service for a comprehensive dementia assessment.

6. A Shared Approach to Delayed Transfers of Care (DTC)

Within the Better Care Fund Policy Framework (2016/17) there are new National Conditions which all BCF programmes must action. One of these is the development of a Delayed Transfer of Care Action Plan and a locally agreed target for the reduction of DTCs.

The number of recorded Delayed Transfers of Care (DTC) from the December 2015 National DTC report shows that 2.2% of transfers were delayed. This is significantly lower than the national average of 3.5%. There has been significant progress in the last 12 months to support the reduction in DTCs within Rotherham.

The Transformation Board has recently endorsed a Memorandum of Understanding (MoU) between Rotherham Foundation Trust, Rotherham CCG and the Local Authority on hospital discharge which has now been signed up to by all providers. The MoU covers DTC and all other patients who are 'medically fit for discharge'. The main purpose of the MoU is to ensure that patients are discharged as soon as they are medically fit and that they have the appropriate care packages in place which reduces the risk of readmission

The next step for the Transformation Board is to develop robust risk sharing agreements relating to DTC as part of further development of the MoU. We will develop reporting systems which incorporate data on DTC and other patient cohorts who have an impact on patient flow. The Transformation Board will further develop the MoU so that it considers the following issues;

- Predicting times of discharge to enable effective community planning
- Interface with integrated rapid response
- Management of MDT's for patients who change wards during their acute stay
- Discharge arrangements for patients in Intermediate Care.

Relevance to The Health and Wellbeing Strategy

The Community Transformation priorities will support the aims and objectives of Rotherham's Health and Wellbeing Strategy. Table 1 shows how the Community Transformation priorities line up with those of the Health and Wellbeing Board.

Table 1: Relevance to Health and Wellbeing Strategy

HWB Aim	BCF Priority	Impact on HWB objectives
All Rotherham people enjoy the best possible mental health and wellbeing	Integrated health and social care Teams	<ul style="list-style-type: none"> • Improved support for people with enduring mental health needs, including dementia • Reduction in common mental health problems among adults • Reduction in social isolation
	Shared approach to delayed transfers of care (DTC)	
Healthy life expectancy is improved for all Rotherham people and the gap in life expectancy is reduced	Development of a reablement hub incorporating intermediate care	<ul style="list-style-type: none"> • Reduction in early death from cardiovascular disease and cancer • Improved support for people with long term health and
	A multi-disciplinary rapid response service	

	A single health and social care plan for people with long term Conditions	disability needs
	A joint approach to care home support	
Recommendations:		
<p>It is recommended that the Health and well Being Board;</p> <ul style="list-style-type: none">• Note the progress that has been made on community transformation• Support the programme of activity currently underway		

Summary Sheet

Council Report

Rotherham Local Safeguarding Children Board Annual Report 2015-2016

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

Not applicable

Strategic Director Approving Submission of the Report

Ian Thomas

Report Author(s)

Christine Cassell, Independent Chair of the LSCB (from November 2015).

Ward(s) Affected

All wards

Summary

Since April 2010, Local Safeguarding Children Boards (LSCBs) have been required to publish an annual report on the effectiveness of safeguarding children in the local area. This report introduces the 2015-16 Rotherham LSCB Annual Report and offers background information to it.

Recommendations

It is recommended that the HWBB:

1. ensures a focus on safeguarding children in its commissioning decisions,
2. supports LSCB priorities through the implementation of the Health and Wellbeing Strategy,
3. undertakes safeguarding impact assessments on major budget and organisational change,
4. reports back to the LSCB on the impact of its work in support of LSCB priorities.

List of Appendices Included

Rotherham Local Safeguarding Children Board Annual Report 2015 - 2016

Background Papers

None

Consideration by any other Council Committee, Scrutiny or Advisory Panel

The report will be considered by the RMBC Improving Lives Select Commission 21st September 2016.

Council Approval Required

No

Exempt from the Press and Public

No

Rotherham Local Safeguarding Children Board – Annual Report 2015-2016

1. Recommendations

It is recommended that the HWBB:

1. ensures a focus on safeguarding children in its commissioning decisions,
2. supports LSCB priorities through the implementation of the Health and Wellbeing Strategy,
3. undertakes safeguarding impact assessments on major budget and organisational change,
4. reports back to the LSCB on the impact of its work in support of LSCB priorities.

2. Background

The requirement for LSCBs to produce and publish an annual report on the effectiveness of safeguarding children in the local area is mandated in the Children Act 2004 (S14a) as amended by the Apprenticeships, Skills, Children and Learning Act 2009.

Under revised statutory guidance, *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children* (HM Government March 2015), the annual report:

- Should be published in relation to the preceding financial year and should fit with local agencies' planning, commissioning and budget cycles. The report should be submitted to the Chief Executive, Leader of the Council, the local police and crime commissioner and the Chair of the health and well-being board.
- It should provide a rigorous and transparent assessment of the performance and effectiveness of local services. It should identify areas of weakness, the causes of those weaknesses and the action being taken to address them as well as other proposals for action. The report should include lessons from reviews undertaken within the reporting period.

3. Key Issues

In 2015 -16 the LSCB, in response to the Ofsted Inspection in autumn 2014, received increased resources from key statutory partners. This has supported the development of a partnership Performance Management Framework and an increase in case audit activity. In combination with the work of the LSCBs Sub Groups and the Children's Improvement Board this has enabled a comprehensive overview of the effectiveness of the safeguarding system in the borough and enabled the LSCB to provide appropriate scrutiny and challenge to organisations and services for children and their families.

The LSCB publishes a biennial business plan, which outlines the agreed priorities of focus for the Board and its partners which guides the activity of the Board business unit and the Sub Groups of the LSCB.

Key priorities for 2016-18

Governance and accountability – There needs to be a clearer articulation and understanding of the responsibilities and relationship between the LSCB and the Health and Well Being Board, Children's Partnership, Children's Improvement Board and Community Safety Partnership. The LSCB needs to have defined priorities for focus of its work in the context of the work of other strategic partnership boards. The LSCB needs to have greater influence in terms of the priorities and planning for other partnership boards and partners need to hold each other to account much more in relation to safeguarding practice and issues.

Community engagement and the voice of children – The Board needs to do more in terms of engagement with local communities in relation to raising awareness and listening to their views. The voice of children needs to be taken into account more when evaluating safeguarding outcomes for children and young people. The council has declared its intention to be a child centred borough. The Board will test the evidence that the council and its partners are providing child centred services.

Scrutinising front-line practice – There needs to be continued, regular and effective monitoring of frontline practice including the use of thresholds and the impact of Early Help. Smarter opportunities need to be used for learning from practice and sharing the learning across the partnership.

Children in specific circumstances – Safeguarding of Looked After Children, Child Sexual Exploitation and Children who go Missing, and Neglect have been identified as priority areas of safeguarding where the LSCB needs to challenge and monitor progress.

Contact:

Christine Cassell,
Independent Chair, Rotherham LSCB
christine.cassell@rotherham.gov.uk

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

<http://modern.gov.rotherham.gov.uk/ieDocHome.aspx?Categories=>



Rotherham

Local Safeguarding Children Board

Annual Report

2015 - 2016

Table of Contents

1. Foreword by the Independent Chair.....	4
2. Local background and context	6
<i>Rotherham – demographic profile</i>	<i>6</i>
<i>What do children and young people think about living in Rotherham in 2015 –2016?</i>	<i>10</i>
3. The statutory role of Local Safeguarding Children Boards	11
4. Governance and accountability arrangements.....	13
<i>Local partnership and accountability arrangements</i>	<i>13</i>
<i>Financial arrangements</i>	<i>14</i>
5. Effectiveness of arrangements to keep children in Rotherham safe	16
<i>Early Help Services</i>	<i>16</i>
<i>Contacts and Referrals</i>	<i>16</i>
<i>Children’s Assessments</i>	<i>19</i>
<i>Section 47 Enquiries</i>	<i>20</i>
<i>Children in Need</i>	<i>21</i>
<i>Children on Child Protection Plans</i>	<i>22</i>
<i>Looked After Children</i>	<i>23</i>
<i>Looked After Children - Placement Stability.....</i>	<i>24</i>
<i>Looked After Children - Reviews and Visits.....</i>	<i>25</i>
<i>Looked After Children – Health & Dental Care.....</i>	<i>26</i>
<i>Children in specific circumstances.....</i>	<i>27</i>
<i>Child Sexual Exploitation</i>	<i>27</i>
<i>Domestic Abuse</i>	<i>29</i>
<i>Children missing from care or home</i>	<i>31</i>
6. Learning and Improvement	34
<i>Performance Management Framework.....</i>	<i>34</i>
<i>Quality Assurance, Audits and Case Reviews.....</i>	<i>35</i>
<i>Outcomes and impact of Audits and Case Reviews.....</i>	<i>37</i>
<i>Section 11 Audit for statutory agencies</i>	<i>39</i>
<i>Child Death Overview Panel.....</i>	<i>40</i>
<i>Multi-Agency Safeguarding Learning and Development</i>	<i>43</i>
<i>Safeguarding children policies and procedures</i>	<i>45</i>
7. Managing Allegations against staff, volunteers and foster carers.....	48
8. Conclusion and recommendations for future priorities	52

<i>Governance and accountability</i>	<i>52</i>
<i>Community engagement and the voice of children</i>	<i>52</i>
<i>Scrutinising front-line practice</i>	<i>52</i>
<i>Children in specific circumstances.....</i>	<i>52</i>
9. Appendices.....	53
<i>Appendix 1 – Board Member attendance 2015-16.....</i>	<i>53</i>
<i>Appendix 2 – Financial Statement 2015-16</i>	<i>54</i>
<i>Appendix 3: Glossary.....</i>	<i>55</i>
<i>Contact details</i>	<i>56</i>

1. Foreword by the Independent Chair

Welcome to the Rotherham Local Safeguarding Children's Board (RLSCB) Annual Report for 2015-16. I took over as Independent Chair in November 2015 and was therefore been in post for the last five months of the year covered by this report. Prior to that Stephen Ashley had chaired the Board until September 2015 and I would like to acknowledge his work in leading the Board during a very challenging period.

I would like to thank everyone across all agencies in Rotherham for the warm welcome and support I have received as independent chair. I have been impressed by the commitment to safeguarding children expressed by the leaders in the borough and by the energy directed towards improving safeguarding practice.

It is important to set the context for the year that this report covers. An Improvement Board was in place as a result of the direction to improve issued to Rotherham in October 2014. This was chaired by the Commissioner for Social Care, who worked with the Strategic Director for Children's Services in driving the necessary improvements. Following the Casey Report, commissioners had been appointed (February 2015) to take over the responsibilities of elected members across the council and as a consequence of these changes, most of Rotherham's boards and committees were reconstituted or ceased to exist. The Rotherham Local Safeguarding Children Board therefore needed to identify its role in relation to the Improvement Board and to build relationships and protocols with newly emerging structures. In addition to these changes there was a complete restructure of the senior leadership of the council and many staffing changes at other levels. All of this change took place under significant national scrutiny.

The purpose of this report is to set out the work of RLSCB for 2015-16 in co-ordinating and ensuring the effectiveness of partner activity in safeguarding children in the borough and how its functions have improved since the Ofsted inspection of 2014 that had found the RLSCB to be inadequate. The report comments on the evidence of the effectiveness of safeguarding by all agencies, including the response to child sexual exploitation, the area in which the borough failed so seriously in the past.

During 2015-16 the RLSCB focussed on making sure that up to date policies and procedures were in place to ensure that everyone knew what action to take when they had a concern about a child. We have strengthened our performance and quality assurance arrangements and now have a comprehensive performance framework and audit programme. We have refreshed our sub group supporting learning and improvement and extended our influence with boards that commission and plan services.

There is further progress to be made and we will continue to strive to be an excellent partnership working to keep the children in Rotherham as safe as possible. Our priorities for the coming year will be to extend our influence with key decision making bodies and the wider community and to increase the ways in which partners hold one another to account and challenge safeguarding practice at all levels.

We will have particular focus on children who are in care, children at risk of child sexual exploitation, those who go missing and children who suffer from neglect. In working on these priority areas we will listen to what children and young people and the community tell us about what they feel will help to keep Rotherham's children safe. We need to reach a point where the people of Rotherham can feel proud of the way in which their local services and the community itself work together to protect its children.

A handwritten signature in black ink, appearing to read 'C. Cassell', written in a cursive style.

Christine Cassell

Independent Chair
Rotherham Local Safeguarding Children Board

2. Local background and context

Rotherham – demographic profile

Rotherham is one of four metropolitan boroughs in South Yorkshire, covering an area of 110 square miles with a resident population of 260,100 (Office for National Statistics (ONS) mid-year estimate for 2014). The population of Rotherham has been growing, increasing by 11,800 (4.8%) between 2001 and 2013.

Key information

Population Profile:

- The latest mid-year estimate of Rotherham's population is 260,100 as at June 2014
- Rotherham's population increased by 9,400 (3.8%) between 2001 and 2011
- There are 56,400 children and young people age aged 0-17 (21.7% of the population)
- 51% of the population is female and 49% male, similar to the national picture
- Rotherham's Total Fertility Rate peaked at 2.15 births per woman in 2008 and despite a 9% reduction, remains above the national average
- 8.1% of the population were from Black and Minority Ethnic (BME) communities in 2011, twice the proportion in 2001

Population projections:

- Rotherham's population is projected to rise by 3.5% between 2015 and 2025 to 270,000
- The population is ageing with the oldest age groups increasing at the fastest rate
- Life expectancy has been rising although it remains below the national average
- The number of people aged 16-19 is projected to fall by 1,100 (9%) between 2015 and 2020

Other Facts about Rotherham:

- 66.5% of the population are Christians, 4.4% other faiths and 22.5% have no religion
- The number of international migrants arriving in Rotherham peaked at 1,220 in 2007/08 and was 790 in 2014/15
- 66% of international migrants to Rotherham are from new EU states, mainly from Slovakia, Poland and Romania
- Rotherham has 8,500 lone parents with a 21% increase projected between 2011 and 2021
- Rotherham is the 52nd most deprived district in England (in most deprived 16% nationally)
- 19.5% of the population live in areas within the most deprived 10% nationally
- Key challenges exist in terms of the Health, Education/Skills and Employment domains
- 70% of the Borough's land area is rural
- Rotherham LGBT (Lesbian, Gay, Bi-Sexual , Transgender) population could number up to 4,400 aged 16+

Population

2012-based population projections by ONS project Rotherham's population in 2015 to be 260,800 which, given the 2014 estimate, looks realistic. The population is expected to rise by an average of 900 per year over the next ten years (an increase of 9,100), to reach 269,900 by 2025. The projected increase reflects a combination of rising life expectancy, continued natural increase (more births than deaths) and net migration into the Borough.

Around half of the Borough's population lives in the Rotherham urban area (including Rawmarsh and Wickersley), in the central part of the Borough. Most of the remainder live in numerous outlying small towns, villages and rural areas. About 15% of the population live in the northern Dearne Valley area which covers Wath, Swinton, Brampton and Wentworth. Around 35% live in the southern Rother Valley area which covers Maltby, Anston, Dinnington, Aston, Thurgroft and Wales.

Rotherham is a diverse borough with a mixture of people, cultures and communities. There are densely populated multi-ethnic inner urban areas, large council built housing estates, leafy private housing suburbs, industrial areas and rural villages. About 70% of the Borough's land area is rural so the most widespread feature is extensive areas of open countryside, mainly agricultural with some parkland and woodland.

There are approximately 203,700 adults resident in Rotherham (2014 Mid Year Estimate) of whom 64,100 people are aged 60 and over (24.6% of the population); 37,100 are aged 18 to 29 years (14.3%) and 102,400 are aged 30 to 59 years (39.4%). The number of children and young people aged 0 to 17 years is 56,400 (21.7%) of whom 16,100 aged 0-4 (6.2%).

Rotherham has significantly more people aged over 60 than children under 18. There are 99,500 people aged 50 or over which equates to 38.3% of the total population, a proportion which is rising. The total number of children has been falling although those aged under 5 years have increased in recent years. However, the number of children aged 0-4 is projected to stabilise before falling slightly to 15,800 by 2019. The largest reduction will be in young people aged 16-19, whose numbers are projected to reduce by 9% from 12,200 in 2015 to 11,100 to 2025.

In Rotherham, there are 132,300 (50.9%) females and 127,800 (49.1%) males, which are similar proportions to the national average. Live births in Rotherham have followed a similar pattern to England, decreasing from over 3,700 in 1991 to 2,730 in 2001. The numbers of births then increased each year after 2001 to reach 3,263 in 2008 before dropping slightly to 3,092 in 2009 since when the number has fluctuated. There were 3,230 live births in 2010, 3,057 in 2011, 3,264 in 2012, 3,120 in 2013 and 3,072 in 2014. The average number of births in Rotherham 2010-15 was 3,149.

The number of households with dependent children is projected to rise in line with total household growth, from 31,000 in 2011 to 32,700 in 2021, a 5% rise. The number of households with 3 or more dependent children is projected to rise by 7%, from 4,900 to 5,300 in 2021.

Ethnicity and Religion

Rotherham's Black and Minority Ethnic (BME) population is relatively small but has been growing and becoming increasingly diverse. The BME population more than doubled between 2001 and 2011, increasing from 10,080 to 20,842. 8.1% of the population belong to ethnic groups other than White British (6.4% are from non-white groups), well below the English average of 20.2%. It follows that 91.9% of Rotherham residents are White British.

The majority of Rotherham's BME residents were born abroad (55%) and are more likely to lack English language skills than those born in the UK. 19% of those born outside the UK cannot speak English well. Of those born outside the UK, 30% arrived as children aged 0-15 and 57% arrived as young adults aged 16-34. Ethnic groups where more than two thirds were born outside the UK in 2011 were Other White (63% born in Eastern Europe), Black African (73% born in Africa), Arab (54% born in the Middle East) and other ethnic groups. 81% of people with Mixed or Multiple Heritage were born in the UK. 61% of Rotherham's Pakistani community were born in the UK and 36% were born in South Asia (Pakistan and Kashmir).

Immigration and natural increase means that Rotherham's BME population has grown steadily in recent years. The white minority population (almost all European) was 2,368 in 2001, rising by 82% to 4,320 in 2011, mainly as a result of immigration within the EU. Most minority ethnic groups have young populations, including Pakistani/Kashmiri (33% under 16), Black African (31% under 16) and Eastern European (24% under 16). The mixed or multiple heritage population is growing rapidly as a result of mixed marriages or relationships, 50% are aged under 16. The Irish community is by far the oldest ethnic group with 42% aged 65+.

The fastest growing groups have been Black African communities and other new communities, including Eastern Europeans, have also settled in Rotherham. The Slovak, Czech and Romanian Roma community is estimated at around 4,100 people (many were missed in the 2011 Census count of 1,689 from EU Accession countries other than Poland, Lithuania and Romania). BME communities have a younger age profile compared to the general population which means that children and young people in Rotherham are far more ethnically diverse than older people.

People from states which joined the EU post 2004 make up 66% of all overseas migrants to Rotherham. The countries with the most migrants to Rotherham are Romania, Slovak Republic and Poland, which together accounted for 51% of migrants in 2014/15. Two thirds of arrivals in Rotherham between 2007/08 and 2014/15 moved to the three central wards. A high proportion of Slovak, Czech and Romanian migrants are from Roma communities.

In 2001, 2.6% of Rotherham's population belonged to minority religions and by 2011 this had increased to 4.4%, still well below the national average of 8.7%. 22.5% of the local population say they have no religion compared to 24.7% nationally and this group has more than doubled in size since 2001. The largest minority religion in Rotherham is Islam with 3.7% of the population stating they are Muslims, below the English average of 5%.

72% of Muslims in Rotherham are of Pakistani ethnicity, 9% are other South Asian and 5% are Arabs. Rotherham has 433 Hindus, 73% of Indian ethnicity, and 293 Sikhs of whom 75% are Indian. There are 401 Buddhists, mainly White British, Chinese or "Other Asian".

Other religions with between 50 and 200 followers in Rotherham are Jewish, Pagan, Wicca and Spiritualist. 17,030 people (6.6%) did not state their religion in the 2011 Census.

The arrival of EU migrants from Poland, Slovakia, Romania and other eastern European countries since 2004 has increased the number of Christians in Rotherham, mainly Roman Catholics and Eastern Orthodox. For example, it is estimated that approximately 90% of Polish people are Roman Catholic with over 50% attending church regularly.

Deprivation

According to the Index of Multiple Deprivation (IMD 2015), Rotherham is the 52nd most deprived out of 326 English districts (based on rank of average score). Rotherham's IMD rank improved from 63rd in 2004 to 68th in 2007 before deteriorating to 53rd in 2010 and 52nd in 2015.

31.5% of Rotherham's population live in areas which are amongst the most deprived 20% in England, which has changed little since 2004. However, the most deprived areas of Rotherham have seen deprivation increase the most between 2007 and 2015.

The key drivers of deprivation in Rotherham are: Health and Disability (21% in English Top 10%), Education and Skills (24% in English Top 10%) and Employment (24% in English Top 10%). Rotherham has more average or lower levels of deprivation in other domains such as Crime (15% in English Top 10%) and Living Environment (2% in English Top 10%).

Income and crime deprivation show above average concentrations in Rotherham and there are high levels of both income deprivation and crime in some areas. Children are more likely than adults to be affected by income deprivation and child poverty shows a very high level of inequality between the most and least deprived areas.

Figure 1 below shows the geographical distribution of the Index of Multiple Deprivation 2015 across the Borough. The main area of high deprivation is in central Rotherham, stretching from Meadowbank in the west to Thrybergh in the east. There are also pockets of high deprivation in Wingfield, Rawmarsh, Wath, Swinton, Maltby, Dinnington, North Anston, Thurgroft and Aston.

The most deprived areas in Rotherham are Ferham, Eastwood, East Herringthorpe and Canklow where about 60% of the population are affected by income deprivation. The areas with the lowest deprivation levels are found in South Wickersley, South Anston, Herringthorpe, Stag, Swallownest and Harthill.

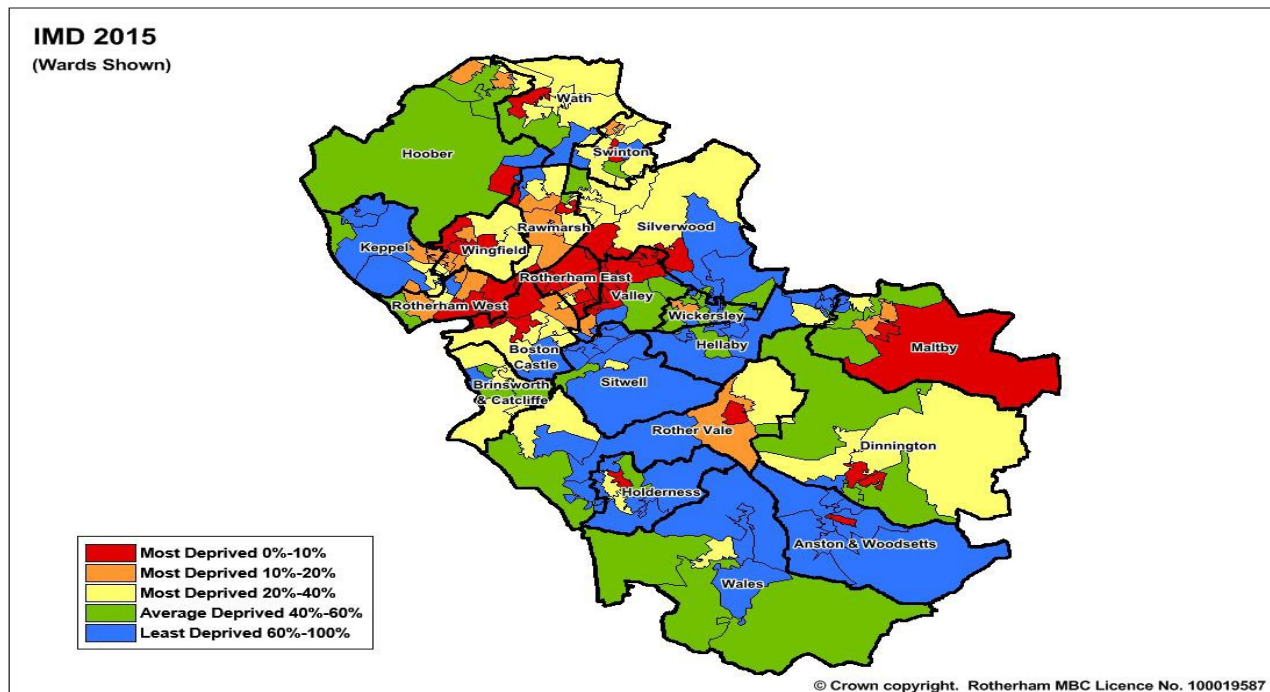


Figure 1: Indices of Multiple Deprivation 2015 in Rotherham Metropolitan Borough Council

What do children and young people think about living in Rotherham in 2015 –2016?

Rotherham Local Safeguarding Children Board strongly believes that children and young people should have a say when decisions are made which may affect them. We also believe that children and young people should have the means and opportunities to be able to raise issues which are important to them, and ensure they are listened to. By doing so, we will create a stronger child protection system that is more responsive to the needs of our most vulnerable children.

In 2015 the Lifestyle Survey was conducted within secondary schools in Rotherham. In total 3110 children and young people participated in the 2015 lifestyle survey. Of the pupils that completed the 2015 survey, 1624 (52%) were female and 1486 (48%) were male. 1624 (52%) were in year 7 and 1,486 (48%) were in year 10. Participation in the survey varied widely between schools, the variances ranged between 14% to 90% participation rates from one school to another.

Positive Results

- There has been an increase in the number of young people having school dinners and an overall reduction in the number of young people not having lunch at all
- More young people are participating in regular exercise
- Good awareness amongst young people where they can get support if they have any issue relating to mental health
- More young people are aspiring to go to university
- Almost all young people aware of internet safety

- Reduction in the number of young carers but greater awareness of Young Carers Service
- Fewer young people report being bullied
- Increase in positive responses against the participation in smoking, drinking alcohol and use of drugs – gives positive message against the peer pressure to partake in these
- Reduction in the number of young people actually smoking or trying alcohol
- Improvement in all areas of young people feeling safe in all areas including Rotherham town centre locations

Areas for attention

- Greater awareness around disability and long-term illnesses, with more young people putting themselves in this category
- A proportion of young people in Y7 saying they use the internet to meet new friends
- Although less young people reported bullying, less young people also said that they felt as though they were helped after being bullied
- Less young people wanting to stop smoking
- Increase in number of young people trying electronic cigarettes
- One third of young people who said they have drunk alcohol, have tried it before the age of 12
- Large proportion of young people who said they have drunk alcohol, said they have been drunk in past 4 weeks
- Education around sexual exploitation, 40% of Y7 and 29% of Y10 say they still need to be taught this
- Almost a quarter of those pupils who said they have had sex, did not use contraception
- Young people visiting Rotherham town centre has reduced
- Y10 girls are the most likely not to recommend living in Rotherham or want to live in Rotherham in 10 years' time

3. The statutory role of Local Safeguarding Children Boards

Section 13 of the Children Act 2004 requires each local authority to establish a Local Safeguarding Children Board (LSCB) for their area and specifies the organisations and individuals) that should be represented on LSCBs.

The way in which a LSCB delivers its functions and objectives are set out in the statutory guidance: *Working Together to Safeguard Children: a guide to interagency working to safeguard and promote the welfare of children (2015)*.

Statutory objectives and functions of LSCBs are:

- (a) to coordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area; and
- (b) to ensure the effectiveness of what is done by each such person or body for those purposes.

Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out that the functions of the LSCB, in relation to the above objectives under section 14 of the Children Act 2004, are as follows:

1(a) developing policies and procedures for safeguarding and promoting the welfare of children in the area of the authority, including policies and procedures in relation to:

- (i) the action to be taken where there are concerns about a child's safety or welfare, including thresholds for intervention;
- (ii) (ii) training of persons who work with children or in services affecting the safety and welfare of children;
- (iii) recruitment and supervision of persons who work with children; (iv) investigation of allegations concerning persons who work with children;
- (v) safety and welfare of children who are privately fostered;
- (vi) cooperation with neighbouring children's services authorities and their Board partners;

(b) communicating to persons and bodies in the area of the authority the need to safeguard and promote the welfare of children, raising their awareness of how this can best be done and encouraging them to do so;

(c) monitoring and evaluating the effectiveness of what is done by the authority and their Board partners individually and collectively to safeguard and promote the welfare of children and advising them on ways to improve;

(d) participating in the planning of services for children in the area of the authority; and

(e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned. Regulation 5(2) which relates to the LSCB Serious Case Reviews function and regulation 6 which relates to the LSCB Child Death functions are covered in chapter 4 of this guidance. Regulation 5

(3) provides that an LSCB may also engage in any other activity that facilitates, or is conducive to, the achievement of its objectives.

LSCBs do not commission or deliver direct frontline services though they may provide training. While LSCBs do not have the power to direct other organisations they do have a role in making clear where improvement is needed. Each Board partner retains its own existing line of accountability for safeguarding.

In December 2015, the Department for Education (DfE) asked Alan Wood CBE to lead a review of the role and functions of Local Safeguarding Children Boards (LSCBs) in England. As part of the review he also looked at Serious Case Reviews and Child Death Overview Panels. A consultation exercise was undertaken with the review findings and the government response expected in 2016. The implications of the review for RLSCB will be reported in the annual report next year.

4. Governance and accountability arrangements

Local partnership and accountability arrangements

To enable the RLSCB to deliver on its statutory duties, an independent chair is in place to lead and chair the board.

Though not a member of the Board, ultimate responsibility for the effectiveness of the LSCB rests with the Chief Executive of Rotherham Metropolitan Borough Council who also has the responsibility to appoint or remove the LSCB Chair with the agreement of a panel including LSCB partners and Lay Members. The Strategic Director of Children's Services reports to the Chief Executive of the Council.

The independent chair meets regularly with:

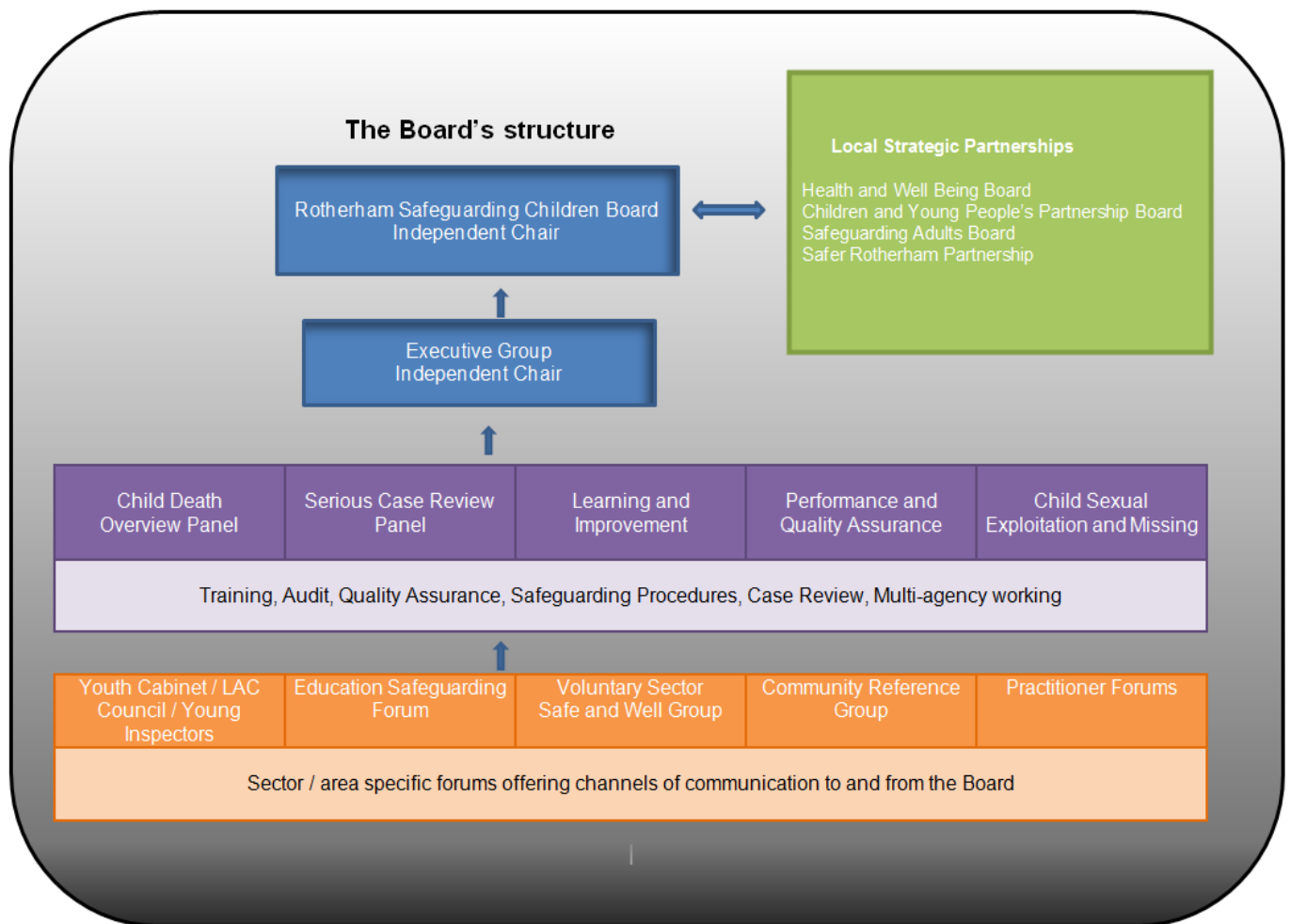
- Council Chief Executive
- Council's Strategic Director for Children and Young People's Services
- Government appointed commissioners for the council
- Chair of the Health and Well Being Board

Members of an LSCB should be people with a strategic role in relation to safeguarding and promoting the welfare of children in their organisation and should be able to speak for their organisation with authority; commit their organisation on policy and practice matters; and hold their own organisation to account and hold others to account.

The elected councillor who has lead responsibility for safeguarding children and young people in the borough (known as the Lead Safeguarding Children Member) sits on RLSCB as a 'participating observer'. This means that the Lead Member is able to observe all that happens and can contribute to discussion, but cannot participate in any voting. This allows the Lead Member to scrutinise RLSCB and challenge it where necessary from a political perspective, as a representative of elected members and Rotherham citizens.

Lay members are full members of the Board, participating on the Board itself and relevant Sub Groups. Lay Members help to make links between the LSCB and community groups, support stronger public engagement in local child safety issues and facilitate an improved public understanding of the LSCB's child protection work. Lay members are not elected officials, and therefore are accountable to the public for their contribution to the LSCB. They do, however, provide a lay perspective and transparency for the work of the Board, in the addition to the involvement of elected members.

The main Board meets four times per year with additional board meetings when required. In order to deliver its objectives the Board has an Executive Group which consists of the chair and the chairs of the Board's Sub Groups; and five Sub Groups to undertake the detailed work of the Board's Business Plan.



- Business Manager
- Quality Assurance Officer
- Practice Audit Officer
- Learning and Development Coordinator
- Learning and Development Administrator
- Child Death Overview Panel Administrator (0.65 WTE)
- Administrative Officer (0.8 WTE)

Board Members attendance at Board Meetings can be found at Appendix 1.

Financial arrangements

The Board's budget is based on partner organisations contributions to an agreed formula. The funding formula and 2015-16 budget statement can be found at Appendix 2.

Budget - 2015/16 Outturn

Income: £334,669

Expenditure: £334,669

Overall expenditure for 2015/16 was within budget. There was no surplus or deficit to carry forward to the 2016/17 budget.

In February 2016 the LSCB held a development day to evaluate its own effectiveness and establish priorities for the business plan. The Board's self-evaluation was that the serious weaknesses identified by Ofsted had been addressed but that there were still areas for improvement. There had been significant improvement in performance and quality monitoring and good progress in audit activity which enabled the LSCB to have a better overview and challenge of the effectiveness of safeguarding in the borough. The work of the child sexual exploitation sub group was identified as an area of strength. There was still further work required to extend the influence of the LSCB with other key partnership bodies and to develop the learning and improvement function. The self-evaluation has informed the priorities in the business plan for 2016-17 and will be tested through peer review during the coming year.

5. Effectiveness of arrangements to keep children in Rotherham safe

Early Help Services

Early help services work with children and their families to prevent problems from getting worse. The Multi-Agency Safeguarding Hub (MASH) is the first point of contact when there are concerns about a child.

In 2015-16 there was a significant redesign of the Early Help services on offer in Rotherham. In October 2015 the new integrated Early Help locality service was created, bringing together staff from a range of previously separate services and professional disciplines. These include: Education Welfare, Youth Offending, Children Centres, Integrated Youth Support, Family Support and Troubled Families programme. This was swiftly followed by the establishment of the Early Help Triage Team to work alongside the Multi-Agency Safeguarding Hub (MASH), where concerns about a child's needs are first reported. The improved arrangements had an immediate impact with the previous backlog of Early Help Assessments cleared within two weeks and an increase in requests for early help where risks to children were not present.

The LSCB supported the re-launch of the Early Help offer in February 2016 when a weekly Panel was introduced to make sure that children who were no longer at risk of harm received appropriate support services. Since the panel began in February, 232 children have been receiving support from services within the community.

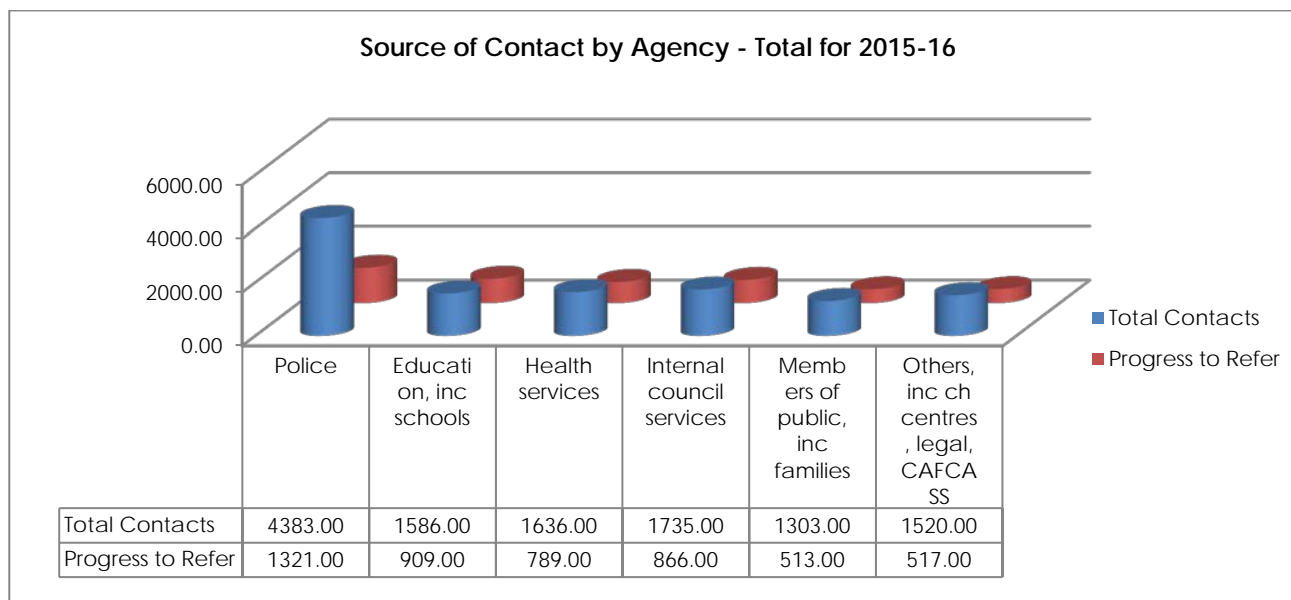
From April 2016 new data and information will be available which will enable the LSCB to monitor and evaluate what difference services are making for children and their families. The LSCB will continue to promote Early Help services and support the Early Help offer through its training and communications.

Contacts and Referrals

These are the requests for help when a child is thought to have support needs or to be at risk of harm.

The Rotherham Multi-Agency Safeguarding Hub (MASH) went live in April 2015. An independent review of the MASH in December 2015 reported to the Improvement Board in March 2016 that whilst there was still further work to do, 'enormous progress' had been made in a very short space of time.

Overall there has been a 16% increase in contacts to the MASH in 2015/16 with 12,165 made compared to 10,517 in 2014/15. This is approximately 1,000 requests for help or notification of concerns per month. The independent review of the MASH stated that there will be a number of factors that impact on the volume of contacts received. One is that as confidence in how the MASH works increases there would be an expectation that the number of contacts would rise. Another factor is that as partner organisations have a better understanding of needs and risks, there might be a reduction of contacts for children with a lower level of risk or need as they would go directly to the early help service.



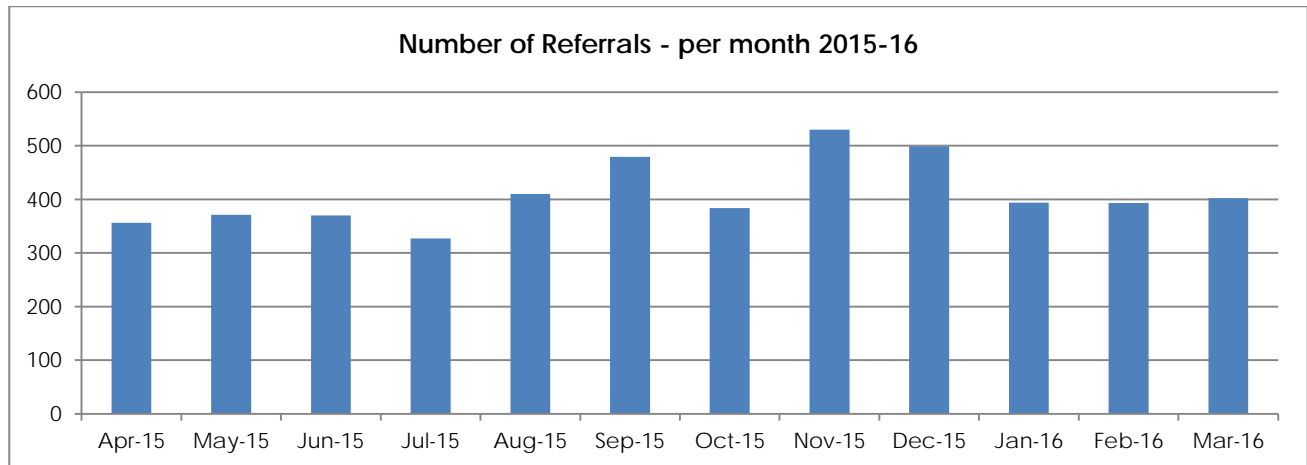
When the past 12 months' data is reviewed it appears that contacts made by education, which includes schools, have risen over the past few months. On the basis of feedback from schools it is understood that this is indicative of an increased confidence in the quality and helpfulness of the service within the MASH. There has been some reduction in the number of contacts from health services which may be an indication of better understanding of the thresholds for social care. The majority of the contacts received from the Police relate to domestic abuse incidents. A daily multi-agency triage system has been put in place to deal with domestic abuse incidents.

The triage system is where services who are or have been involved with the family, share information within one working day to decide what course of action needs to be taken.

The New MASH service was introduced on 1 April 2015. The LSCB undertook a desk top review of all contacts received on a single day in April 2015 which sought to determine the quality of case recording and multi-agency practice. The review identified some inconsistencies within the screening process of contacts. Clear guidance regarding screening expectations was explored with MASH team managers and individual workers. This was further communicated within the MASH Team meeting. Clarity around screening expectations is included within MASH Operational Guidance V.1 June 2015 and a subsequent audit found significant improvements.

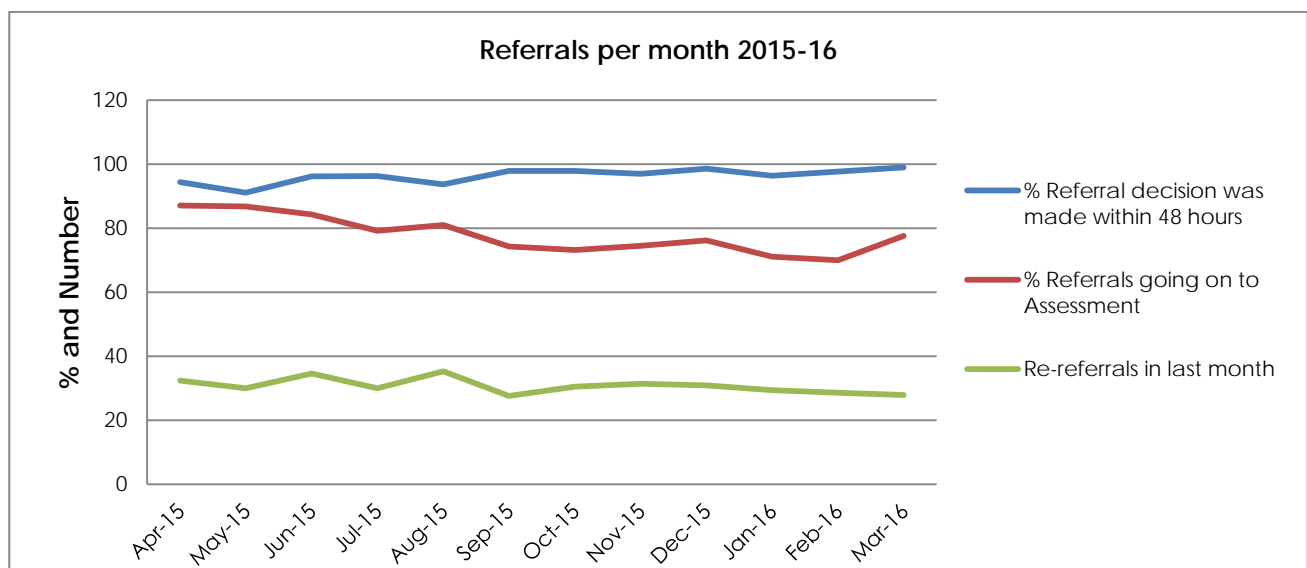
The MASH response rate is good. 96.5% of contacts and 99.0% of referrals had decisions made about them within timescales. The quality of these decisions has been validated by Ofsted during 3 separate improvement visits and by the independent review reported to the Children's Improvement Board in March 2016. Similar to contacts, month on month referral numbers are consistent at approximately 400 per month. In total there have been 4,915 referrals in 2015/16, a 9% increase on the 4,513 in 2014/15. There has been a month-on-month downward trajectory in the proportion of these which are re-referrals; following a mid-year high of 35.3% in August 2015 this has now reduced to 27.9% in March 2016.

A re-referral is where a child has had children's social care services involved with them in the previous 12 months and a further referral has been received relating to concerns about their welfare.



In addition, as the MASH has developed, more work is undertaken at referral stage in terms of information sharing and effective triage before progression to social work assessment teams. This has resulted in fewer referrals progressing to an assessment, with 77.6% in March 2016 compared to 87.1% in April 2015. This in turn allows for social care resources to be better targeted and families to receive a more appropriate response. The independent review of the MASH (2016) found that 'Social work analysis and articulation of need, harm and risk within the MASH is good. This is apparent in social work analysis and the recommendations being made by those making the decisions.'

Where a contact about a child indicates that the child might have complex needs or there is a risk of harm, a referral is created. If after further information sharing this remains the case then a multi-agency assessment is undertaken, led by a social worker.



Children's Assessments

An assessment is where those involved with a family work together with the parents and child to find out the needs of the child and any risks to them.

A review was conducted by the LSCB in conjunction with The Rotherham NHS Foundation Trust (TRFT) and Children and Young People's Services (CYPS) to evaluate two cases of newborn babies where there were safeguarding concerns and a potential delayed discharge from hospital. The review concluded that in one case there was not an undue delayed discharge from hospital whereas the second case did have an unnecessary delay because of the lack of timely pre-birth assessment and planning processes. As a result the LSCB Safeguarding Unborn and Newborn Babies procedure has been amended to include the details of additional standards and guidance. A Memorandum of Understanding (MOU) has been developed between TRFT and CYPS with the expectation that in the event of a baby or child that is medically fit for discharge but it is not safe for them to return to their parents, the escalation process must be followed. Discharges from hospital of children with safeguarding concerns are now being monitored on a routine basis through the Performance Management Framework.

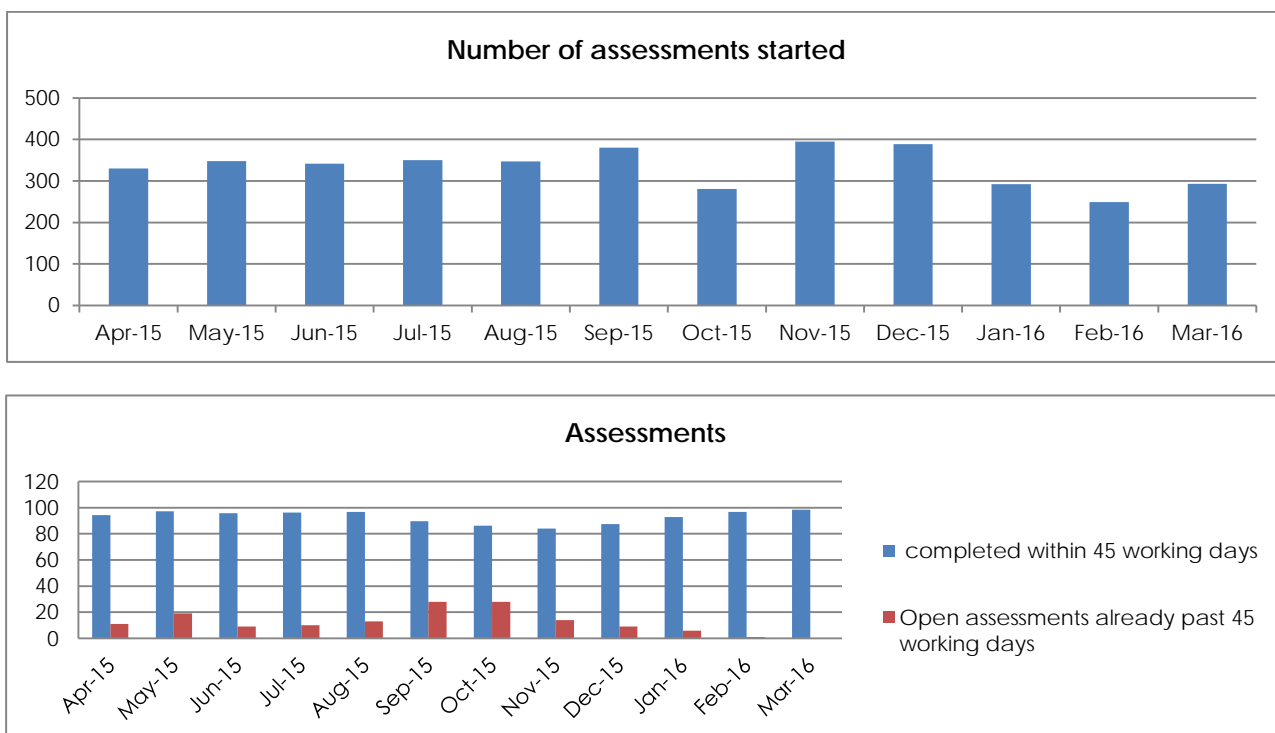
Thresholds for need and harm are used as evidence with professional judgement to decide what action needs to be taken to make sure children are safe and well.

Although the numbers of contacts and referrals have both increased over the last 12 months the reduction in those which go on to an assessment means that fewer assessments are now being started. Feedback from social workers and auditors however suggests an increase in the complexity of the cases coming through. The overall trend of the proportion of assessments resulting in no further social work involvement is downwards, which is a positive reflection of the improvement in quality of decision making and application of the thresholds of need and harm.

A combination of the reduction in volume of work, changes to the way duty teams are organised and increased management oversight has seen a significant improvement in the timeliness of assessment completion again this month; 98.4% of assessments were completed within 45 working days compared to an in-year low of 83.9% in November. 92.8% of all assessments completed in 2015/16 were completed in time compared to 88.8% in 2014/15.

The timeliness of an assessment for a child is important because it means that their needs or the risks to them are identified quickly and they are not left to drift. The upper time limit for assessments to be completed is 45 working days.

Although timeliness of the assessment is important the quality of it is equally key to achieving good outcomes for the child. Feedback from the March 2016 Ofsted improvement visit identified a number of examples of 'good' assessments during their visit though there remains further work to do to ensure consistently good quality assessments are produced right across the service.



Section 47 Enquiries

Section 47 Enquiries are the investigations which social workers, the police, and other professionals do to find out whether children have suffered from or are at risk of abuse or harm.

The numbers of Section 47 (S47) investigations remain high and this is currently the subject of intensive review by children's services. The number undertaken over the year (1478) was higher than when benchmarked against the national average, statistical neighbours, and the best performing local authority.

An audit by the LSCB and The Rotherham NHS Foundation Trust (TRFT) was undertaken to assess the impact of the redesigned paediatric assessment (child protection medical) for the child abuse and neglect pathway launched in September 2014. This development was, in part, in response to anecdotal information that suggested that the process and procedures in place prior to this were resulting in social workers experiencing difficulties in arranging timely paediatric assessments and that children were experiencing long delays waiting to be seen after they had attended for their assessment appointment at the hospital. The findings provided evidence that children were not experiencing unnecessary delays but identified that a new recording template was required for the assessments which has now been implemented.

Using the number of children per 10,000 child population is a standard way to compare and measure how well we are doing against other authorities.

	Rotherham		Statistical Neighbours	National Average	Best Performing LA
	Number	Per 10,000 children of the population			
Section 47 Enquiries in 2015/16	1478	168	149.2	138.2	75

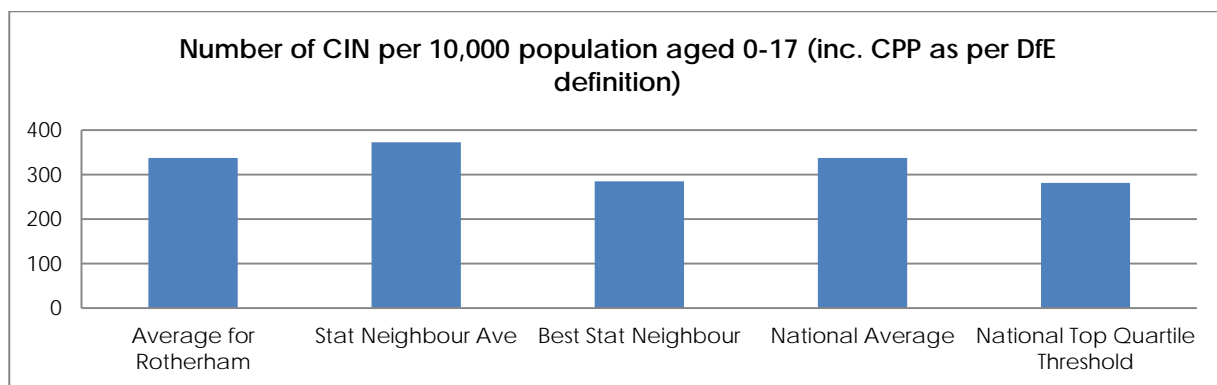
Analysis indicates an ongoing lack of confidence by professionals in addressing risks to a child in any way other than by focussing on child protection issues. This is a practice common in local authorities who have failed and are in government intervention. The number of S47 investigations which concluded there was no continuing risk of significant harm to the child suggests that an assessment conducted under S17 Children in Need may have been more appropriate.

The LSCB undertook an audit to evaluate the quality of Strategy Discussions and Section 47 enquiries. The findings evidenced that these were not conducted to a consistently good enough standard. The LSCB developed and contributed to the implementation of a multi-agency Strategy Discussion template and training sessions for chairs of Strategy Meetings that provided a clear framework to improve practice. A follow up audit will take place in 2016.

Children in Need

A child in need is one where a social worker and other professionals are working with them and their family to provide family support to meet the child's needs.

Although there is no good or bad indicator in relation to the numbers of children in need, it is important to monitor this against statistical neighbour and national averages as numbers considerably higher or lower than these averages can be an indicator of other performance issues. On average each month of the year there were 1497 children classed as open Children in Need cases.

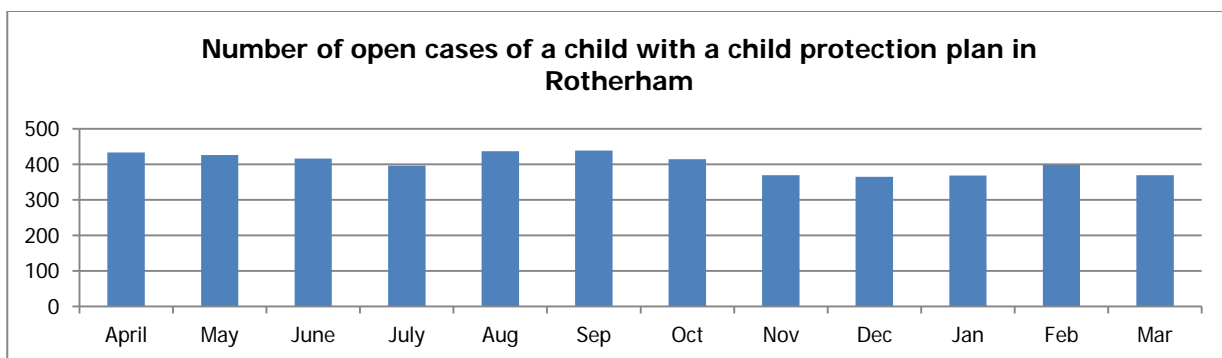
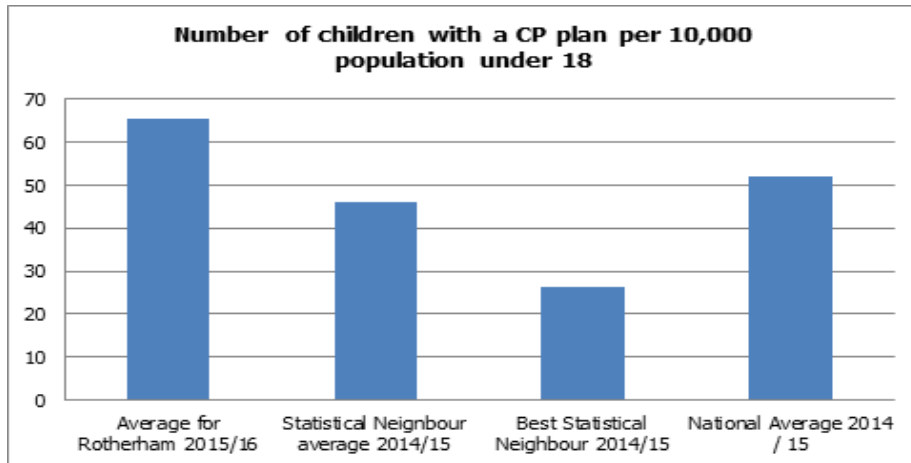


One of the measures of success of the Early Help offer will be, over time, a reduction in the numbers of Children in Need as families are offered support at an earlier point before concerns escalate. It is far too early in the development of the Early Help provision to conclude that the last three months' reductions in numbers are the beginning of a trend. It is more likely that it represents a review that has been undertaken of all open Children in Need cases during the reconfiguration of the locality teams which has led to closure and transferring of some cases to early help services where appropriate. It is still predicted that for a period of time the numbers of Children in Need in Rotherham may rise as those with a Child Protection Plan reduce.

Children on Child Protection Plans

Children who are risk of abuse or neglect have a Children Protection Plan to help make sure they are safe from significant harm.

At the end of March 2016 there were 369 children subject to a Child Protection Plan (CP Plan), which is a significant reduction from March 2015 when there were 433. However the rate per 10,000 child population of 65.4 demonstrates that this is still high when compared to statistical neighbours and the national average of 46.1 and 42.9 respectively.



It is expected that the numbers of children with a Child Protection Plan will continue to fall as practice improves and the care plan is worked more effectively and managers become more confident in their decision making. This is supported by the Strengthening Families Framework which was introduced in August 2015. The 'Strengthening Families' model encourages positive working between professionals and families; families are asked to put forward their views, to talk about what is working well for them as well as any concerns they have, and to offer ideas about the best way forward. This provides a more balanced picture of the family including how things that are going well for the family can be built upon to safeguard the child.

Of the children subject to a CP plan at the end of the year, 94.2% of their reviews over the entire year were completed in time which is a decline on the previous year which was 96.5%. The reasons for any late reviews are scrutinised and where necessary management action is taken. There have been a number of occasions when family issues have been the reasons for conferences being postponed and these have outnumbered the occasions where there has been fault on the part of children's social care services.

In the last 12 months there has been a very significant improvement in performance in relation to the duration of CP Plans. The data has been checked for those children becoming subject to plans for a second or subsequent time and it has been established that none of the children in the cohort have been subject to a previous CP Plan in the last two years.

An audit undertaken by the LSCB examined whether children and families subject to child protection conferences are being notified in a timely manner and provided with good quality written information that they can discuss with the professionals who have written them prior to the conference. 50 child protection conferences were subject to audit. The findings showed that there were delays sharing reports with families and the child protection conference chair person; and that this was not being challenged. As a result multi-agency training regarding "Strengthening Families Framework" specifically includes professional responsibilities and attendance at Child Protection conferences and the importance of sharing written reports at least 2 working days before. In addition there has been the development and implementation of a Challenge Protocol to enable conference chairs to constructively challenge colleagues within and between agencies to provide robust scrutiny to this area of work.

Every child who has a Child Protection Plan should be visited by their social worker every two weeks.

At the end of March 2016, 99% of children subject to a Child Protection Plan had been visited and seen within timescales compared to 92% at the end of March 2015.

Looked After Children

A Looked After Child is one who is in the care of the local authority and is sometimes called a "child in care" or "LAC".

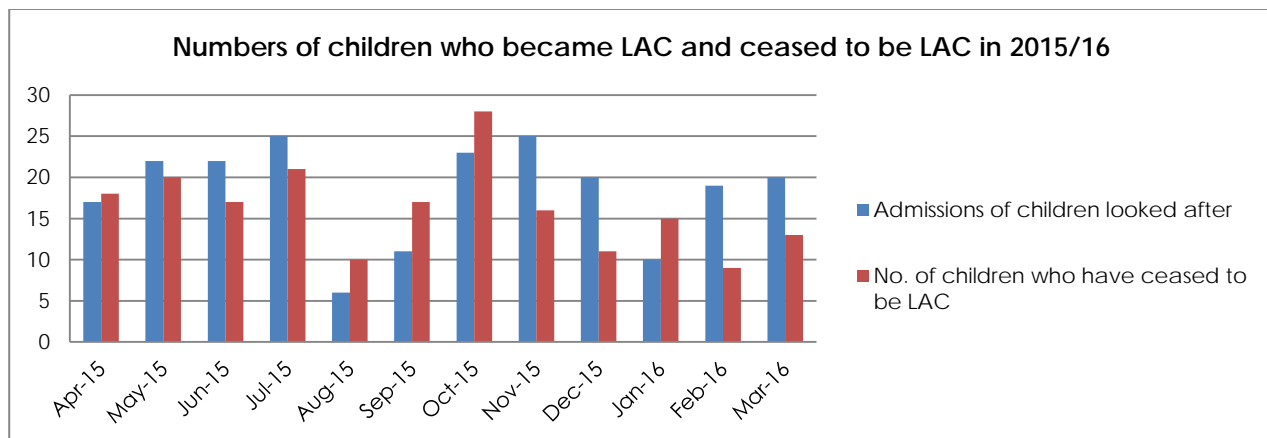
At the end of March 2016 there were 432 children in care which equates to 76.6 per 10,000 children in the population. Although this still places Rotherham broadly in line with statistical neighbours we are far higher than the national average and there is an upward trajectory as admissions to care have increased.

Arrangements need to be strengthened over time to prevent the need for children to come into care and developing this service forms a key strand of the Children In Care Sufficiency Strategy.

The sufficiency strategy aims to provide enough good quality placements for there to be a choice about where a child is placed.

This is particularly the case in respect of adolescents entering the care system for the first time. Outcomes are rarely improved for young people coming into care in adolescence and work is being initiated to develop a service specifically to work with this group.

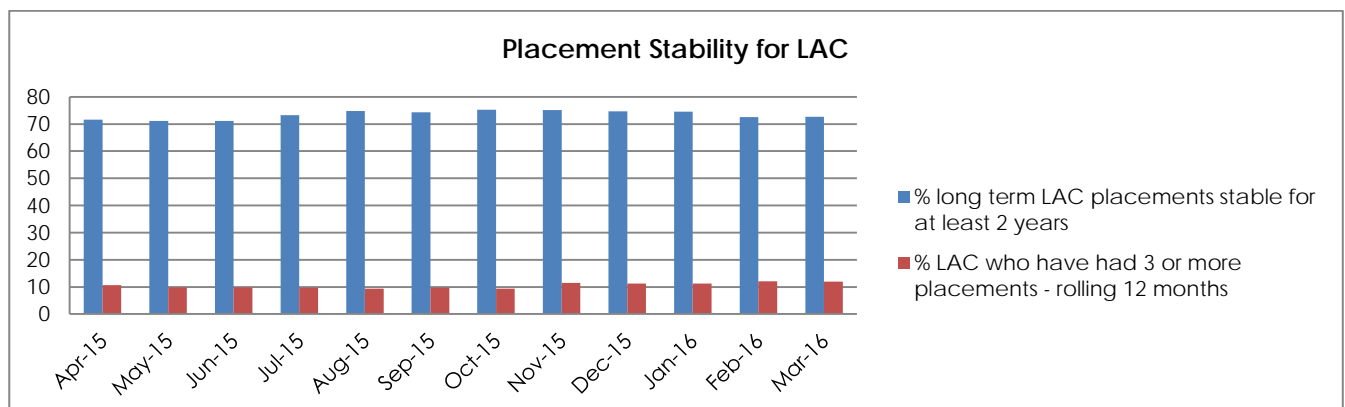
It is common for numbers of children in care in an authority in government intervention to rise as action is taken to address children's cases which have been drifting previously. The rise in the numbers of care proceedings in Rotherham is testimony to this happening locally. There is no feedback from the family courts to suggest that any children's cases are being brought before them unnecessarily.

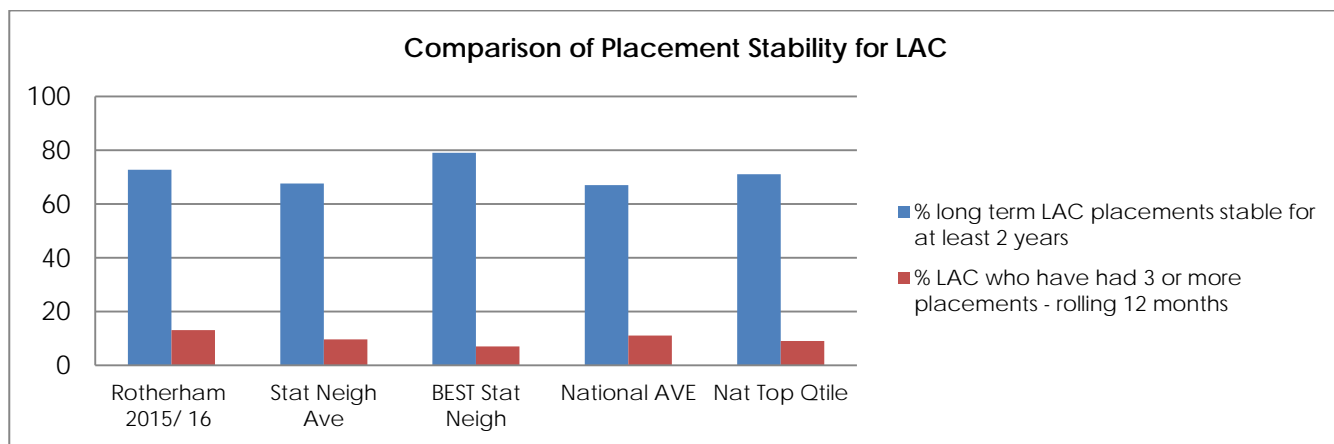


Looked After Children - Placement Stability

A Looked After Child has the right to stay somewhere for as long as they need to and moving from placement to placement can be detrimental to their welfare.

At the end of March 2016, 72.7% of long term Looked After Children have been in the same placement for at least two years. This placement stability is better than the national average of 67% however it is important to be confident that what appears to be stability is not in fact masking drift in planning for children. The sufficiency strategy identifies that there are too many children placed in residential care settings. Work which commenced in January 2016 to address this has resulted in a number of young people being identified who will be moving to more local provision. This may impact on the long term placement stability indicator but will result in better outcomes for those individual young people.

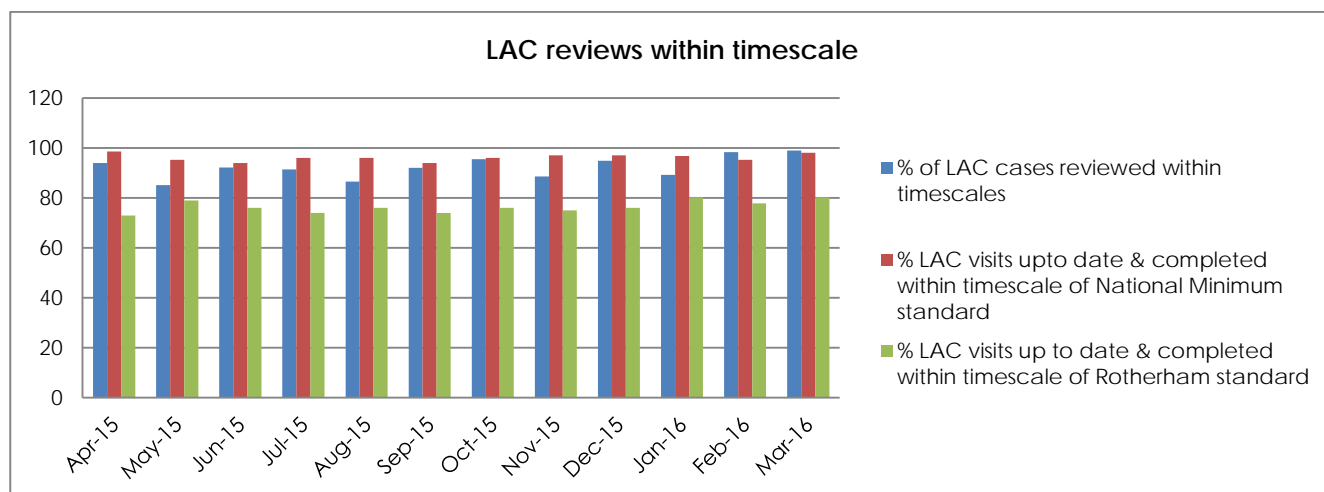




11.9% of Looked After Children have been in three or more placements in the last 12 months; this is broadly in line with national average of 11.0%. Although placement stability measures compare well against statistical neighbours and national averages, performance in relation to children who have had 3 or more placement moves in a year is still of concern and in particular to the numbers of children in care who have had missing episodes which count against this indicator. All children who have been missing or who are identified as being in 'unstable' placements are now subject to particular focus by way of regular 'Team Around the Placement' meetings. In the future they will also be considered as 'exceptions' in fortnightly performance meetings.

Looked After Children - Reviews and Visits

A Review is a meeting where the plans for a child's care are monitored by an independent person. These take place at set timescales to ensure that there is no delay for the child.



Of the eligible children in care 83.3% of their reviews over the entire year were completed in time which is a decline on the previous year (94.9%). This equates to 15 children having at least one review over timescales and relates to performance issues earlier in the year. Of the reviews held in March 2016, 99% were within timescales with only one child whose review could not take place in time. The reasons for any late reviews are fed back to children's social care managers and action taken to address any practice issues.

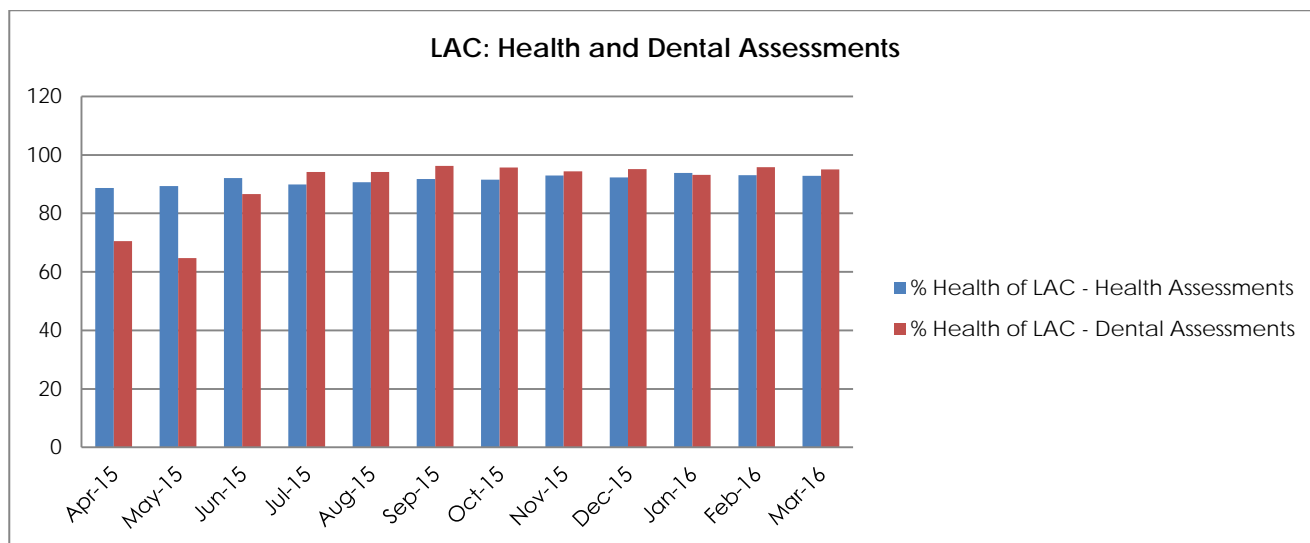
All children in care have to be visited regularly by their social worker – usually every 4 weeks which a local Rotherham standard and is better than the national standard which is 6 weeks.

Performance in relation to visits to Looked After Children within the National Minimum Standards remains well above 90%. Any visit exceeding the statutory minimum timescales is examined on a child by child basis to ensure that they have been subsequently visited and to ensure the reason for the delay is understood. In addition to National Minimum Standards, Rotherham has set a local standard that exceeds the national one. Performance in relation to the local standard is still not good enough and will continue to be the focus of sustained management attention. There are some children in care, however, who are visited more often than the Rotherham standard according to their needs at any particular time and this is good practice.

Looked After Children – Health & Dental Care

For children in care it is important that their health and dental needs are closely monitored and that they receive diagnosis and treatment without delay.

Performance in relation to health and dental assessments was very poor in previous years and has been the focus of concerted joint effort resulting in improvement in the last 12 months from 81.4% (March 2015) to 92.8% (March 2016) for Health Assessments and from 58.8% (March 2015) to 95.0% (March 2016) for Dental Assessments.



From reviews of some children's cases where they are not receiving these assessments it is known that some of these are the older young people who are recorded as 'refusers'. This is now being actively explored with health colleagues, regarding how the reviews can be promoted as something useful and young person friendly. Encouragement will be focused with young people on the things that interest them such as weight, hair and skin as well as other aspects of health. It will also be ensured that we are creative in thinking about how young people can be actively engaged, rather than expecting them to attend a standard clinic appointment. However, there are a number of potential reasons why performance in this area is not as good as it should be and will be the focus of an in depth 'check and challenge' audit in 2016-17.

Children in specific circumstances

Child Sexual Exploitation

In response to the Jay Report into CSE in Rotherham the LSCB developed a new strategy: [Child Sexual Exploitation - The Way Forward for Rotherham 2015-18](#)

This strategy articulates the commitment from the partnership and the progress of the Child Sexual Exploitation (CSE) Delivery Plan is reported to the CSE Sub Group and the main Board. The commitment articulated in the strategy is visible in the drive by the multi-agency partnership to support a number of large and complex past and current CSE enquiries. This maturing partnership between the Council, South Yorkshire Police and other agencies has resulted in several successful prosecutions; most recently the trial and conviction of three men and two women totalling 45 sexual offences committed against 15 young victims. A sixth defendant had already pleaded guilty to offences before the trial.

Ofsted has recently commented favourably on the child-centred approach taken by some of these enquiries, notably in terms of responding to juvenile perpetrators in an educational setting. The current multi agency response to CSE enquiries is employing the approach outlined in this strategy: PREVENT, PROTECT, PURSUE and PROVIDE support and this has successfully supported a number of child and adult survivors in obtaining justice and protection.

Key achievements in response to CSE in Rotherham in 2015-16 include:

- April 2015 – Implementation of the EVOLVE multi-agency Child Sexual Exploitation Team.
- July 2015 – publication of the new CSE Strategy - The Way Forward for Rotherham.
- July 2015 – new Taxi licensing policy introduced.
- August 2015 - Barnardo's receive £3.1m to support tackling CSE in Rotherham and rebuild the lives of victims.
- August 2015 - Good practice observed in managing complex CSE cases with Police partners.
- August 2015- £1.2m secured for an innovation programme to support victims and those at risk of CSE across South Yorkshire; including support of specialist foster carers to provide safe placements for young people.
- October 2015 - Second Ofsted visit confirms continuing strong "front door" arrangements and effective CSE practice.
- November 2015 - Rotherham man sentenced to 10 years as part of live CSE investigation (Operation Thole).
- December 2015 - High-profile Operation Clover trial commences at Sheffield Crown Court. 21 victims, 49 prosecution witnesses in total and 8 defendants
- January 2016 – ReachOut outreach service launched, delivered by Barnardo's.
- February 2016 - Operation Clover - 6 people were guilty in court of Child Sexual Exploitation offences.

To support the local response to CSE and the EVOLVE Multi-agency CSE Team a Multi-Agency Risk Management Panel was introduced. This considers intelligence, hotspots and directs disruption activity alongside having an overview of all major operations. Wider council services including licencing, regulation, housing and leisure services are now making an active contribution to these arrangements. The service in Rotherham has been transformed to what is an effective multi-agency victim led approach and this has been demonstrated by the impact the EVOLVE team has achieved since its inception.

The team has achieved major successes with two large operations involving the engagement of over 160 young people, the subsequent identification of nearly 30 victims and the identification of a significant number of suspects. The team have pioneered some exemplary work on developing support plans for juvenile perpetrators and schools in the community. To date, there has been one successful conviction with the defendant receiving a lengthy custodial sentence.

The victim management strategy employed by the team has been an outstanding success with none of the survivors withdrawing from the process. This has involved the collaboration of six separate agencies that have provided intensive support to these survivors, many with complex and challenging needs. Further multi-agency investigations are progressing well and will continue throughout 2016 and into 2017.

Operation Stovewood, the investigation into historical CSE, directed by the National Crime Agency (NCA), is now taking shape and they have now referred to the Council a number of potential suspects or victims for further information gathering and a number of arrests have been made.

The Jay Report identified potentially 1,400 survivors of child sexual exploitation. The Council responded in 2014 by investing in additional immediate support services but this was in the absence of a detailed understanding of the needs of survivors, the role different partners could play and an understanding of the role services in the community could play.

A LSCB multi-agency audit and practitioner learning event was undertaken on five children at high risk of CSE. It had a particular focus on child and victim centred investigations and support services. The review concluded that the CSE training and awareness across the partnership was making a difference and the screening tool was being used well to identify risks and vulnerabilities. On one of the cases where it was difficult to build a trusting relationship, the CSE Nurse Practitioner had made a significant positive difference to the outcomes for the young person. The review also found, however, that in some cases there was a frequent change of social worker and professionals were not always of the pathways to access specialist services.

Over the past 12 months the Council and partners have made good progress in strengthening the support to victims and survivors. A detailed needs analysis was completed and this was supported in late summer 2015 by a piece of research undertaken by Salford University to capture the voice of survivors, their families and those in the voluntary and community sector supporting them. The Council has now commissioned services for an initial period of three years to provide support to survivors.

The three areas of service included are:

- Practical, emotional support and advocacy for young people (up to the age of 25) who have experienced child sexual exploitation. This includes support to immediate family members;
- Practical, emotional support and advocacy for adults who have experienced child sexual exploitation. This includes support to immediate family members;
- Evidence based therapeutic interventions for young people and adults who have experienced child sexual exploitation.

At the end of January 2016, the new assertive outreach service for children and young people at risk of CSE was launched. Known as ReachOut, it is funded by contributions from the Department for Communities and Local Government, the Department for Education, the Council, Barnardo's and the KPMG Trust. The team of 15 staff will be engaging with children, young people and families as well as community groups, schools, colleges and health services and will also raise awareness of how to spot the signs of sexual exploitation. The team has already been successfully engaged in supporting recent CSE operations.

Both the Jay and Casey reports identified failings in the functioning of licensing services and in particular taxi licensing, as well as concerns at the links between child sexual exploitation and the taxi trade. As part of the intervention all decision making on licensing matters has been taken by one of the council's commissioners.

The Council has implemented a new Private Hire and Taxi policy. The new policy was agreed by the Commissioner on 6th July together with an implementation scheme which set requirements for compliance with the policy. The new policy includes higher standards of the 'fit and proper person' test of drivers including: how convictions, softer intelligence and complaints are considered; revised requirements for training, including Business and Technology Education Council (BTEC) and compulsory safeguarding training; and more stringent requirements regarding safety, age of vehicles and use of cameras in taxis.

By February 2016 the Commissioner will have held individual hearings and taken decisions on 135 taxi licensing cases. Importantly, arrangements for the exchange of information between the service and South Yorkshire Police (SYP) and the participation by the Business Regulation Manager in the Child Sexual Exploitation (CSE) intelligence exchange meetings has ensured that licensing are playing their full part in tackling CSE and other safeguarding issues.

Domestic Abuse

Domestic abuse is a feature within the family for 70% of Rotherham children who are subject to a Child Protection Plan of protection, in line with national trends.

Domestic abuse is defined as any incident or pattern of controlling, coercive or threatening behaviour or abuse between those ages 16 and over, who are or have been intimate partners or family members, regardless of gender or sexuality. This encompasses, but is not limited to, physical, emotional, psychological, sexual and financial abuse. Domestic Abuse includes forced marriage, "honour" based violence, partner and ex-partner stalking and harassment.

Domestic abuse causes harm not only to the individual but also to other members of the family, community and wider society. Victims of domestic abuse may suffer long term physical and mental health problems and are more likely to face economic consequences, unemployment and welfare dependency. 30% of domestic abuse starts in pregnancy

The impact of domestic abuse on children includes increased levels of vulnerability and higher risks to their welfare as a result of domestic abuse occurring in their household.

MARAC or Multi-Agency Risk Assessment Conference is a meeting of professionals which looks at the high risk domestic abuse cases and develops a plan to keep the victim safe.

Indicator – 2015/2016	Number or % of cases
Number of all domestic abuse incidents reported to South Yorkshire Police	6297
Numbers of repeat cases reviewed by MARAC	202
Number of 16/17 year old referrals to MARAC	31
Number of cases reviewed by MARAC	534
Number of MARAC cases with children involved	204
Number of repeat referrals to MARAC with children involved	66
Number of repeat referrals to MARAC	202
Number of referrals to IDVA	481
Rate of engagement with IDVA	78.5%
Total Referrals to IDVAs	581
High Risk Referrals	489
Successfully Contacted (High Risk) - %	90
Engaging (High Risk) - %	79
Medium or Low Risk Referrals	86
Successfully Contacted (Medium Risk) - %	49
Engaging (Medium Risk) - %	35
High Risk referrals	100%
Male Referrals - %	5
LGBT Referrals - %	1
16/17 yr old referrals - %	6
BME referrals - %	6
Disability Referrals - %	7

An IDVA or Independent Domestic Violence Advocate is someone with the specialist knowledge and skills that can provide support to victims of domestic abuse.

Nationally, in 2011/12, 7.3% women (1.2 million) and 5% men (800,000) reported having experienced domestic abuse. It is recognised nationally and locally that domestic abuse is under reported. Rotherham has seen an increase in reported incidents, also in referrals to MARAC when compared to previous years. This trend is expected to continue and reflects the national picture.

The increase in reported abuse may be related to increased awareness of domestic abuse alongside economic adversity and austerity, the impact of which is putting more families at risk of psychological stress and family breakdown. There are concerns that welfare reform measures could lead to an increased risk of financial abuse and women in particular could become more financially dependent.

In terms of responding to the impact of domestic abuse on children the arrangements and process for dealing with referrals to the MASH (Multi-Agency Safeguarding Hub) in relation to domestic abuse in the family was changed in order to improve safeguarding outcomes for children. Since September 2015, all referrals identified as high or medium risk received in relation to domestic abuse are reviewed on a daily basis by the MASH within 24 hours (working week) by a multi-agency meeting consisting of a social worker, police officer, health and education professionals, probation officer and an IDVA. The meeting ensures that all relevant information is shared before a risk assessment is undertaken, a safety plan is put in place for the victim and the appropriate safeguarding response is initiated for the child(ren).

For high risk cases, the child's school and health practitioners (e.g. GP, health visitor, school nurse) involved with the family are alerted to ensure the child is supported and monitored after experiencing a Domestic Abuse incident the night before. The high risk cases are also referred to the next MARAC (Multi-Agency Risk Assessment Conference) for review. For some of the lower level risk cases the new early help triage team are able to respond proportionally to the needs of the child.

Children missing from care or home

'Running away is often symptomatic of other issues in a child or young person's life: children who decide to run away are likely to be unhappy, vulnerable and potentially at risk of harm' (Children's Society 2015)

It is important that local arrangements to identify, risk assess and support children and young people who go missing are well coordinated to prevent harm and safeguard those who have additional vulnerabilities and are most at risk.

In 2014 Ofsted found that the arrangements in Rotherham to identify and protect children who go missing from home or care were inadequate because:

- Processes for identifying and tracking children missing from home and care were not robust enough.
- Return home interviews weren't making a difference and not all children benefitted from a return home interview after going missing.
- There was no reporting mechanism which resulted in a lack of management oversight.

Children and young people who are missing from home or care had been identified as a priority for the LSCB because of their particular vulnerability. All contacts for one week in April 2015 related to a young person who was reported as missing were examined. As a result the use of the "Missing from Home – Trigger Plan" was identified as best practice and is now routine when a young person has been reported as missing frequently. Trigger Plans" are now routinely sent to other Police Forces when a Child in Care from Rotherham is placed out of borough. Feedback from our partners in the Police and Foster Carers and Residential Providers has been very positive. In addition every missing young person referred is offered a timely Return Home Interview.

One of the key actions to address the deficit identified by Ofsted was to implement a tracking system to monitor individual children and young people and a way of reporting how many children were going missing in Rotherham. The development of a report to count how many children go missing required significant changes to the case management system and the data below represents the most recent overview of missing episodes.

		Jan 2016	Feb 2016	Mar 2016
Missing Episodes	Total Number of missing episodes	83	60	56
	Total number of individual children	66	40	46
	Including number of Looked After Children missing episodes	29	23	26
	Including number of individual Looked After Children	17	13	20
Return Home Interviews (RHI)	Number of missing episodes referred for RHI	70	55	54
	Number of RHI Refused by Child or young person	0	3	8
	Number of Referrals still outstanding	23	24	0
	Number of RHI completed this month	50	31	46
	Number of completed after the 3 days of child or young person being found	14	5	10
	Number completed within the 3 days of found	36	26	36

A follow up audit was conducted by the Practice Audit Officer, RLSCB and the CSE/Vulnerable Person's Coordinator in September – October 2015 using 50 cases of children who were reported as missing during that period. The audit addressed:

- Thematic analysis of the reasons why young people go missing to identify the most significant indicators and risk factors – the “push” and “pull” factors and particular areas of vulnerability
- An assessment of the quality of practice provided to the young people from the initial call to the police, contact and screening by MASH or the Missing Team, response to the episode by police, and assessment and service delivery by social care
- Recommendations to improve practice and services to children who go missing.

As a result of the audit, the following recommendations were made and implemented:

- Align the missing notification and referrals within the MASH to further improve information sharing and screening.
- Parents (including carers, foster carers and residential care workers) should be engaged in the Return Home Process to ensure the “push” and “pull” factors identified in the RHI with the young person are understood and addressed in order to reduce the frequency of the missing episodes / risks / vulnerabilities.
- Placement providers and carers must have training to ensure their understanding of children and young people who go ‘missing’ from home or care informs the care they provide.
- The views and “voice” of children and young people who go missing must be listened to and used to inform decisions about their lives. A leaflet designed by young people to be given at RHIs should be developed and views utilised to inform and shape services.

A Return Home Interview is where an independent person speaks to the child in order to hear what they have to say and how they feel about their home life and circumstances and helps to prevent them from going missing again.

Key improvements over the past year to the response to children who go missing include:

- The appointment of a Missing Person coordinator and Return Home Interview support workers.
- The Missing Team are located in the MASH (Multi-Agency Safeguarding Hub) which improves information sharing.
- The implementation of a tracking system which enables the sharing of key information and coordination of services.
- A multi-agency monthly Missing Evaluation Review Team which monitors the operational processes that support children and young people who go missing
- Revision of the Missing Protocols and procedures to create clear pathways and accountability between services.
- Initiating 'Trigger Plans' for all young people who have gone missing or are vulnerable to going missing.
- A Missing Screening Tool has been developed to assist practitioners and managers about factors relating to a child going missing.
- The Council has signed up to the National Runaways Charter.

A Trigger Plan is a profile of a young person which helps the police to find them if they go missing.

There have been significant improvements in relation to the practice in relation to missing and this has translated into improved outcomes for children and young people.

Case example:

A 15 year old girl had been reported missing on more than one occasion and had been found in Manchester where she had put herself at risk of harm. The Return Home Interview established that the girl was exploring her sexuality and had been trying to access information and services, which she had found on the internet, in Manchester. As a result of the Return Home Interview she was able to access appropriate local support in Rotherham and did not go missing on any more occasions.

6. Learning and Improvement

In order to improve outcomes for children in Rotherham, the LSCB has to check and challenge the effectiveness of services. The LSCB provides safeguarding training and up to date safeguarding policies and procedures for people who work with children in Rotherham to make sure they are confident in providing the services.

Performance Management Framework

The RLSCB Performance Management Framework includes a process for gathering and analysing information to answer the questions:

- What do we know about all children in the area and what are their needs?
- What do we know about children with particular needs, including early help?
- What do we know about children who need protection?
- What do we know about looked after children and care leavers?

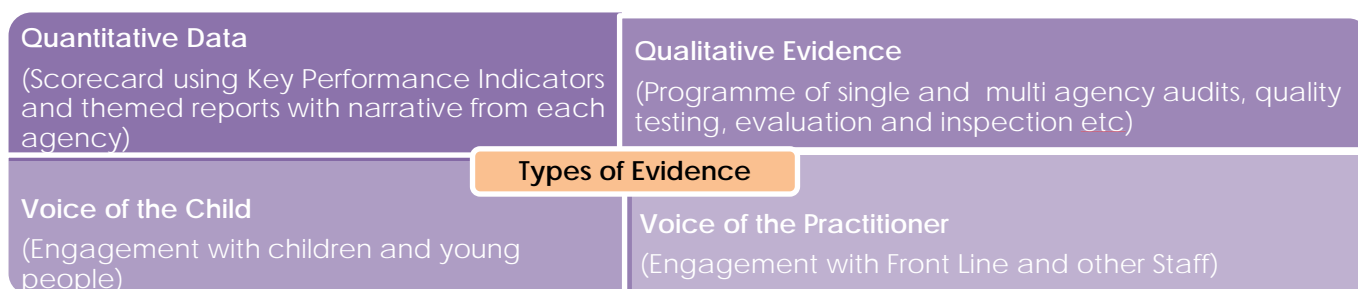
In considering these questions, we will consider the following:

- How much have we done and how do we compare with others?
- How well have we done it and what difference are we making to the lives of children?

These questions will be answered using:

- Quantitative data to compare with other authorities (Statistical Neighbours; Yorkshire & Humber region; Best Performing Local Authorities and LSCBS), monitor over time, track trends and evaluate effectiveness
- Qualitative data in the form of strategic (section 11) and case file audits, inspection reports, evaluation from training and procedures
- Feedback from children and young people
- Feedback from frontline professionals and understand workforce perspectives
- Feedback from single agency perspectives triangulated with feedback from other agencies and external processes

This diagram illustrates the sources of information:



This is an example of how we will gather evidence for each safeguarding priority:

Safeguarding Priority				
How much have we done?		How well have we done it?		What difference are we making?
Performance Data and Trends	Audits, evaluations and thematic reports	Voice and experience of the child	Workforce, Training and Voice of practitioners and carers	Inspection Reports, Corporate parenting

The evidence is provided by single agencies and the local authority. It has been an evolving process that has improved as agencies understand what they need to contribute to the overall understanding of effectiveness. Agency information is also presented in the four quadrants illustrated above and increasingly includes a report from a senior manager or safeguarding lead and feedback from children and young people and their families.

The quarterly reports provide a context for monitoring and evaluating the effectiveness of what is done by Rotherham Local Safeguarding Children Board and its Board partners individually and collectively to safeguard and promote the welfare of children. The reports are considered at the multi-agency Performance & Quality Assurance Subgroups which are held six weekly. Alternate meetings focus on performance and auditing. The Subgroup Chair provides a report to the Board to inform their scrutiny of multi-agency arrangements.

Our aspiration is to provide an understanding of what difference we are making to the outcomes of children and young people based on information from each of the quadrants, for example:

- How many children and young people each agency works with , and how many specifically for safeguarding reasons
- How many referrals they make to MASH for safeguarding concerns and early help; how many multi-agency meetings they attend (e.g. CP conferences, core groups, strategy discussions etc)
- Summaries of work they have undertaken to measure the difference their work has made to the lives of children and young people - their individual and collective outcomes
- Summary of audits they have undertaken to quality assure their work
- Summary (feedback) of questionnaires / surveys from staff in relation to safeguarding / training / supervision etc
- Report how they have worked with children and young people to contribute to the development of their service and other services.

Quality Assurance, Audits and Case Reviews

Quality Assurance is a process which checks the quality of services and what needs to change to improve them. It establishes what is working well and where there are improvements needed. Conducting audits (checks) and reviews of children's cases is one of the ways the quality of services is monitored.

Audit and reviews of multi-agency frontline practice	
Thematic review strategy discussions Jan 2015 – Feb 2015	April 2015
An audit was undertaken to evaluate the quality of strategy discussions and subsequent sec 47 enquiries; a total of 273 strategy discussions held between 1st January 2015 and 18 February 2015 were audited.	
Audit of MASH contact and referral outcome decisions	April 2015
The New MASH service was introduced on 1 April 2015. This was a desk top review of all contacts received on a single day in April 2015 which sought to determine the quality of case recording and multi-agency practice.	

Missing Children Audit	May 2015
Children and young people who are missing from home or care had been identified as a priority for the RLSCB because of their particular vulnerability. All contacts for one week in April 2015 related to a young person reported as missing were examined. This audit was undertaken to provide a baseline for future audits.	
Audit of Paediatric Assessments (Child Protection Medicals) for Child Abuse and Neglect	May 2015
This audit was undertaken to assess the impact of the redesigned paediatric assessment for child abuse and neglect pathway launched in September 2014. This development was, in part, in response to anecdotal information that suggested that the process and procedures in place prior to this were resulting in social workers experiencing difficulties in arranging timely paediatric assessments and that children were experiencing long delays waiting to be seen after they had attended for their assessment appointment at the hospital. This initial audit provides a baseline for the future audits post implementation of the pathway.	
MASH workforce survey July – August 2015	August 2015
A survey monkey questionnaire was jointly developed between partners within Health, Children's Social Care Services and the LSCB business unit. The survey consists of 14 questions that covered the full gamut; from the clarity of MASH process through to the delivery of improved outcomes for children. The survey aimed to establish where partners thought that the MASH had made any impact and to identify what further work needs to happen moving forward.	
Audit of timeliness of children protection conferences	September 2015
This audit examined whether children and families subject to child protection conferences are being notified in a timely manner and provided with good quality written information that they can discuss with the professionals who have written them prior to the conference. 50 child protection conferences were subject to audit.	
MASH 'No Further Action' dip sample audit	September 2015
This was a follow up dip sample audit following the more comprehensive benchmarking audit undertaken in April 2015. A desktop review was undertaken on a 100 contacts received by the MASH between the 25-31 July 2015. This represented 40% sample size of the 239 contacts received in this time period. The audit sought to determine the quality of case recording and multi-agency practice.	
Missing Children re-audit	October 2015
This audit was a follow up to the benchmarking audit May 2015. Significant changes had been made to practice in the intervening time. This audit aimed to address three main areas: the reasons why young people go missing, the quality of practice provided to the young people and to make recommendations to improve practice and services to children and young people who go missing.	
Evolve CSE Thematic Audit	November 2015
A multi-agency desktop review was undertaken of 5 individual children by individual partner agencies using a developed CSE audit tool. The review of these cases sought to qualitatively determine the effectiveness of the multi-agency practice and working together arrangements of EVOLVE with a particular focus on child and victim centred investigations and support services.	
MASH children's workforce survey	December 2015
A survey monkey questionnaire should be developed and distributed seeking feedback regarding individual practitioner experiences of accessing the MASH from across the partnership. It was designed to seek practitioners' opinion regarding their experience of contacting the MASH service as well as establishing how confident they felt regarding the quality of the decisions made and the advice provided.	
Audit of Strategy Discussions	February 2016
This audit was a follow up to the benchmarking audit conducted in April 2015, and was specifically undertaken to test compliance to the statutory guidance and RLSCB procedures. A desktop review was undertaken using 30 Strategy Discussions conducted by the Rotherham Children's and Young Peoples Service between September and December 2015.	

Child Case Reviews
Case A <p>Concerned a 4 month old baby who was subject to a child protection plan and suffered a non-accidental injury; the subsequent paediatric assessment also identified a healing fracture of the ulna. The focus of the review was to review the multiagency CP plan, visits schedule across the partnership, content of visits (quality) and efficacy of core groups to establish if there was any learning regarding the joint CP practice in this case.</p>
Case B <p>Concerns a 17 year old female who had experienced domestic abuse perpetrated by her partner and concerns regarding her mental health. She had been sectioned under section 2 MHA 1983 (2007) 2015 and placed in a neighbouring authority prior to transfer to Rotherham; she was discharged from the section in July 2015. The focus of the review was to review the practice of practitioners from partner agencies in relation to this young woman particularly regarding effective communication.</p>
Case C <p>Root cause analysis undertaken concerning a 9 month old male infant who was admitted to the Children's Ward, Rotherham General Hospital in April 2015 following an arranged hospital appointment with the Dietician. His weight was below the 0.4th centile, he appeared visually thin and at the time of admission concerns were expressed by medical staff regarding his obvious failure to thrive and developmental delay. Prior to his admission an anonymous referral was made to children's social care expressing concerns about his weight and appearance.</p>
Cases D & E <p>This was a review two specific cases where the discharge from hospital of new-born babies subject to safeguarding processes may have been delayed after they were deemed medically fit for discharge. The purpose of the multi-agency review of the two cases was to assess the effectiveness of the current procedures and practice for safeguarding unborn and new-born babies to ensure they are in line with best practice and the recommendations made by the Care Quality Commission (CQC) following their CLAS Inspection undertaken in February 2015.</p>

Outcomes and impact of Audits and Case Reviews

The RLSCB developed and contributed to the implementation of a multi-agency Strategy Meeting/ discussion template and training sessions that provide a clear framework and structure as well as practice guidance to ensure effective meetings.

Use of the "Missing from Home – Trigger Plan" has been identified as best practice and is now routine when a young person has been reported as missing previously and for all Looked After Children aged over 10 years. Trigger Plans are routinely sent to other Police Forces when a Child in Care from Rotherham is placed out of borough. Feedback from our partners in the Police and Foster Carers and Residential Providers has been very positive.

The Missing from Home or Care and Runaways Multi-agency protocol has been reviewed in light of audit work and agreed with partner agencies in Rotherham and then across the South Yorkshire region. As a result a Return Home Interview (RHI) process has been agreed and every missing young person who is referred is offered a timely RHI. The take up of RHIs has increased significantly and there is practice evidence that this intervention and support has had a positive impact on engaging young people, reducing missing episodes and providing targeted support to young people at risk of significant harm.

The RLSCB Learning and Development Co-ordinator has ensured that the multi-agency training regarding "Strengthening Families Framework" specifically includes professional responsibilities and attendance at Child Protection conferences and importance of sharing written reports at least 2 working days before.

The RLSCB procedure for initial and review child protection conferences have been updated and published to provide clarity about professionals' expectations of engagement with children and their family and the provision of written reports.

As a result of audit work, the CYPS Safeguarding Unit has made changes to ensure that all conference minutes are distributed and available within the child's record in a timely manner. There has been a significant improvement, but continues to be monitored closely with increasing consideration how to complete minutes in a more focussed efficient manner without losing the essential evidence.

The Development and implementation of a Challenge Protocol was undertaken for the use of the Child Protection Conference Service. This enables conference chairs to constructively challenge colleagues within and between agencies to provide robust scrutiny to this area of work.

The protocol regarding "Paediatric Assessments for Child Abuse and Neglect" has been reviewed and aligned with the guidance provided by Royal College of Paediatrics and Child Health "The Child Protection Companion" 2nd ed. 2013 and agreed with partner agencies in Rotherham. An agreed procedure has been added to the LSCB Procedures on line and awareness raised amongst partner agencies and the procedure through the RLSCB level 3 safeguarding training.

An audit had identified inconsistency within the screening process within the MASH. Clear guidance regarding screening expectations was explored with MASH team managers and individual workers. This was further communicated within the MASH Team meeting. Clarity around screening expectations is included within MASH Operational Guidance V.1 June 2015.

The LSCB Safeguarding Unborn and New born Babies procedure have been amended to include the details of additional standards and guidance relating to contingency arrangements the development of a planning template with stakeholders to support the production of Pre-Birth Plans.

A formal written agreement or Memorandum of Understanding (MOU) has been developed between The Rotherham NHS Foundation Trust (TRFT) and Children and Young People's Services with the expectation that all children in hospital, who are subject to safeguarding concerns, should not be subject to a delayed discharge. In the event that it is not safe to discharge them, an escalation procedure is in place between the two services.

To support this a regular (bi-monthly) meeting between the Head of Midwifery (TRFT) and Head of Safeguarding / Head of Service – Locality Social Work (CYPS) now provides a forum to review all cases of babies born where there have been safeguarding concerns and ensures that plans are in place for those expected to be born in the next period. As a result of a case review the RLSCB has developed and implemented a new procedure for "contact between parents and their children in hospital where there are safeguarding concerns."

Section 11 Audit for statutory agencies

The S11 audit evaluates and challenges organisations arrangements to safeguarding children.

Section 11 (4) of the Children Act 2004 requires each person or body to which the duties apply to have regard to any guidance given to them by the Secretary of State and places a statutory requirement on organisations and individuals to ensure they have arrangements in place to safeguard and promote the welfare of children.

Rotherham LSCB currently operates a 4 stage Section 11 audit process:

- **Stage 1** - A self-assessment is undertaken by each partner agency using an agreed audit tool that encompasses 8 standards.
- **Stage 2**- Participation in a "Challenge Meeting" which involves the agency RLSCB member, the organisation's section 11 auditor, the RLSCB Independent Chair and the RLSCB Quality Assurance Officer; and another Board Member peer reviewer.
- **Stage 3** – Each agency commences work against the improvement actions agreed at the S11 challenge meetings and contained with their feedback letter.
- **Stage 4** - Involves the identification of emerging themes and findings and production of a summary report providing a level of assurance to the LSCB.

Agencies which were subject to the S11 Audit in 2015-16
South Yorkshire Police
Rotherham Clinical Commissioning Group
RMBC Children and Young Peoples Services
RMBC Corporate
Rotherham Youth Offending Service
Rotherham, Doncaster and South Humberside NHS Foundation Trust (RDASH)
The Rotherham NHS Foundation Trust (TRFT)
NHS England
South Yorkshire Fire & Rescue (SYFR)
National Probation Service (NPS)
Sodexo South Yorkshire Community Rehabilitation Company (SYCRC)

All agencies that were requested to complete a section 11 report did so and were received by the LSCB business unit in February 2016. Between the 9 and 16 February 2016 three challenge days were held.

This year the decision was taken to incorporate a Board Member peer reviewer on the challenge panel. The challenge meeting is part of the LSCB's collaborative approach to continuous improvement, the objective being to facilitate honest and constructive challenge, as well as providing an opportunity for organisations to share their practice, indicate future actions and provide assurance about their safeguarding children arrangements. The aim is to increase both the effectiveness of inter-agency working and to improve the understanding in relation to organisational roles and responsibilities.

Feedback has strongly indicated that those completing the audit found it a valuable exercise. Agencies advised that the audit had acted as a prompt, reinforcing their obligation to have arrangements in place which serve to protect and safeguard children and young people - with some agencies revising their own policies and amending procedures to address gaps identified by the audit.

As a result of these discussions the reviewers were in a position to conclude that overall, agencies had an awareness of their safeguarding arrangements, that their self-evaluations were a realistic review of their current position and that these will provide a base line to measure future progress. All agencies provided examples of evidence that supported their self-evaluation. An opportunity for resubmission was given and the updated evidence and action plans have been reviewed by the LSCB advisors and the Performance and Quality Assurance Sub Group to monitor progress.

Key Themes Arising from Section 11 Audit

3 key themes were seen cross cutting all of the 8 individual standards:

- 1) Agencies do not always provide enough evidence either through specific practice examples or quantitative data to support the statements being made regarding the safeguarding arrangements within their organisations.
- 2) Organisations continue to find the increased focus on evidencing “outcomes” to be a challenge with a tendency to rely on descriptive evidence of process and procedure; however the challenge meetings did provide an opportunity to identify evidence of improved outcomes for children and families but answering the “So what?” question is an area that continues to require further partnership working and will need to subject to further review and challenge over the next 12 months.
- 3) There is limited sharing of single agency audits with the LSCB where there are safeguarding elements being scrutinised. The findings from these audits are not routinely shared with the LSCB which is a missed ‘added value’ opportunity for shared learning, development of best practice and providing assurance across the partnership.

Child Death Overview Panel

The Child Death Overview Panel (CDOP) is a multi-agency panel. It looks at every case where a child has died in the borough to see if there are things which can be changed in the future to prevent a similar death.

The number of child deaths in any particular age range within the local area is small in number. This means that generalisations are rarely appropriate, and for lessons to be learned data needs to be collected and reported on nationally and over a number of years. Current methods of data collection mean that accurate regional and national comparisons are not readily available.

CDOP promotes the sharing of information and learning to all organisations, in both the statutory and voluntary sector, about how to reduce the likelihood and impact of modifiable risks which might lead to the death of a child. By so doing, the panel seeks to reduce risks, prevent avoidable deaths and improve the health, welfare and safety of the children across the Borough.

Remit of the Child Death Overview Panel

The functions of the CDOP include:

- Reviewing all child deaths, excluding those babies who are stillborn and planned terminations of pregnancy carried out within the law;
- Collecting and collating information on each child and seeking relevant information from professionals and, where appropriate, family members;
- Discussing each child's case, and providing relevant information or any specific actions related to individual families to those professionals who are involved directly with the family so that they, in turn, can convey this information in a sensitive manner to the family;
- Determining whether the death was deemed preventable, that is, those deaths in which modifiable factors may have contributed to the death and decide what, if any, actions could be taken to prevent future such deaths;
- Making recommendations to the Local Safeguarding Children Board (LSCB) or other relevant bodies promptly so that action can be taken to prevent future such deaths where possible;
- Identifying patterns or trends in local data and reporting these to the LSCB;
- Where a suspicion arises that neglect or abuse may have been a factor in the child's death, referring a case back to the LSCB Chair for consideration of whether a Serious Case Review (SCR) is required;
- Agreeing local procedures for responding to unexpected deaths of children; and
- Cooperating with regional and national initiatives – for example, with the National Clinical Outcome Review Programme – to identify lessons on the prevention of child deaths.

In reviewing the death of each child, the CDOP should consider modifiable factors, for example, in the family environment, parenting capacity or service provision, and consider what action could be taken locally and what action could be taken at a regional or national level.

The aggregated findings from all child deaths should inform local strategic planning, including the local Joint Strategic Needs Assessment, on how to best safeguard and promote the welfare of children in the area. Each CDOP should prepare an annual report of relevant information for the LSCB. This information should in turn inform the LSCB annual report.

Child Death Reviews 2015-16

During 2015-16 CDOP met on three occasions, with a total of 7 deaths being reviewed.

Case	Age Range	Gender	Ethnicity	Expected/Unexpected	Modifiability	Category
1	<28 days	Female	Unknown	Expected	Non Modifiable	Perinatal/neonatal event
2	<28 days	Female	Asian Pakistani	Expected	Non Modifiable	Chromosomal, genetic & congenital anomalies
3	28 to 364 days	Female	White British	Expected	Non Modifiable	Perinatal/neonatal event
4	<28 days	Male	White British	Expected	Non Modifiable	Chromosomal, genetic & congenital anomalies
5	<28 days	Male	White British	Expected	Non Modifiable	Chromosomal, genetic & congenital anomalies
6	1-4 years	Male	White British	Unexpected	Non Modifiable	Acute medical or surgical condition
7	28 to 364 days	Male	White British	Unexpected	Modifiable	Sudden unexpected, unexplained death

CDOP Activity 2015-16

In 2015-16 Rotherham CDOP reviewed 7 cases of children who had died.

Rotherham CDOP undertook the following review and developmental work in 2015-16:

- Participated in a South Yorkshire wide study being carried out by Sheffield Children's Hospital relating to deaths of children with a life limiting illnesses.
- Actively contributed to South Yorkshire CDOP meetings.
- Undertook a modifiability exercise to ensure that CDOP members understood the complexities at arriving at such a judgement and applied the criteria consistently.
- Reviewed the membership of CDOP to strengthen the work of the panel.
- Commissioned a Safe Sleep Audit for infants which was undertaken by The Rotherham NHS Foundation Trust and Rotherham Public Health

Key Learning Points from 2015-16

- To provide clear guidelines for handover communications between midwifery and health visitors / Family Nurse Partnership (FNP), to ensure that identified risks are recorded and shared between professionals, and where necessary re-assessment takes place.
- To provide guidance for midwifery, health visitors and FNP when reassessment and/or escalation are required.
- To update The Rotherham NHS Foundation Trust (TRFT) Safe Sleeping Policy to include assessments, procedures and processes

- CDOP reviewed a case where there were vulnerable young children living in poor housing conditions and there were potential options to address this with the landlord using a range of housing regulations and enforcement actions. It was established that the council's housing department can take action against irresponsible housing landlords including for example, issues such as damp, bare wiring, no heating, unsafe conditions. This key area of learning was disseminated through the partnership workforce.
- Where a teenager is receiving treatment in an acute medical setting (hospital) there needs to be a care pathway developed to ensure the child receives the same medical interventions and reviews as if they were on a paediatric ward. This needs to include the use of a paediatric history sheet and charts, and training amongst staff on how to effectively use this pathway.

Multi-Agency Safeguarding Learning and Development

Training and other learning and development activity is provided by the RLSCB to a wide range of professionals and volunteers who work with children and families in Rotherham.

The RLSCB currently offers a wide range of multi-agency safeguarding children training which supports the development of the workforce in Rotherham who work or come into contact with children, young people and their families. Training is delivered through a blended approach with face to face training and e-learning courses and aims to support individuals and organisations to undertake their safeguarding roles and responsibilities in a committed, confident and competent manner.

During 2015/16 the LSCB offered 48 different themed training courses delivered through 205 training sessions to 4857 attendees. Examples of the training subjects included:

Training courses delivered in 2015/16
Child Sexual Exploitation and Safeguarding
CSE: Understanding a Child Victim's Response to Sexual Exploitation
Safeguarding Children and Understanding Thresholds of Need
Working with Resistant Families
WRAP Training (Workshop to Raise Awareness of Prevent)
Domestic Abuse
Early Help - Assessment Skills Training
Early Help - Introduction to Childhood Neglect
Female Genital Mutilation
Strengthening Families Framework
Safeguarding Disabled Children and Young People

All Rotherham Safeguarding Children Board courses are free of charge to all partner agencies and non-profit organisations.

Agencies who attended included

- South Yorkshire Police;
- Rotherham Clinical Commissioning Group;
- The Rotherham NHS Foundation Trust;
- Voluntary sector organisations including Action Housing, Rotherham Women's Refuge, MySELF Project, GROW, Rotherham and Barnsley Mind;
- RMBC social care; Educational settings;
- South Yorkshire Fire and Rescue;
- Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH)
- Rotherham Foster Carers.

The LSCB training offer is continually reviewed to ensure that it responds to local need and priorities and the training strategy takes into account national, regional and local factors, including acting on the recommendations of serious case reviews, child death reviews, and other reviews such as audits.

The training programme identifies the aims and learning outcomes for all courses and identifies which groups of staff the training is appropriate. It is aligned to the National Competency Framework for Safeguarding Children. Attendees are asked to provide evidence of the impact of the training both on their practice and for children and families. The evidence shows that the majority of attendees report increased confidence, improved skills and the fact that having attended the training they felt it had impacted positively on their safeguarding practice. The following offers an insight into some of the feedback received:

Developing Understanding and Insight into the Impact of Child Sexual Exploitation on Victims' Responses and Disclosures:

"To be focused and assess the referral from different viewpoints. To put the young person first. To work with others."

"It will make me more aware and more able to identify any children at risk." and "The video 'Sick Party' changed my views on how I thought and gave me different insights."

Female Genital Mutilation:

"It will enhance my practice to help me answer difficult questions and respond more sensitively"

"It has increased my confidence, increased my awareness of its prevalence and the indicators and provided clarity around the do's and don'ts"

Working with Resistant families:

"You must hear the voice of the child, make sure you hear and see them"

"It will help me with my reflective practice and confidence in challenging families"

Basic Child Protection:

"Child protection is everyone's responsibility"

"To not make assumptions better to say something than not"

Safeguarding Training for Education - Designated Safeguarding Leads:

"I need to review and update my own learning regularly to keep up with the changes"

"It has given me adequate information which has given me confidence should a safeguarding incident take place in my work setting"

Safeguarding children policies and procedures

These are the multi-agency procedures and processes that professionals must follow where there are concerns about a child's safety or welfare.

Safeguarding Children Policies and procedures can be developed or amended as a result of any of the following:

- Changes to legislation or statutory guidance
- Recommendation from a local learning process, such as audits or practice reviews
- Recommendation from Serious Case Reviews or Child Deaths
- Research evidence or best practice guidance

Safeguarding procedures updated in 2015/16

During the year there were two updates to the online multi-agency safeguarding children procedures:

In the summer of 2015 a review of all procedures in the "Core Procedures where there are Concerns about a Child's Safety and Welfare" were extensively reviewed to ensure they were consistent with Working Together 2015 and other statutory guidance and legislation, research and best practice guidelines and current practice in Rotherham. The documents were reviewed by the RLSCB Business Unit in conjunction with key multi-agency stakeholders. New or significantly revised procedures included:

"Referring Safeguarding Concerns about Children"

- Referring Safeguarding Concerns about Children
- Multi-Agency Referral Form (MARF) Guidance
- Action Following Referral of Safeguarding Children Concerns
- Practice Guidance:
- Indicators of Abuse; Significant Harm: The Impact of Abuse and Neglect; Neglect

"Child Protection - Investigation and Conferences"

- Strategy Discussions/Meetings
- Section 47 Enquiries
- Paediatric Assessment for Section 47 Enquiry (Child Protection Medical)
- Initial Child Protection Conferences
- Implementation of a Child Protection Plan - Lead Social Worker and the Core Group Responsibilities
- Child Protection Review Conferences
- Practice Guidance: 2013 Protocol and Good Practice Model Disclosure of information in cases of alleged child abuse and linked criminal and care directions hearings (October 2013)
- Practice Guidance: Achieving Best Evidence in Criminal Proceedings Guidance on interviewing victims and witnesses, and guidance on using special measures (March 2011)
- Appeals in Relation to Child Protection Conferences

New procedures developed and added to the manual during the year included:

- As a result of the Care Quality Commission inspection of The Rotherham Foundation NHS Trust in 2015, new procedures for Safeguarding Unborn and Newborn Babies and Concealment and Denial of Pregnancy were developed.
- Supporting Children and Young People Vulnerable to Violent Extremism
- Safeguarding Girls and Young Women at Risk of Abuse through Female Genital Mutilation
- The South Yorkshire Runaways Joint Protocol Running Away from Care and Home

Significantly reviewed were the following procedures:

- Safeguarding Children and Young People who go Missing from Home and Care
- Children and Families who go Missing
- Children Moving Across Boundaries

- Children Living Away from Home (including Children and Families Living in Temporary Accommodation)
- Safeguarding children subject to Private Fostering arrangements
- Safeguarding Children at Risk of Modern Slavery
- Neglect Procedure was updated and the Rotherham Graded Care Profile was added.
- Underlying Policy, Principles and Values
- Information Sharing and Confidentiality
- Statutory Framework
- Practice Resolution Protocol: Resolving Professional Differences of Opinion in Multi-Agency working with Children and their Families
- Contact between Parents and their Children in Hospital where there are safeguarding concerns
- Multi-Agency Practice Review Group Terms of Reference

National guidance documents were added, including

- ACPO – A Guide to Investigating Child Deaths
- DBS Eligibility Criteria
- Raising Concerns at Work: Whistleblowing Guidance for Workers and Employers in Health and Social Care
- Anti- Social Behaviour, Crime and Policing Act 2014
- Safeguarding Children at Risk of Modern Slavery

7. Managing Allegations against staff, volunteers and foster carers

Investigations where there are concerns about those professionals or volunteers who work with children.

Working Together 2015 requires that each Local Authority has a designated officer to deal with allegations made against professionals or persons who are a part of the children's workforce. In practical terms, the role of the Local Authority Designated Officer (LADO) is to:

- Provide advice and guidance to agencies and individuals, in relation to issues surrounding the conduct of their staff (whether paid or unpaid) which concern actions or behaviours giving rise to safeguarding concerns;
- Ensure co-ordination and proportionate, fair and safe outcomes in relation to these matters, specifically regarding the safeguarding of any / all children concerned, the investigation of any criminal matters and the associated human resources processes;
- Convene, chair and record strategy meetings for this purpose;
- Manage and oversee individual cases from the commencement of the process through to conclusion and outcome.

The LADO will become involved, where there is reasonable suspicion that a person who works with children (whether paid or unpaid) has behaved in such a way as to:

- Cause or potentially cause harm to a child;
- Commit a criminal offence against or related to a child; or
- Indicate that he or she would pose a risk of harm if they were to work regularly or closely with children.

Both historical and current allegations of this kind are considered. An incident or behaviour occurring in the context of a person's private life will also be considered where this suggests that the person may pose a risk of harm to children.

In 2015-16 there were 233 recorded enquiries, 99 of these progressed to a strategy meeting and investigation. This is an increase on the figures for 2014-2015 when 83 allegations were progressed into a full LADO investigation. The referral source for those initial 99 enquiries was as follows:

Professional Source of LADO referral	Total
Children's Social Care Services	45
Residential Child Care Service	2
Children's Contact Service	1
Secondary Education	7
Primary Education	11
Early Years Services	3
Fostering Service RMBC	9
Independent Fostering Agency	1
Health:	
Rotherham Doncaster and South Humber NHS Trust	1
Sheffield Children's Hospital NHS Trust	1
The Rotherham Foundation NHS Trust	1
Other NHS Trust	1

Professional Source of LADO referral	Total
NSPCC	1
Police	10
RMBC Children's Rights2Rights Service	2
RMBC	1
CYPS Safeguarding Services	2
Total	99

Of the 99 initial enquiries that progressed to strategy discussion and investigation, the nature of the issues was as follows:

Nature of issue	Total
Physical abuse	30
Physical restraint	9
Emotional abuse	11
Sexual abuse	11
Inc Historical sexual abuse	3
Sexual exploitation	4
Person who may pose a risk of harm	14
Neglect	17
Total	99

Of the 99 enquiries that progressed to strategy discussion and investigation, the outcome was as follows:

Outcome	Total
Substantiated	30
Unsubstantiated	40
Unfounded	11
Malicious	4
Other	4
Investigation ongoing	10
Total	99

A range of outcomes is recorded in respect of the perpetrator's employment as follows (in each case there are one or more outcomes):

Outcome	Total
No further action taken	55
Resigned	12
Dismissed	5
Formal warning (written or verbal)	3
Ceased using services	3
Additional monitoring and supervision for specified period	14
De-registered (foster carers)	5

Outcome	Total
Police caution	2
Criminal proceedings ongoing	5
Policies and procedures reviewed	1
Additional support offered in the classroom	4
Additional Safeguarding training recommended	Unquantified but frequent (especially in schools)
Referral to regulatory body	5

Quality and Thematic Issues

Increasing volume of referrals to the Local Authority Designated Officer (LADO)

The growing number of enquiries to the LADO provides some evidence that an increased awareness of the allegation management process is evident and is embedded throughout the Rotherham partnership. In specific agencies (e.g. Police and Health) the number of enquiries that reach the LADO threshold and therefore become full LADO Investigations is high, suggesting a clearly embedded understanding of the types of issue that require a LADO involvement and an awareness of the process to be applied.

Awareness raising and the profile of the LADO role

The LADO has facilitated a number of training events across the partnership this year in order to improve and facilitate further and more consistent understanding of the LADO role, type and nature of issue to be referred. Presentations about the work of the LADO and process for managing allegations against staff have been made as follows:

- Two presentations to the Education Safeguarding Forum;
- Primary Head Teachers and School Governors;
- Housing and Licensing representatives;
- Catering and Facilities Managers.
- Residential Social Workers and as part of the Safer Recruitment Training delivered by the LSCB;
- Senior Managers of the Integrated Youth Service;
- Staff working in the Mosques across Rotherham as part of a general safeguarding training session;
- Taxi Operators as part of a safeguarding briefing event presented with the Passenger Transport Services.

Thematic and Qualitative Overview

There have been a number of complex matters referred to the LADO in the year. These have included serious allegations against members of staff employed in a variety of settings across the partnership. Particular referrals this year still have reference to historic allegations, some of which relate in part to larger scale police investigations.

In January 2016, a number of historical safeguarding incidents in respect of Taxi Drivers were brought to the attention of the Safeguarding Unit through work of the internal audit department within the council. These raised general issues about the safety of local arrangements around the licensing and commissioning of transport for children in the borough as well as having generated enquiries into the specific allegations and incidents.

Though, in line with Working Together guidance, the LADO remit generally covers adults who are employed to work directly with children the above was an example where a particular group of workers were not previously routinely being referred to the function. Given the above issues relating to some taxi drivers in the borough it is now explicit that taxi drivers (who regularly transport children and young people as part of their job or contract) should be considered by the LADO where there are relevant allegations. Taxi operators have been consulted and engaged in relation to this change to procedure.

Broader procedural change, relating to the licencing of taxi drivers, commissioning and procurement of taxi's or other transport for children in the borough and the use of taxis by residential care providers has resulted from this work.

There has been a slight increase in the number of perpetrators reported who have regular access to children and young people through other forms of employment, involving driving. For instance, there have been referrals in respect of two driving instructors. These referrals have generated positive links with the regulatory body for driving instructors who have been particularly proactive in recognising the safeguarding responsibilities of their organisation and assisting with LADO investigations.

Some incidents were not immediately and appropriately referred to the LADO. One such incident occurred in a school where an immediate internal investigation determined that the incident would not meet LADO threshold. Subsequently, the parents reported that the child received an injury and a full LADO investigation was undertaken which resulted in a criminal charge against the teacher.

8. Conclusion and recommendations for future priorities

We need to make sure that we have good information about how good safeguarding practice is in Rotherham, that we listen to children, young people and the wider community and that we influence the people who commission services to make improvements where it is needed. In drawing up our business plan we have taken account of the report from the Ofsted inspection in 2014, information from Ofsted monitoring visits and the Board's self-evaluation of its effectiveness.

This has resulted in the following key priority areas for the LSCB 2016 -18 Business Plan:

Governance and accountability

There needs to be a clearer articulation and understanding of the responsibilities and relationship between the LSCB and the Health and Well Being Board, Children's Partnership, Children's Improvement Board and Community Safety Partnership. The LSCB needs to have defined priorities for focus of its work in the context of the work of other strategic partnership boards. The LSCB needs to have greater influence in terms of the priorities and planning for other partnership boards. Partners need to hold each other to account much more in relation to safeguarding practice and issues.

Community engagement and the voice of children

The Board needs to do more in terms of engagement with local communities in relation to raising awareness and listening to their views. The voice of children needs to be taken into account more when evaluating safeguarding outcomes for children and young people. The council has declared its intention to be a child centred borough and the Board will test the evidence that the council and its partners are providing child centred services.

Scrutinising front-line practice

There needs to be continued, regular and effective monitoring of frontline practice including the use of thresholds and the impact of Early Help. Smarter opportunities need to be used for learning from practice and sharing the learning across the partnership.

Children in specific circumstances

Safeguarding Looked After Children, Children who are at risk of harm due to Child Sexual Exploitation, Children who go Missing, and Children who are at risk due to Neglect have been identified as priority areas of safeguarding where the LSCB needs to challenge and monitor progress.

For more information, see the [RLSCB Business Plan 2016 – 2018](#).

9. Appendices

Appendix 1 – Board Member attendance 2015-16

Agency Attendance at RLSCB	Jun	Sep	Dec	Mar	% Attendance
Independent Chair	✓	✓	✓	✓	100%
Adult Services, RMBC	Aps	D	Aps	✓	50%
CAFCASS	✓	Aps	Aps	Aps	25%
Rotherham Clinical Commissioning Group	D	✓	D	✓	100%
Councillor – Cabinet member CYPs	✓	Aps	✓	Aps	50%
CYPs Voluntary Services Consortium	Aps	Aps	Aps	✓	25%
Children & Young Services, RMBC	✓	✓	✓	✓	100%
Housing, RMBC	✓	✓	Aps	Aps	50%
Lay Members	✓	Aps	Aps	✓	50%
NHS England	✓	Aps	✓	✓	75%
National Probation Service	✓	✓	✓	Aps	75%
Public Health England	✓	✓	✓	✓	100%
Rotherham & Doncaster and South Humber NHS Foundation Trust (RDASH)	✓	✓	✓	Aps	75%
Schools & Colleges Representative	✓	✓	✓	✓	100%
Sodexo Justice	✓	✓	✓	✓	100%
South Yorkshire Fire & Rescue	Aps	X	Aps	Aps	0%
South Yorkshire Police	✓	✓	✓	✓	100%
The Rotherham NHS Foundation Trust (TRFT)	D	✓	✓	Aps	75%
Yorkshire Ambulance Service	X	X	Aps	✓	50%
Youth Offending Service, RMBC	Aps	Aps	✓	✓	50%

Key	
x	Agency is not invited or does not have a current representative
Aps	Apologies were tendered with no deputy attending
✓	Attended
D	Deputy attended

Appendix 2 – Financial Statement 2015-16

Budget Statement 2015/16 Outturn	Funding Formula	Budget 2015/16	Outturn 2015/16
	%	£	£
Income			
Annual Contributions			
Rotherham MBC	55.80%	162,231	162,231
Rotherham CCG	25.90%	75,315	75,315
South Yorkshire Police & Crime Commissioner	15.30%	44,475	44,475
South Yorkshire Probation	2.70%	7,849	5,330
CAFCASS	0.30%	830	550
Other Contributions			
Surplus / Deficit from previous year		0	0
Rotherham CCG - L&D contribution		22,000	22,000
Rotherham MBC - L&D contribution		22,000	22,000
Rotherham MBC – Printing contribution		1,200	1,200
Income generation - Training		0	1,568
Total Income		335,900	334,669
Expenditure			
LSCB Salaries *		238,150	223,724
Public Liability Insurance		800	1,168
IT & Communications		900	3,279
Printing		2,900	3,108
Stationery and Equipment		50	0
Learning & Development		49,800	49,604
Independent Chair		39,800	42,056
Software licences & maintenance contracts		3,500	7,150
Independent Chair Recruitment		0	4,080
NWG Network Membership		0	500
Total Expenditure		335,900	334,669
Surplus / Deficit		0	0

Appendix 3: Glossary

BME	-	Black and Minority Ethnic
BTEC	-	Business and Technology Education Council
CAADA	-	Coordinated action Against Domestic Abuse
CAF	-	Common Assessment Framework
CAFCASS	-	Children and Family Court Advisory and Support Service
CDOP	-	Child Death Overview Panel
CIN	-	Children in Need
CLAS	-	Children Looked After and Safeguarding
CP Plan	-	Child Protection Plan
CSC	-	Children's Social Care Services
CSE	-	Child Sexual Exploitation
CQC	-	Care Quality Commission
CYPS	-	RMBC Children & Young Peoples Services
DBS	-	Disclosure & Barring Service
DfE	-	Department for Education
FNP	-	Family Nurse Partnership
IDVA	-	Independent Domestic Violence Advocate
LAC	-	Looked After Children
LADO	-	Local Authority Designated Officer
LSCB	-	Local Safeguarding Children Board
MARAC	-	Multi Agency risk Assessment Conference
MARF	-	Multi-Agency Referral Form
MASH	-	Multi-Agency Safeguarding Hub
MOU	-	Memorandum of Understanding
NCA	-	National Crime Agency
NPS	-	National Probation Service
NSPCC	-	National Society for the Prevention of Cruelty to Children
OFSTED	-	The Office for Standards in Education, Children's Services & Skills
ONS	-	Office for National Statistics
RDASH	-	Rotherham, Doncaster and South Humber NHS Foundation Trust
RHI	-	Return Home Interview
RLSCB	-	Rotherham Local Safeguarding Children Board
SCR	-	Serious Case Review
SYFR	-	South Yorkshire Fire & Rescue
SYP	-	South Yorkshire Police
TRFT	-	The Rotherham NHS Foundation Trust
WRAP	-	Workshop to Raise Awareness of Prevent

Contact details

Rotherham LSCB

Independent Chair: Christine Cassell, christine.cassell@rotherham.gov.uk

Vice Chair: Rob Odell, rob.odell@southyorks.pnn.police.uk

LSCB Business Unit (Tel: 01709 254925 / 01709 254949)

Emails to: CYPs-SafeguardingBoard@rotherham.gcsx.gov.uk

healthwatch

Rotherham



Annual Report 2015/16

Contents

Message from our Chair	4
Message from our Chief Executive	5
The year at a glance	6
Who we are	7
Listening to people who use health and care services.....	9
Giving people advice and information	14
How we have made a difference	16
Our work in focus	22
Our work in focus: Prescribing of transgender medications.....	23
Our work in focus: Young Ambassadors	24
Our work in focus: Changing Face of GP Services.....	25
Our work in focus: CAMHS	26
Our work in focus: Learning Disability	27
Our plans for next year	28
Our people.....	30
Our finances.....	33
Get in touch	35

Message from our Chair



It gives me great pleasure to introduce the third annual report. This report covers the excellent work undertaken in the past 12 months.

The report highlights just a selection of work undertaken over the past year. Some big impacts have taken place, notably the change around learning disabilities. For 92% (80% mild, and 12% moderate) of people with learning disabilities, they were not supported. This change has recently occurred, so will take time to see an impact.

For many of those that use the advocacy service the changes that have happened for individuals are just as important. I am delighted when I see the wall of thank you cards in the office.

The relationships we have made at a strategic level are so important to help

make sure the people's voice is heard. The team have direct access to the senior staff at Rotherham CAMHS service as we are working together and are in constant dialogue, driving for improvement. We are also driving Healthwatch England to bring the CAMHS issue to the national forefront as it is an issue for many areas across the country.

The work on the Young Ambassadors is going very well and I hear good things at the various meetings I attend. I also understand that at the national Healthwatch Conference a big launch was made regarding resources for engaging with young people, and within that resource Healthwatch Rotherham feature. My thanks to our young ambassadors who give up a lot of time to support us.

Our achievements this past year have only been possible as a result of the tireless work and effort of our staff, our hard working young ambassadors, volunteers and the Members of our Board.

Naveen Judah

Message from our Chief Executive



Details of some of the changes we have helped to bring about with the help of local feedbacks are included within this report, but there is still much to be done. We have to use our limited resources carefully to achieve maximum impact.

The demand for advocacy work has increased, and during the year we were able to employ another member of staff to cope with demand.

The Board of directors made a significant investment last year in a new and innovative CRM system (provided by LHM Media) and we are starting to see the results of that. The number of comments we were able to collect in the past 12 months was 4,557 compared to 1,411 in the previous year and we are on course for bigger numbers in the year ahead. We will continue to use other engagement methods and will be having an older person's event in September. During the next year we are aiming to have our first Healthwatch Rotherham awards to celebrate and reward all the positive experiences that we hear about.

I have developed and maintained a positive, cooperative working relationship with RMBC, Rotherham NHS CCG, The Rotherham Foundation Trust, RDASH and Public Health. I look forward to building on these relationships to make sure the public voice is at the heart of service improvement in health and social care.

Healthwatch Rotherham has developed into a key partner on the Rotherham Health and Wellbeing Board, acting as the critical friend to make sure the public voice is heard. This was clearly demonstrated around the work on learning disability thresholds, which is detailed within this report.

We have had our budget reduced by 10% this year and whilst we will make every effort to maintain the outstanding level of service we now have a reputation for - it will be unsustainable as we progress year on year, particularly as demand for our service inevitably increases.

Finally a big thank you to the great team of people at Healthwatch Rotherham, from the Board of directors, the staff team, to our young ambassadors and volunteers. Without every one of them we would not have achieved such a successful year.

Tony Clabby

The year at a glance

This year we signposted 298 people



18 volunteers helped us during the year



Our volunteers gave us 605 hours of exceptional service



We supported 114 advocacy cases in the last year



We have gathered 4,557 comments in the past 12 months



We've met hundreds of local people at our community events



Who we are

We are here to make health and social care better for ordinary people. We believe that the best way to do this is by designing local services around their needs and experiences.

We exist to make health and care services work for the people who use them.

Everything we say and do is informed by our connections to local people. Our sole focus is on understanding the needs, experiences and concerns of people of all ages who use services and to speak out on their behalf.

We are uniquely placed as a national network, with a local Healthwatch in every local authority area in England.

Our role is to ensure that local decision makers and health and care services put the experiences of people at the heart of their work.

We believe that asking people more about their experiences can identify issues that, if addressed, will make services better.

Our vision

Healthwatch Rotherham will be known by all communities and individuals as delivering on its promises backed up by robust action and supported by improvements in local services.

To be the first point of contact for all of Rotherham's communities and individuals, to help them to have a means of improving their own and others quality of health, wellbeing and social care.

We will do this by promoting local people's rights to the following:

- ✓ The right to essential services
- ✓ The right of access
- ✓ The right to a safe, dignified and quality service
- ✓ The right to information and education
- ✓ The right to choose
- ✓ The right to be listened to
- ✓ The right to be involved
- ✓ The right to live in a healthy environment

Our Values

To be an impartial and trusted friend to help communities and individuals achieve their desired results and be recognised for being a fiercely independent organisation by the citizens of Rotherham.

Our Strategic priorities

Issues raised by the public have been prioritised by Healthwatch Rotherham, and have formed the basis of our work during the year.

Example of this work includes:

- Child and Adolescent Mental Health Services (CAMHS)
- Adult Mental Health
- Learning Disability services
- Autism services
- NHS Complaints Advocacy

Our Role

Involving

To promote and support local people to be involved in the planning and delivery of health and social care services

Listening

To gather your views, needs and experiences of health and social care services

Reporting

To report your views, needs and experiences to the people who plan, commission and provide health and social care services

Monitoring

To help local people check the quality of health and social care services

Signposting

To provide information about local health and social care services so that you can make informed choices.













Listening to people who use health and care services



Gathering experiences and understanding people's needs

The key to our success is the number of people we hear from. To ensure we get the views of all people we have to make sure Healthwatch is accessible. We use many methods to collect views from the people of Rotherham, these include:

-  Website
-  Facebook
-  Twitter
-  Local events
-  Telephone
-  Email
-  Drop in sessions
-  The High Street shop
-  Friends and Family comments from The Rotherham NHS Foundation Trust
-  Radio

A significant investment was made in a new innovative CRM System, provided by LHM Media. This system allows people to use the website to leave reviews about services and sentiment analysis is performed on comments collected.

Healthwatch Rotherham has been gathering local people's views over the last 12 months. We have gathered 4,557 comments (last year it was 1,411) about experiences of services which local

people have received. Within these comments there are several issues. The issues have been a mix of positive and negative and relate to many care services, as people tell us about their whole journey.

We have gathered 4,557 comments in the past 12 months (last year it was 1,411) about experiences which local people have received.

During the year we ran an advert on RotherFM

"Each day throughout Rotherham, health and social care services are helping you; the community!"

When it comes to sharing experiences, highlighting issues, and initiating improvements - Healthwatch Rotherham are your voice.

We've already instigated change in several areas, but we always need your views on the health and social care services in Rotherham!

Whether it's good stories we can promote, or bad ones we can take to the relevant body.

Visit our easy to use website - Healthwatch Rotherham dot org dot uk - where you can contribute, review and find a list of services available to you.

Call us on 01709 71 71 30.

Healthwatch Rotherham - It's your health, your care. Your voice counts!

Healthwatch Rotherham was also an associated sponsor of the annual

Rotherham Show and also the Christmas Lights switch on.

We opened our drop in sessions across Rotherham Borough. We run fortnightly sessions where people can come and see us in their community or near where they work.

-  Maltby Lesiure Centre
-  Dinnington
-  Swinton

The sessions run from 2:00pm - 4:30pm. We have ensured the sessions can be accessed by children and young people after school hours. We recognise that not everyone in the Rotherham Borough can access the Rotherham Town centre

Drop-ins also take place at Rotherham Hospital and at the two campuses of Rotherham College (Town Centre and Dinnington).

We also attend Shiloh on a Friday morning. Shiloh is a drop in support centre for the homeless community. At Christmas time, the Healthwatch Rotherham staff decided not to have a Christmas meal, and instead gave a donation to the Charity. Two members of Healthwatch Rotherham staff volunteered on Boxing Day to serve to the homeless.

To all at Healthwatch, I write to thank all who ensured the marvellous donation of pies and sweets to Shiloh rather than going out for their Christmas meal. Such kindness helped us provide food and shelter when technically Shiloh was closed. Huge Thanks Again.
Jonathan Lang - Operations Manager
Shiloh Homeless Project

Social media are used by Healthwatch Rotherham. We recognise this form of media is becoming more widely used by the population as a source of information and contacting services. Our new CRM System identifies comments posted on social media about Rotherham services which are able to be used.

We use all these methods to help Healthwatch Rotherham communicate with young people (under 21) and older people (over 65) as well as people volunteering or working in the area but who may not live in Rotherham.

People who are seldom heard can have the opportunity to make their views known through the drop in sessions, visiting the town centre shop or using electronic methods, whichever method they feel comfortable using.



Town Centre Shop

The shop is open for public access 5 days a week Monday to Friday 9.30 - 4.30. We are on the High Street, with disabled access. The shop is also contactable via phone and email during opening times.

The shop is on the the Rotherham High Street. The shop provides a fantastic opportunity to engage with local people and promote Healthwatch and the wider voluntary sector. We advertise numerous events in our shop and on our notice boards and offer a full range of information on health and social care issues and services.

Enter and View

As a critical friend our approach is to speak to the service provider first.

We realise that it is the service provider that will make changes to improve. The quicker they can do this the more people will benefit. That is why we aim to always talk to the provider first. We have found that some providers are not aware of what people's views are of their service, but they all welcome feedback from their customers.

Healthwatch Rotherham has not undertaken any Enter and View activities. The decision of when to use Enter and View is detailed in the Escalation policy.

We have had responses from all the providers we have contacted. Changes have been made to services following the comments from the public we have passed on. Our newsletters show the impact of our work.

The Board have not had enough evidence to support the use of our statutory power to Enter and View a health or social care setting.

NHS Advocacy Service

Healthwatch Rotherham provides local people with an Advocacy service to help people make NHS complaints. We understand that making an NHS complaint can be difficult for some people for many reasons. We also take into account the comments we receive about services when a complaint is made. Within these comments, there is usually a positive issue.

The Advocacy service has helped 114 (last year 106) people to make an NHS Complaint.

Thank you very much for all your help. We couldn't have done it without you. Best wishes. Mr M

Some of the impacts that have occurred are a direct result of the advocacy case work undertaken. An example would be: Following a complaint raised with Rotherham Hospital a meeting was

arranged with the Integrated Medicine department. The hospital responded with both the Chief Operating Officer and the Head of nursing from the Division of medicine writing letters to the complainant expressing their sincere condolences. Not only has the patient experience been shared as part of the Hospital patient story for future learning, but the complainant was offered and has accepted an offer to present the story at one of the protected learning time events. The Hospital has openly shared that they are grateful for the feedback and are to make the necessary changes to improve the experience of patients and their relative at the Trust.

CAMHS Advocacy Service

Healthwatch Rotherham provide an advocacy support service to children and young people (CYP) & families who are accessing or about to access mental health services

In December 2014, Rotherham CCG and RMBC jointly produced an “Emotional

Wellbeing and Mental Health Strategy for Children and Young People, 2014-2019” for Rotherham. This also included an “Analysis of Need”, which outlined the specific challenges in Rotherham.

Recently Rotherham Youth Parliament produced a report “Mind the Gap - A report about Mental Health” in July 2015. This report made twelve recommendations which are reflected in the CAMHS Transformation Plan.

All CCG’s are required to develop a ‘Local CAMHS Transformation Plan’ and a need for a CYP CAMHS advocacy service is included within the Rotherham CCG CAMHS Transformation Plan.

Healthwatch Rotherham have been fully involved in the production of the Local CAMHS Transformation Plan.

The Transformation Plan recognises that enabling CYP to speak up is vital and a key part of individual involvement. It used extra funding to commission Healthwatch Rotherham to provide an advocacy role for 2 days per week.



Giving people advice and information



Helping people get what they need from local health and care services





Healthwatch Rotherham aims to provide people with as much information as needed and in a format which is best suited to help people to access the right services and make decisions about their care.



We have signposted 298 people to services.

Healthwatch Rotherham provides information and signposting in diverse ways to reach as many residents as possible. We have excellent links to and knowledge of service providers in the area, enabling us to empower people to make choices about their care.

“You give me so much confidence. When you say you will call back, you do that. When you say you are going to do something you do it”









Key methods used to provide information and signposting include:

-  our shop on the High Street
-  attendance at community events
-  our stalls in the reception areas of Rotherham Hospital
-  our user-friendly website

-  presentations to community supports groups.
-  prompt replies to email and telephone queries

One of our key challenges is recording the signposting activity we perform, because we simply just do it.

We have recorded signposting of 298 people (last year 301) to services. The most popular services are:

-  Dentists Accepting NHS Patients
-  NHS Choices
-  Lifeline
-  CAMHS
-  Independent Age
-  British Heart Foundation
-  Age Concern
-  Action on Hearing

We have a large selection of information leaflets and posters in our High Street Shop, plus our website, facebook and twitter accounts are updated regularly.

We are currently in the process of creating a directory of mental health services in the Rotherham area.

“I cannot thank Healthwatch enough, I feel just a simple thank you isn't worth the thumb I'm typing this with as you guys have maybe changed our lives forever. “ *Parent*

How we have made a difference



Our reports and recommendations

Your voice counts. From all the views, comments, compliments and complaints Healthwatch Rotherham has collected, we have seen many changes in health and social care.

These impacts benefit the citizens of Rotherham and ensure services are more effective in saving public money.

Some of these changes are...

Discrepancies on the wards on Rotherham Hospital have been identified regarding discretionary parking tickets. The hospital are working to make wards more aware about the offer available.

St Annes Surgery agreed to make complaints forms and processes more visible both in the actual surgery and on their website. Also they are changing the complaints forms to be more legible and easily understandable.

When a podiatry service was going to close down in Swinton in February, the first thing they did was to contact Healthwatch to let us know that the service was going to stop at its current location in 6 months time but also to seek ideas on how the patients could be helped with alternative arrangements for that area such as a new location.

A person who had a bad experience last year following a broken arm, returned to hospital this year as they had broken the other arm. After the previous experience

they were very apprehensive as the first visit made them contact Healthwatch Rotherham to put in a complaint about the experience they had received. The second experience was much better and they could see the changes that the hospital said it was going to make after the complaint implemented and experienced at first hand. The assessment was done immediately and after care sorted before leaving the hospital.

Healthwatch Rotherham has supported a client around a case of teenage cancer. The Walk-in-Centre is developing a workshop to train staff in recognising that although teenage cancers are rare, they often present to emergency and urgent care services such as Walk-in-Centre's and Out of Hours. To ensure that staff have further awareness of the possibility of serious illness in teenagers who present with unusual symptoms and that critically no assumptions should be made about the individual teenager and all assumptions and signs are treated on their merits. The Walk-in-Centre have chosen to adopt Teenage Cancer Trust charity as the focus of their fundraising activities for 2016.

Working with other organisations

When we identify significant concerns or a member of the public requests it, we share information with the Care Quality Commission.

The Care Quality Commission (CQC) monitor services' performance against national standards. They regulate:

- Treatment, care and support provided by hospitals, GPs, dentists, ambulances and mental health services.
- Treatment, care and support services for adults in care homes and in people's own homes (both personal and nursing care).
- Services for people whose rights are restricted under the Mental Health Act.
- Registered care homes and commissioning activity.

They have the power to enforce change and in some cases closure of services which do not meet the standards of good quality and safe services.

We have passed concerns to The CQC which has aided their visits to care providers.

The working practices between Healthwatch Rotherham and the CQC are highlighted in case studies presented to other local healthwatch as good practice. The report was called "Local Healthwatch and CQC Working Together". Healthwatch Rotherham helped CQC to gather information

reaching groups across the outlying areas of Rotherham.

Rotherham Healthwatch shared a significant amount of good quality information about local people's experience of using and accessing services at their local hospital. It included 77 pages of themed comments that were dated and related to specific services and wards - valuable and easy to use intelligence that we couldn't have accessed anywhere else."

CQC Information Analyst

The views and comments we have received from the people of Rotherham have been used to feed into The Rotherham NHS Foundation Trust Quality Accounts. Quality Accounts tell the public which areas of quality the organisation has worked on over the last year and what they plan to work on in the coming year.

Healthwatch Rotherham has assisted with PLACE assessments at Rotherham Hospice and The Rotherham NHS Foundation Trust.

Healthwatch Rotherham has made strong links with the organisations which


commission health and social care services in Rotherham.

Regular meetings take place with commissioners and quality leads, giving us the opportunity to raise the issues and comments the people of Rotherham give to us.

We have worked with the Dementia Alliance to become a Dementia Friendly Organisation. All Healthwatch Rotherham Staff have had dementia training and all have become Dementia Friends. Our Dementia Action Plan can be found at http://www.dementiaaction.org.uk/members_and_action_plans/3122-health_watch_rotherham

Healthwatch Rotherham successfully delivered a jointly branded Healthwatch Rotherham and Rotherham NHS CCG event at the New York Stadium, which included the Rotherham NHS CCG AGM. The Rotherham NHS CCG were very happy as the atmosphere was great and the AGM part was well attended with a higher attendance than previous years. Ray Hearne took people's comments and made them into a song, which was sung prior to the start of the AGM.

Healthwatch Rotherham and the Rotherham NHS CCG did a piece of work together around support from Patient Participation Groups.



Healthwatch Rotherham
NHS Rotherham Clinical Commissioning Group

Healthy Balance event
Wednesday 3rd June 2015 at New York Stadium

11am-1pm	<p>Market stalls highlighting key projects and the current big issues</p> <ul style="list-style-type: none"> Developing your Emergency Centre Transforming mental health Keeping children safe Watching our figures Efficiency challenge <p>Healthwatch – launching 'how we listen to you'</p> <p>We want this to be an opportunity to raise issues important to you and to your community, and to design the way we listen to you in the future.</p> <p>In addition the fabulous Ray Hearne will be capturing your comments and words and writing a song to present to the Annual General Meeting (AGM). Don't miss the opportunity to have your words immortalised!</p>
1-2pm	<p>NHS Rotherham Clinical Commissioning Group (CCG) AGM</p> <p>CCG will present an overview of achievements, and future plans and challenges. Members of the public are invited to attend, and will be able to ask questions and offer comments.</p>
2-4 pm	<p>NHS Rotherham CCG Governing Body</p> <p>Members of the public are invited as observers.</p>

Drinks and a sandwich will be available. If possible, please book a place to allow us to better plan! It would be helpful if you can let us know in advance if you plan to attend. **Call Naomi on 01709 302114 or email naomi.jarrett@rotherhamccg.nhs.uk**

We really want this day to be accessible to everyone. If you need support to attend, or materials in an accessible format, please let us know what we can do to support you to get to the venue and on the day. You can call or email as above to talk about any support that you need.

Healthwatch Rotherham staff took part in a super-learning day at Wales High School, with 150 pupils involved, delivering “Nothing About Me Without Me” workshop about the NHS constitution. The hour long sessions were delivered by Healthwatch Rotherham staff and volunteers.

“In Practice: School Engagement
Healthwatch Rotherham wanted to start conversations with students in local secondary schools about their local NHS services. “
Get Your Rights Resource Kit - National Children’s Bureau

All Healthwatch Rotherham staff along with some Healthwatch Rotherham volunteers undertook some ASIST: Applied Suicide Intervention Skills Training.

Healthwatch Rotherham is a member of the:

- Rotherham Health and Wellbeing Board.
- Rotherham Adult Safeguarding Board.
- Rotherham NHS CCG Patient, Public Experience & Communications Sub-Committee.

Healthwatch Rotherham attends:

- Rotherham NHS CCG Primary Care Sub-Committee.
- Rotherham NHS CCG CAMHS Transformation Plan
- NHS England (North Region, Yorkshire & the Humber) Patient Experience Forum.
- The Rotherham NHS Foundation Trust Patient Experience Group
- Rotherham NHS CCG Patient Participation Group
- Healthwatch England Regional and national update meetings.

Rotherham Health and Wellbeing Board

Healthwatch Rotherham is a full member of the Rotherham Health and Wellbeing Board with Tony Clabby (CEO) attending.

Healthwatch asks questions of the other members of the board with the comments and issues the citizens of Rotherham bring to us.

An example is the following minute:

“Health and Wellbeing Steering Group

Would support and steer the work of the Board, co-ordinate the work of the Strategy and action plans and inform the Board’s future work programme.

Healthwatch Rotherham would also be represented to ensure connection with local people and it would be chaired by the Director of Public Health.” (February 2016)










Stakeholder Feedback

80% strongly agreed and 20% agreed that Healthwatch Rotherham is a respected voice in the borough.

Rotherham MBC performed a stakeholder feedback survey on the Healthwatch Rotherham Service.

The results of that feedback survey were.....

-  60% of respondents agreed and 40% strongly agreed that Healthwatch Rotherham reflects a range of views, not just the loudest voices.
-  60% of respondents strongly agreed and 40% agreed that Healthwatch Rotherham pro-actively engages with local communities.
-  80% strongly agreed and 20% agreed that Healthwatch Rotherham is a respected voice in the borough.
-  40% strongly agreed and 40% agreed that Healthwatch Rotherham is influencing health and care services and systems in the borough.
-  “The CCG enjoys a very constructive relationship with Healthwatch and will continue to work closely with them to ensure patient voices are heard”.
-  “Excellent at engaging young people”
-  “I think it does very well with limited resources and capacity”

Our work in focus



Our work in focus:

Prescribing of transgender medications

It was brought to our attention the problems that some members of the transgender community are having in accessing medication. A letter was sent to Rotherham NHS CCG regarding prescribing transgender medications

We were informed that the pathway for transgender services is commissioned by NHS England.

Why are transgender medications no longer prescribed by General Practice?

Traditionally there has been very little prescribing for transgender patients undertaken by GPs. Recently increases in the caseload means that it is unsustainable for the clinics to continue to manage all the prescribing and they have begun to request that the patients GP take over the prescribing. The majority of GPs have little if any experience of prescribing for transgender patients and are being requested to prescribe medication outside of its licensed indications. Many GPs do not feel competent to take over the prescribing and do not believe that the current arrangements for the transfer of prescribing to the GP are safe and could place the patient at risk. Our discussions with NHS England would imply that this is not just a South Yorkshire problem but similar issues are being experienced across England.

Why some general practices are refusing to work with the shared care protocol (SCP)

SCPs are usually written in collaboration and ratified by all stakeholders. CCGs and GPs have not had the opportunity to input into the production of the current SCP and as a result there are some issues that are of concern to GPs regarding patient safety. The South Yorkshire and Bassetlaw (SYB) CCGs and local transgender clinic are currently rewriting the SCP to address this.

What plans the clinical commissioning groups have, if any to improve accessibility to services for transgender community to timely receive prescribed medications.

Work is already under way to rewrite the SCP, once completed GPs should be more confident and supported to take on the prescribing of medications for the transgender community. There is a consensus across all five CCGs in South Yorkshire and Bassetlaw to work with NHS England to resolve transgender medication issues, and improve the support in the community for transgender patients.

As a result of discussions, the CCG are currently looking at piloting a named GP for transgender medication.

Our work in focus: Young Ambassadors

Rotherham Healthwatch developed an innovative programme with young people to promote wellbeing and healthy living. The Rotherham Young Healthwatch Ambassador Programme aims to give young people (aged 12 - 25) a voice in the design and delivery of the health services they receive.

This programme was initially piloted with a group of young people from Wales High School. Healthwatch Rotherham Staff took part in a super-learning day at Wales High School, with a 150 pupils involved, delivering “Nothing About Me Without Me” workshop about the NHS constitution.

The aim is that the young Ambassadors will act as peer educators, opening up access to a wide range of health services and promote positive messages about being safe and healthy.

Our first young ambassador is now a governor at RDASH and featured on an ITV news bulletin regarding experiences of a young person placed in an adult mental health unit.

Young Ambassadors and Healthwatch Rotherham staff have taken part in SafeTalk Training, which was training on suicide awareness. Members have featured on an ITV news report about transition between children and adult mental health services.

A small number of Young Ambassadors were invited to visit Swallownest Court Hospital by Rotherham NHS CCG (Clinical

Commissioning Group). The remit for the visit was to look at staying in the hospital from a young person’s perspective. The report they produced was sent to the CCG and to the service.

The Healthwatch Rotherham Young Ambassadors are going to support the implementation of the Rotherham Child and Adolescent Mental Health Services Review of children and young people’s voice and influence. This is a major success for the Young Ambassadors.

The Young Ambassadors meet monthly and receive their own newsletter to keep them up to date with news and events.

We were really impressed with the passion, commitment and desire they (Young Ambassadors) showed and are really grateful for the brilliant ideas and recommendations they put forward. We are looking forward to implementing these and to them visiting us again in the future. Dan - Barnardo’s

Our work in focus: Changing Face of GP Services

Healthwatch Rotherham and Rotherham NHS CCG worked together to put on a public engagement event around key elements of the CCG commissioning plan, at a time when feedback can actively influence the direction of travel and the plans of Rotherham NHS CCG.

It was agreed to focus on primary care, and the changes and challenges the future will bring.

At Healthwatch Rotherham's suggestion external facilitators were brought in to run 2 sessions, namely Ian Macmillan (Poet), and Tony Husband (Cartoonist), who together used creative techniques to capture comments and feedback.

Over 110 people were booked onto the event.



It was agreed to run two sessions, one during the afternoon, and one early evening to enable access for those who were

working during the day. This was successful to a large extent with the evening session proving less popular but attracting a significantly younger audience than many engagement events.

“It was a great way to engage the audience and be creative and perhaps be out of our comfort zone but not in an awkward way. Don't think I have ever laughed so much at an event like that which made a pleasant surprise.”

The two sessions came up with many solutions around several key themes:

- 🌱 Triage/who do I see?
- 🌱 Self Care
- 🌱 Access and alternatives
- 🌱 Using 111
- 🌱 Mental Health
- 🌱 Patient Information

All the input from the session went to inform the Rotherham NHS CCG Primary Care Strategy.

Our work in focus: CAMHS

Following many comments raised about the Rotherham CAMHS service and 2 reports by Healthwatch Rotherham, a contract performance notice was issued by Rotherham NHS CCG to RDaSH. Healthwatch Rotherham actively contributed to the remedial action plan and subsequent CAMHS Transformation Plan.

Enabling Children & Young People (CYP) to speak up is vital and a key part of individual involvement. Healthwatch Rotherham has an advocacy role but is only commissioned to provide this service to adults (but has acted several times in an advocacy role for young people). The Rotherham NHS CCG, through the CAMHS transformation plan commissioned Healthwatch Rotherham to deliver a CYP advocacy service.

Children & Young People are better represented and their voices heard. Services are developed that people want and value. Working in partnership with young people and parents/carers in monitoring services also is key to ensuring real quality, and better outcomes for service users.

Healthwatch Rotherham continues to work with RDaSH and meets with the new assistant director on a monthly basis to discuss issues as they arise with the objective of getting issues resolved as quickly as possible.

Healthwatch Rotherham has supported a number of people through the RDaSH complaints process.

I cannot thank Healthwatch enough, I feel just a simple thankyou isn't worth the thumb I'm typing this with as you guys have maybe changed our lives forever. Parent

“Without Healthwatch Rotherham there is no way we would have got this outcome especially this quick. I cannot fault the care we have had at CAMHS over this last 8 weeks and how our faith in the system has slowly been restored” Parent

Our work in focus: Learning Disability

Following a lobbying campaign by Healthwatch Rotherham CEO, we have successfully persuaded Rotherham NHS CCG and Rotherham MBC to address the issue of unequal access to learning disabilities and autism services faced by Rotherham residents. Up to now, in Rotherham, someone had to be below an IQ threshold of 50 in order to access the service. This has now been raised to 70, to bring it into line with other local authorities. This change of the threshold means that people with mild or moderate learning disabilities can now access the service.

How did the issue come about?

Healthwatch Rotherham holds the NHS Complaints Advocacy service in Rotherham and this issue came to our attention as part of an advocacy complaint. So we investigated further and found that inequity was compounded by the fact that Learning Disability services in Doncaster and Rotherham were delivered by the same organisation, Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH) with different thresholds. This could leave Rotherham Learning Disability Services open to challenge under equality legislation!

What did you do?

The CEO, raised the issue with the Rotherham Metropolitan Borough Council (RMBC) and the NHS Rotherham CCG (RCCG), as the service provision is jointly

commissioned. He also raised the issue at Health and Wellbeing Board level.

A joint paper from RMBC and RCCG went to the Health and Wellbeing Board called “Transforming Services for People with a Learning Disability and/or Autism” This paper describes a population based approach which expects CCGs, LAs and NHS England specialist hubs to work together to look at what services were needed for the local population with a learning disability and/or autism across a Transforming Care Partnership footprint area. This provided the ideal opportunity to raise the issue with the Health and Wellbeing Board around the unequal access in comparison to surrounding local authorities.

Healthwatch Rotherham greatly appreciates the willingness of Rotherham NHS CCG Chief Operating Officer Chris Edwards and Rotherham MBC interim director of adult social services Graeme Betts to resolve this issue.

“I applaud the commitment of Healthwatch Rotherham and other agencies in bringing about this change.” John Healey - MP



Our plans for next year



Future priorities

Our plans for 2016/17 will naturally be determined by the comments we are receiving from the public and we need to be flexible and adaptable to meet those challenges.

We will be working together with Rotherham CCG to improve the engagement and participation of Rotherham residents in improving health and well-being across the Borough.

We will continue to monitor the implementation of the Local CAMHS Transformation Plan and highlight any areas of continuing concern.

One area of focus this year will be around older people services, with more focus on social care and the integration Health and Social Care.

We are also going to look at issues around LGBT access to services.

We also hope to launch the first Healthwatch Rotherham Awards in order to recognise the excellent work that takes place across the Borough.

You Retweeted
 **rush_house** @rush_house · 15h
 @rush_house hosted a launch if our film about drug addiction The Messenger. @HWRotherham + young ambassadors here.



Our people



Anne



Sharon



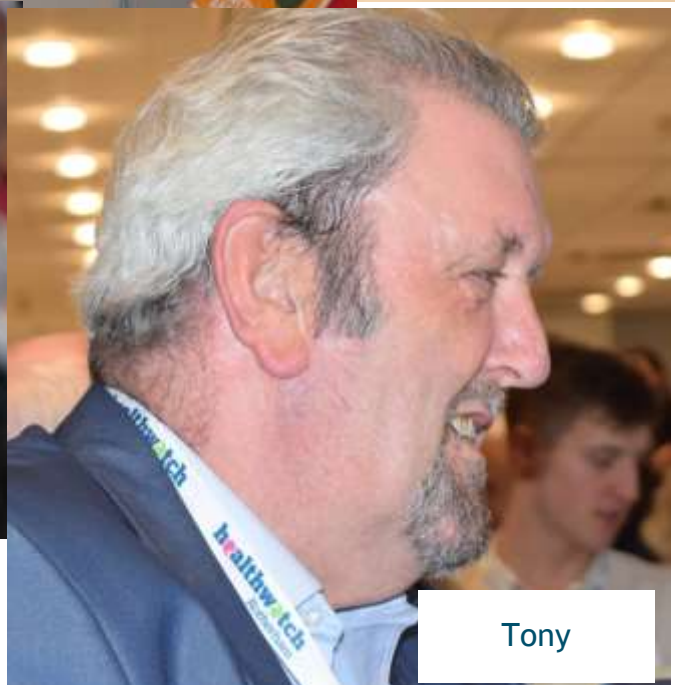
Mike



Nathan



Steve



Tony

Staff

At the end of March 2016, Healthwatch Rotherham employs 6 members of staff.

-  Tony Clabby - CEO
-  Nathan Batchelor - Information & Research Officer
-  Anne Lemm - Advocacy Officer
-  Sharon Cope - Children & Young Peoples Engagement Officer
-  Steve Mace - Engagement Officer
-  Mike Horne - Advocacy Officer

Decision making

Key decisions and work planning are based on the evidence that Healthwatch Rotherham collects from the citizens of Rotherham. They use the decision support tool to aid them and to prioritise the work.

The decision support tool collates the public comments and the local and national strategic relevance. The Board play an important part in gathering and feeding in the strategic relevance as they attend the 6 health and wellbeing board priority workstreams.

The escalation of issues is determined by the operational staff using the escalation policy. This is then fed into the Healthwatch Rotherham Board.

Volunteers

The board is made up of volunteers who were selected due to their skills and experiences.

The Healthwatch Rotherham board and as of 31st March 2016 were:

-  Naveen Judah
-  Sue Barrett
-  Chris Smith
-  Gary Kent
-  Paul May
-  Catherine Porter

The Board make key decisions in our organisation and set the direction of the work we do.

Plans are to increase the number of directors over the coming year. A skills matrix exercise has taken place to see which skills are currently missing.

We recognise that volunteers vary in their availability due to other responsibilities such as work, caring or their own health needs and take this into account.

The volunteers have dedicated a total of 605 hours to Healthwatch ensuring that local people have their say about Rotherham's Health and Social care services.

Wendy Cosgrove has volunteered and provided much valuable help and support during the year. Wendy has started to organise a coffee morning on the last Tuesday every month in the Healthwatch Rotherham Town Centre Shop.

Young Ambassadors



Active young ambassadors during the year were:

- 🌸 Rebecca
- 🌸 Ashley
- 🌸 Toni
- 🌸 Tom
- 🌸 Darren
- 🌸 Georgia
- 🌸 Abbie
- 🌸 Anthony

They have attended:

- 🌸 Health & Wellbeing Working Groups.
- 🌸 Meet the Mayor
- 🌸 Premiere of Rush House Fixers Film
- 🌸 Rush House Drop In
- 🌸 Anti-bullying Campaign briefing
- 🌸 National Children's Bureau
- 🌸 NHS Youth Forum

Workplace Students

In December, four third year medical students from Sheffield University were on placement with Healthwatch Rotherham for 4 weeks. The students helped support Patient Participation Groups in GP Practices.

Feedback from the students: *"I really enjoyed working with everyone, it was great to see what Healthwatch do and great to be a part of it for a little bit! I think that it would be really good to follow through with just 1 GP practice or maybe 2 for the whole 4 weeks and work with them for the aim being the PPG meeting at the end of the 4 weeks. It would be good to get the ball rolling with the GPs early so have meetings with practice managers in the 1st week so that they can discuss what they want and how the med students can help. Think it would be great for the med students to do that as they get to (hopefully) go to a GP that's struggling for PPG members and then by the end hopefully have more members as a result of their work!"*

I do think that the meetings that we went to were also really good as they give you a bit of background behind why there are PPGs as well as the structure of the CCG etc. Also any meetings with hard to reach groups like we saw is great as its something that we would come accross but not really know where to refer and things like that so that was an eye opener

It was great fun working with you guys so please pass on my thanks to everyone again"



Our finances



INCOME		£
Funding received from local authority to deliver local Healthwatch statutory activities		215,000
Additional income		29,836
Total income		244,836
EXPENDITURE		
Operational costs		9,641
Staffing costs		146,117
Office costs		28,805
Provision for contingent liabilities		55,230
Total expenditure		239,793
Surplus for the year		5,043

Get in touch

Address: Healthwatch Rotherham
33 High Street
Rotherham
S60 1PT

Phone number: 01709 71 71 30

Email: info@healthwatchrotherham.org.uk

Website: www.healthwatchrotherham.org.uk

We will be making this annual report publicly available by 30th June 2016 by publishing it on our website and circulating it to Healthwatch England, CQC, NHS England, Clinical Commissioning Group, Health and Wellbeing Board, Overview and Scrutiny Committees, and our local authority Rotherham Metropolitan Borough Council.

We confirm that we are using the Healthwatch Trademark (which covers the logo and Healthwatch brand) when undertaking work on our statutory activities as covered by the licence agreement.

If you require this report in an alternative format please contact us at the address above.

© Copyright Healthwatch Rotherham 2016



info@healthwatchrotherham.org.uk



01709 71 71 30



www.healthwatchrotherham.org.uk



@HWRotherham



www.facebook.com/hwrotherham



33 High Street
Rotherham
S60 1PT

Health and Wellbeing Board Report

21 September 2016

Title

Rotherham Joint Commissioning Strategy for Children and Young People with Special Educational Needs and/or Disabilities (SEND)

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

This is not a key decision

Strategic Director Approving Submission of the Report

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

Report Author(s)

Nicole Chavaudra, Joint Assistant Director, Commissioning, Performance and Quality

Paul Theaker, Operational Commissioner, CYPS

Emma Royle, Senior Commissioning Manager, Rotherham NHS Clinical Commissioning Group.

Ward(s) Affected

All wards

Executive Summary

This report presents the Rotherham Joint Commissioning Strategy for Children and Young People with Special Educational Needs and/or Disabilities (SEND). The Strategy provides an overview of how the joint commissioning of services for children and young people with SEND in Rotherham will be developed and implemented in line with the requirements of the Children's and Families Act 2014 and the associated Code of Practice for SEND.

The Strategy, through a mapping exercise, consultation and a review of transitions with parents/carers and stakeholders, has identified nine priority areas of work that will be implemented over the next three years. The Strategy has been previously approved by the Clinical Commissioning Group's Operational Executive, the Council's Children and Young People's Services leadership team and the Children

and Young People's Partnership Board, and endorsed for sharing with the Health and Wellbeing Board.

Recommendations

It is recommended that the Health and Wellbeing Board endorse the Rotherham Joint Commissioning Strategy for Children and Young People with Special Educational Needs and/or Disabilities (SEND).

List of Appendices Included

Appendix 1 - Rotherham Joint Commissioning Strategy for Children and Young People with Special Educational Needs and/or Disabilities (SEND)

Background Papers

Children and Families Act 2014

Rotherham Joint Commissioning Strategy for Children and Young People – Our Journey to Excellence – August 2015 to August 2018.

Consideration by any other Council Committee, Scrutiny or Advisory Panel

None.

Council Approval Required

No

Exempt from the Press and Public

No

Title: Rotherham Joint Commissioning Strategy for Children and young People with Special Educational Needs and/or Disabilities (SEND)

1. Recommendations

- 1.1 It is recommended that the Health and Wellbeing Board endorse the Rotherham Joint Commissioning Strategy for Children and Young People with Special Educational Needs and/or Disabilities (SEND).

2. Background

- 2.1 The biggest education reforms in a generation for children and young people with special educational needs and disabilities (SEND) became law in September 2014, following the Children and Families Act 2014. The requirements of the Act, and associated Code of Practice for SEND, include extending provision from birth to 25 years of age and giving families greater choice in decisions and ensuring needs are properly met. The new system extended rights and protection to young people by introducing a new education, health and care plan.
- 2.2 The SEND Joint Commissioning Group, which includes representation from education, health and social care services, and the Parents' Forum, undertook a mapping exercise of both Local Authority and Health SEND provision in Rotherham. This included consultation with parents, carers and stakeholders from across education, health and social care, in relation to what works well and not so well around SEND provision.
- 2.3 Furthermore, a review of Transitions, which completed in 2016, provides insights and recommendations into how the Rotherham system could work in a more integrated way to better prepare children and young people for adulthood.
- 2.4 The mapping and consultation work, and the review of transitions, informed the development of the Rotherham Joint Commissioning Strategy for Children and Young People with Special Educational Needs and/or Disabilities (SEND). This Strategy provides an overview of how the joint commissioning of services for children and young people with SEND in Rotherham will be developed and implemented in line with the requirements of the Children's and Families Act 2014.
- 2.5 The Strategy outlines what is joint commissioning, the partners involved in the arrangement, the governance structure, the current Rotherham SEND Local Offer and the Strategy will be implemented.

3. Key Issues

- 3.1 The implementation of the Strategy will require a phased approach to move from the current position. There are nine priority areas of work, which will be taken forward over the next three years, and are described in section 4 of this report.

- 3.2 Work has commenced in taking forward a number of the priority areas, namely, considering how a joint SEND Hub can be created, the re-modelling of services that provide support for children and young people with challenging behaviour, the development of personal budgets, the development of aligned service specifications for education, health and social care services, and the development of pathways to adulthood.
- 3.3 The development of an SEND Assessment Hub is key to improving the co-ordination of SEND provision, as well as formalising joint working arrangements and the streamlining of assessments. The preferred option for the SEND Assessment Hub is Kimberworth Place, as a number of SEND services are already based there and therefore the number of services moving bases would be minimised.

4. Options considered and recommended proposal

- 4.1 The nine priority areas of work contained within the Rotherham Joint Commissioning Strategy for Children and Young People with SEND are as follows:
 - 4.1.1 Create a joint SEND Education, Health and Social Care Assessment hub at Kimberworth Place.
 - 4.1.2 Review and re-model services that provide support for children and young people with challenging behaviour.
 - 4.1.3 Develop a performance and outcomes framework that will be applied across all local authority and CCG SEND provision.
 - 4.1.4 Align local authority and CCG specifications for SEND service provision, so as to facilitate commonality of practice and a consistent approach (thus reducing duplication, improving efficiencies and developing clearer pathways).
 - 4.1.5 Audit the Education, Health and Care Planning (EHCP) process to look at how the assessment process (including the decision making process/panels and allocation of resources) can be streamlined, so as to reduce the multiple assessments that young people and their families have to undertake.
 - 4.1.6 Ensure that there is a co-ordinated joint workforce development plan.
 - 4.1.7 Develop and implement Personal Budgets.
 - 4.1.8 Develop pathways to adulthood.
 - 4.1.9 Develop approaches to improving life experiences.

- 4.2 The priorities outlined in section 4.1 are detailed, along with comments from parents/carers and stakeholders, on pages 11 to 17 of the Strategy and the in the associated joint commissioning plan from page 20 onwards.

5. Consultation

- 5.1 There was consultation with parents/carers, staff within SEND provision and wider stakeholders as part of the development of the Strategy and the nine priority areas of work were based on the feedback from consultation.
- 5.2 The draft Strategy was consulted upon with the Rotherham Parent and Carer Forum, staff within SEND provision and wider stakeholders. The feedback from this consultation was taken into account when refining the Strategy.

6. Timetable and Accountability for Implementing this Decision

- 6.1 It is anticipated that should the Strategy be endorsed by CYPS DLT, it will be submitted to the Children's Partnership Board meeting in May 2016 for consideration and then to the Health and Wellbeing Board meeting in June 2016 for approval.

7. Financial and Procurement Implications

- 7.1 The financial implications arising from implementing the Strategy will be fully explored and identified as part of developing the nine individual priority areas of work.
- 7.2 The financial costs relating to the development of an SEND Assessment Hub at Kimberworth Place will primarily be for moving staff into the building from Riverside House and Rockingham Professional Development Centre and IT costs. Further reports will be submitted to the relevant organisational governance bodies setting out the detailed arrangements for the new hub.

8. Legal Implications

- 8.1 There are no identified legal implications.

9. Human Resources Implications

- 9.1 Any human resource implications that are identified as part of the development of the priority areas of work will be fully explored and contained within future reports to CYPS DLT.

10. Implications for Children and Young People and Vulnerable Adults

- 10.1 The Strategy aims to impact positively on children and young people, through maximising SEND resources to improve the outcomes for children and young people with SEND and their families.

11. Equalities and Human Rights Implications

11.1 The Strategy focuses on children and young people with disabilities, which is a protected characteristic under the Equality Act 2010. The Strategy seeks to mitigate the disadvantage faced by children and young people with disabilities.

11.2 Furthermore, the analysis of findings from the mapping exercise identified other equalities issues in relation to age, which is also a protected characteristic. In particular, a gap in services and support for young people with SEND who are approaching adulthood was identified, and ameliorating this gap is a priority for the Strategy. In addition, a lack of clinical speech and language therapeutic provision for over 11s was identified, which will need to be addressed as part of a 0-25 SEND service.

12. Implications for Partners and Other Directorates

12.1 The priority areas of work arising from the Strategy have implications for Rotherham MBC, Rotherham Clinical Commissioning Group, RDASH CAMHS, Rotherham Foundation Trust, Schools, FE Colleges and the Voluntary and Community Sector. The services that form part of the SEND Local Offer are within scope and are outlined on page 8 of the Strategy.

13. Risks and Mitigation

13.1 Failure to gain endorsement and subsequent approval of the Strategy may result in a delay in implementing the priority areas of work within reasonable timescales.

13.2 There is a risk that the full range of SEND services as outlined in section 12.1 do not fully engage in taking forward the Strategy. This will be mitigated through a robust communication and engagement plan.

14. Accountable Officer(s)

Nicole Chavaudra, Assistant Director, Commissioning, Performance & Quality

Approvals Obtained from:-

Strategic Director of Finance and Corporate Services – Joanne Robertson 3.5.16

Director of Legal Services - not applicable

Head of Procurement - not applicable

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

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

Rotherham Joint Commissioning Strategy for Children and Young People with Special Educational Needs and/or Disabilities.

May 2016

Version 12

Rotherham Joint Commissioning Strategy for Children and Young People with Special Educational Needs and/or Disabilities (SEND)

Introduction

Rotherham is passionately committed to working collaboratively to support children and young people with Special Educational Needs and Disabilities (SEND), and their families. This document provides an overview of how the joint commissioning of services for children and young people with SEND in Rotherham will be developed and implemented in line with the requirements of the Children's and Families Act 2014. Effective joint commissioning will ensure that resources are maximised across our services to improve outcomes for children and young people (0 – 25 years of age) with SEND and their families.

The joint commissioning scope, vision and principles outlined within this document, are in line with the *Rotherham Joint Commissioning Strategy for Children and Young People – Our Journey to Excellence - August 2015- August 2018*.

The arrangements will be subject to external scrutiny through a new SEND Ofsted and Care Quality Commission framework.

What is Joint Commissioning?

Joint commissioning in the context of SEND, consists of two types of commissioning:

1. Individual commissioning for a young person which takes the form of an Education, Health and Care Plan.
2. Joint commissioning in terms of the population of Rotherham SEND population, which is the process for deciding how to use the total resources available for families, in order to improve their outcomes in the most efficient, effective, equitable and sustainable way.

Individual Commissioning

Individual commissioning is a person-centred and joined up approach to identifying and meeting the needs of an individual child or young person and their family. The Education, Health and Care (EHC) Planning pathway facilitates a clear understanding of individual needs and the support and provisions necessary to achieve agreed outcomes. An EHC plan clarifies roles, responsibilities, accountabilities and represents a clear joint commissioning plan for an individual.

The representation of the current SEND Local Offer on page 8 of this document, describes the relationships between the EHC Assessment Team and commissioners within SEND across Children and Young Peoples and Adult Services. It is a representation of how individual commissioning arrangements through the Education, Health and Care Plan process should inform the arrangements for population commissioning.

Joint Commissioning for the population

Joint commissioning facilitates key agencies (Education, Health and Care and others) working together to identify the outcomes that matter to and for children and young people with SEND, their families and communities and the planning, delivery and monitoring of services effectively against how the outcomes are being achieved.

Joint commissioning involves:

- Shared commitment to improve experience and outcomes.
- Common strategies underpinning a joint strategy.
- Agencies jointly designing and managing consultation and feedback activities.
- Jointly designed population needs analysis, which will identify gaps, including the JSNA.
- Joint working groups to review and develop the market.
- Agencies identifying pooled budgets for particular areas, and a joint approach to decision making on budget allocation to meet common objectives.
- Use of Health Act Flexibilities.
- Multi-agency review groups including children, young people, parents and carers ensuring robust joint arrangements for the collection and interpretation of performance information.
- Sharing of risk with market development.
- Agencies issuing joint block contracts or share contract risk.
- Standard joint contract terms that are realistic and deliverable by providers.
- Emerging hybrid roles supporting a joint strategic commissioning function across agencies.
- Clear understanding of the resources and skills required to provide support to joint strategic commissioning
- Joint appointments of commissioning staff.

The Joint Commissioning Framework outlined on the next page uses a typical commissioning cycle across four key steps of understand, plan, do, review. For each of these steps the framework explains what partners will do to jointly commission services for children and young people with SEND and their families. This will be developed into a work plan taking account of the findings from the service mapping work.

Who are the Partners?

The statutory partners, NHS Rotherham Clinical Commissioning Group and Rotherham Council, are committed to improving outcomes for children and young people with SEND and their families. The Children and Families Act sets out clear requirements for each of the partners.

Key to joint commissioning will be the co-production and engagement with children, young people and their families. The strategy will enable a clear relationship and seek to develop joint commissioning approaches.

Section 1.22 of the revised Code of Practice 2014 outlines the principle of joint working:

‘If children and young people with SEN or disabilities are to achieve their ambitions and the best possible educational, health and other outcomes, including getting a job and living as independently as possible, local education health and social care services should work together to ensure they get the right support’

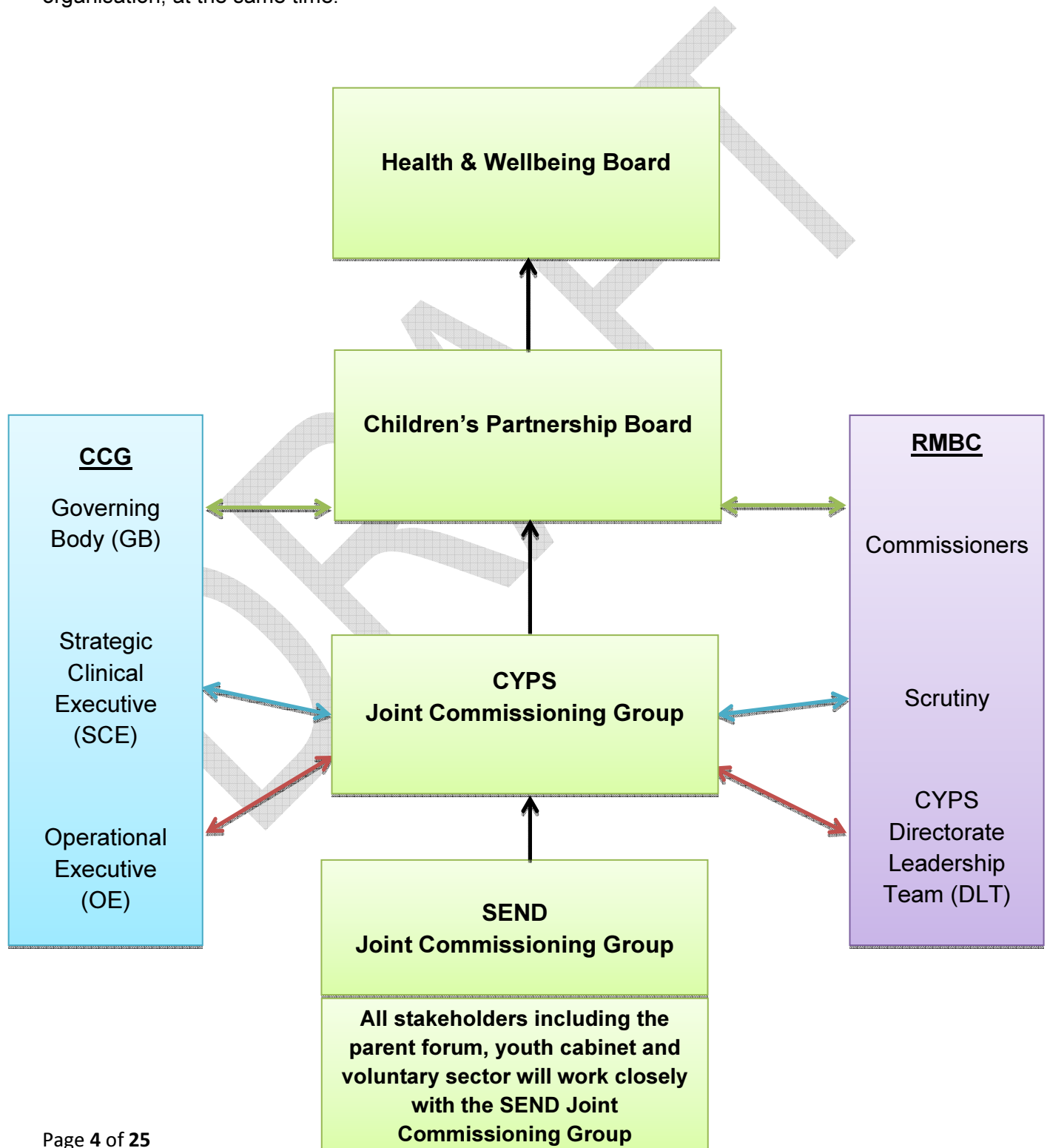
Section 3 of the code details the requirements for working together across education health and care for joint outcomes. In particular, that the joint commissioning cycle will rely on partnerships being established between education, health and social care together with parents groups, children and young people. Involvement with and feedback from schools, pre-school settings and post-16 education providers will be vital in helping to inform the commissioning cycle of ‘joint understanding, joint planning, joint delivery and joint review’.

Covering age 0-25 the Act makes the provision of effective transitions and the development of further joint commissioning across children and adult commissioning structures vital.

The arrangements will be subject to external scrutiny through a new SEND Ofsted and Care Quality Commission framework.

RMBC/CCG Governance Structure

The diagram below shows the governance structure for the joint commissioning process. Papers will be sent through the governance process to the corresponding meeting of each organisation, at the same time.



What are the benefits of Joint Commissioning?

Through working together and putting in place joint decision-making processes, stakeholders can use Joint Commissioning to support early identification of needs, prevention and outcome focused service delivery and work to improve the experiences of services that children, young people and their families. Joint Commissioning can reduce unnecessary duplication of, or barriers between provision and the development of more efficient and effective service provision.

What are our SEND Joint Commissioning Vision and Principles?

The Vision

Our vision for Rotherham children and young people with SEN and disabilities is the same for all of our children and young people; that they be safe, happy, healthy, confident and successful, contributing to a thriving, inclusive community that is welcoming to all.

Their achievements, supported by effective settings and services working in partnership with families and communities, will enable them to enjoy independence, improve experience and have fulfilling lives.

We aim to:

- Lift aspirations and build on existing strengths
- Increase Personalisation – such that provision and support is designed and delivered in collaboration with children, young people and their families so that it is person centred, responsive and better matched to need
- Focus on and improve outcomes that are important to, and for, children, young people, families and communities
- Enhance Partnerships – so that we can jointly commission to collectively achieve and sustain our vision

The Principles

- Provision and service development and delivery will be driven by our collective ambition to achieve the best possible outcomes for children, young people, their families and carers.
- Services will be commissioned in line with the spirit and requirements of the Children and Families Act 2014.
- To encourage education, health and care commissioners and providers to only make changes to SEND structures, provision and entitlements following discussion with partner agencies.
- We will work in partnership with providers who also commission SEND activities, including colleges.
- Joint commissioning approaches will involve co-production with parents/carers and young people.
- We will enhance information sharing and communication
- We will reduce duplication and streamline service management
- Service development and delivery will be driven by the best possible outcomes for children, young people and their families and carers.
- All agencies and services will communicate clearly and regularly with others about their roles

What are our Joint Commissioning objectives?

- To ensure that children, and young people with SEND gain maximum life chance benefits from educational, health care and social care and have the opportunity to achieve their full potential.
- To ensure that children and young people with SEND are fully informed and engaged.
- To ensure progression and continuity of support and care as young people move into adulthood.
- To enable children and young people with SEND to have as much choice and control over their lives as possible.
- To ensure that families and carers are supported.
- To enable children and young people with SEND to benefit from high quality services that are designed around their individual needs.
- To enable children and young people with SEND to be included within and contribute to their community, supporting positive activities, friendships and relationships.
- To ensure that the workforce across agencies, is appropriately skilled, trained and qualified, to promote a better understanding of, and meet the needs of children and young people with SEND.
- To develop and implement clear joint performance mechanisms to evidence individual experience and outcomes as well as value for money.

Where are we now?

The introduction of Education, Health and Care Plans in September 2014 has resulted in improved arrangements for tailored SEND packages for children and young people.

The position as at October 2015, is that there are 705 statements that will need converting into Education, Health and Care Plans (EHCPs), with 251 EHCPs already been issued, 95 cases that are under assessment and 240 conversion that are ongoing or which will be started in the near future.

The Local Offer for Rotherham describes the current range of services and provisions available to families, which represents the totality of commissioned services in Rotherham.

There is a newly established advice and information service and currently there are two independent parental support workers.

However, there is little evidence of joint commissioning of SEND services. The only service that is commissioned within joint commissioning arrangements and aligned budgets, is the Child and Adolescent Mental Health (CAMHS) service. Other services have developed with joint commissioning approaches, such as Specialist Equipment provision and Continuing Health Care packages.

There has been a mapping of SEND services and also a review of SEND arrangements, which has enabled a more detailed understanding of how these services are configured, including information on service delivery, the cohort of service users and their complexity of need, unmet need, service costs and funding source. The key findings from the mapping work are as follows:

Rotherham families tell us that we have:

- A lack of opportunities for supported employment packages
- Gaps in service for those who don't meet the criteria for Targeted Family Support

- A need to improve transitions

The Rotherham Inclusion Focus February 2015 told us:

- The current model of provision for young people with Social, Emotional and Mental Health needs is financial unsustainable and it does not appropriately meets the needs of this very vulnerable group.
- There is more work to do to further develop and implement the SEND Reforms in Rotherham. This includes enhancing the EHC Assessment Team to provide a 0-25 assessment service.

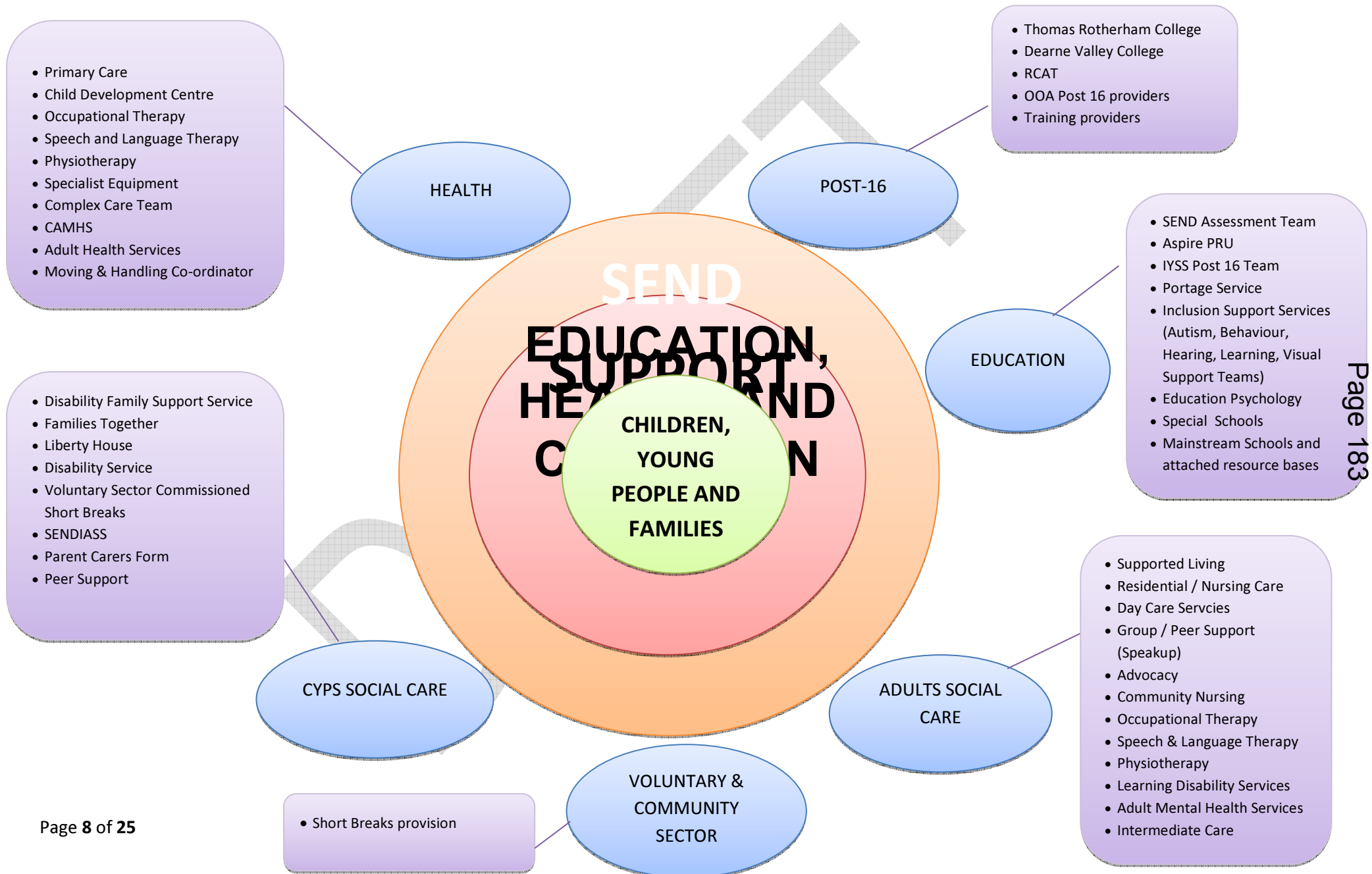
SEND Mapping Exercise October 2014 to February 2015 told us:

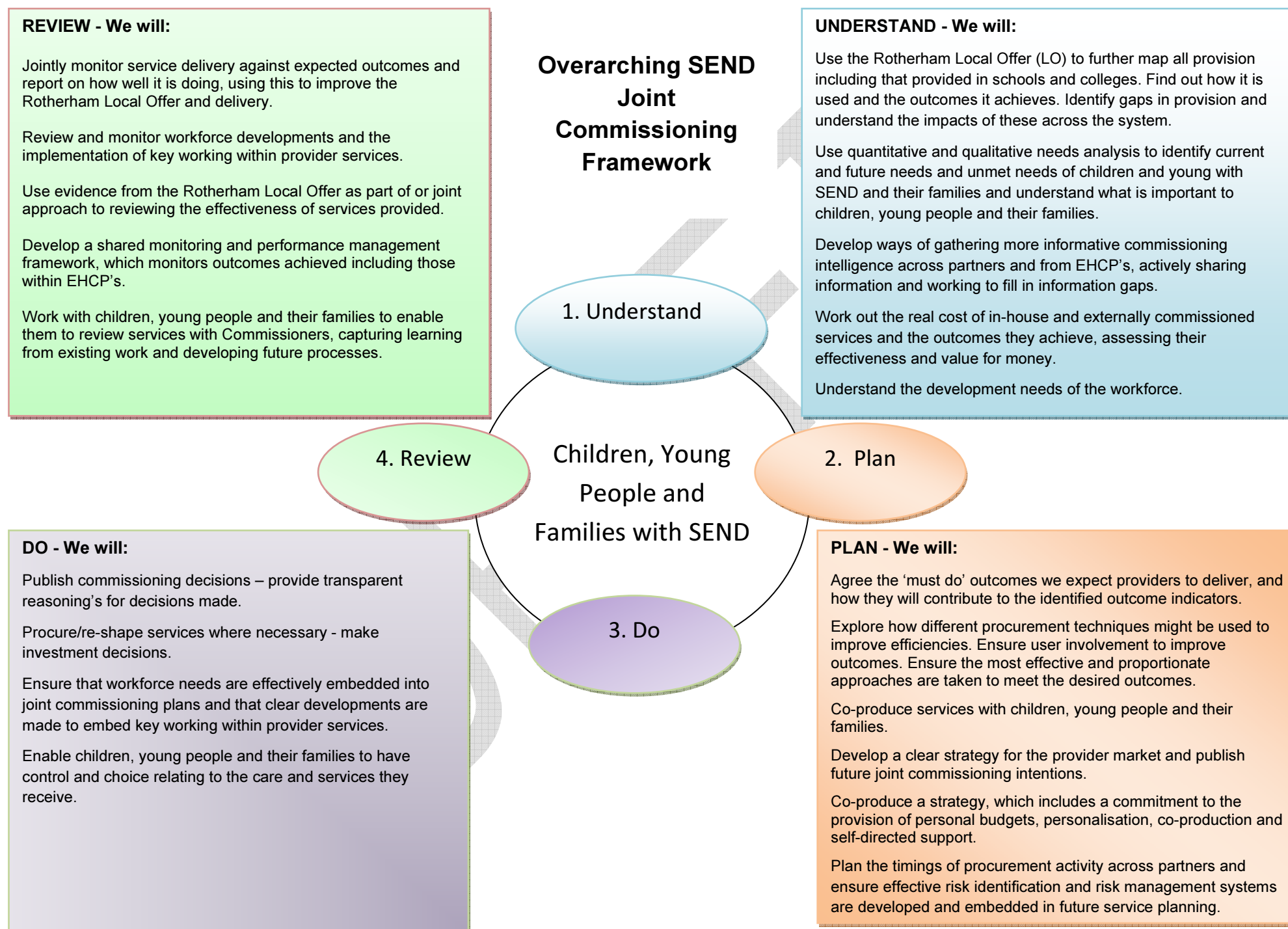
- There is limited out of school support for families post Autism Spectrum Condition (ASC) diagnosis
- Individual service links with the Child Development Centre (CDC) are not strong and there is a view that the CDC is inflexible towards their working with families. The CDC provides a service up to the age of 5 and there is a marked difference in the way that assessment is undertaken by CAMHS for those who are over 5 year
- Hearing Impaired young people: a lack of technical aids for the home and no funding source for extracurricular activities to enhance life experience
- Visually Impaired young people: Resources and equipment is reaching the end of its life. There are good links with the Sheffield eye clinic, but there is less collaboration with the Rotherham eye clinic
- The Education Psychology Service is unable to provide a service to pre-school children, the Aspire PRU, young people who are out of authority and unable to respond to requests from Health (e.g. Paediatrics) for input that does not meet school thresholds
- Opportunity to create efficiencies and flexibility in the way in which home to school transport is delivered
- The Speech and Language Therapy Team does not provide a service above age 11 unless the child has specific needs with regard to ASC. There are long waits for group therapy and intensive therapy is restricted.
- The services at Kimberworth Place (Children's Disability Team, CAMHS, Hearing Impairment Team, Visual Impairment Team, Autism Communication Team and the Child Development Centre) work well together on an informal basis, however a number of key teams may also benefit from being based in Kimberworth Place including the ISS (currently based in Rockingham Development Centre), and the EHC Assessment Team (currently based in Riverside)
- There is a gap for those who don't meet the targeted family support criteria, the Children's Disability Family Support Service criteria or are not the right age for Children's Centres.

A sample of the Current SEND Local Offer

The diagram on page 8 outlines a sample of the key services that form a part of the current SEND Local Offer and that are involved in the development of Education, Health and Care Plans. These services are provided by a range of providers across the statutory and voluntary sector.

A sample of the current Rotherham SEND Local Offer





How will we implement the Framework?

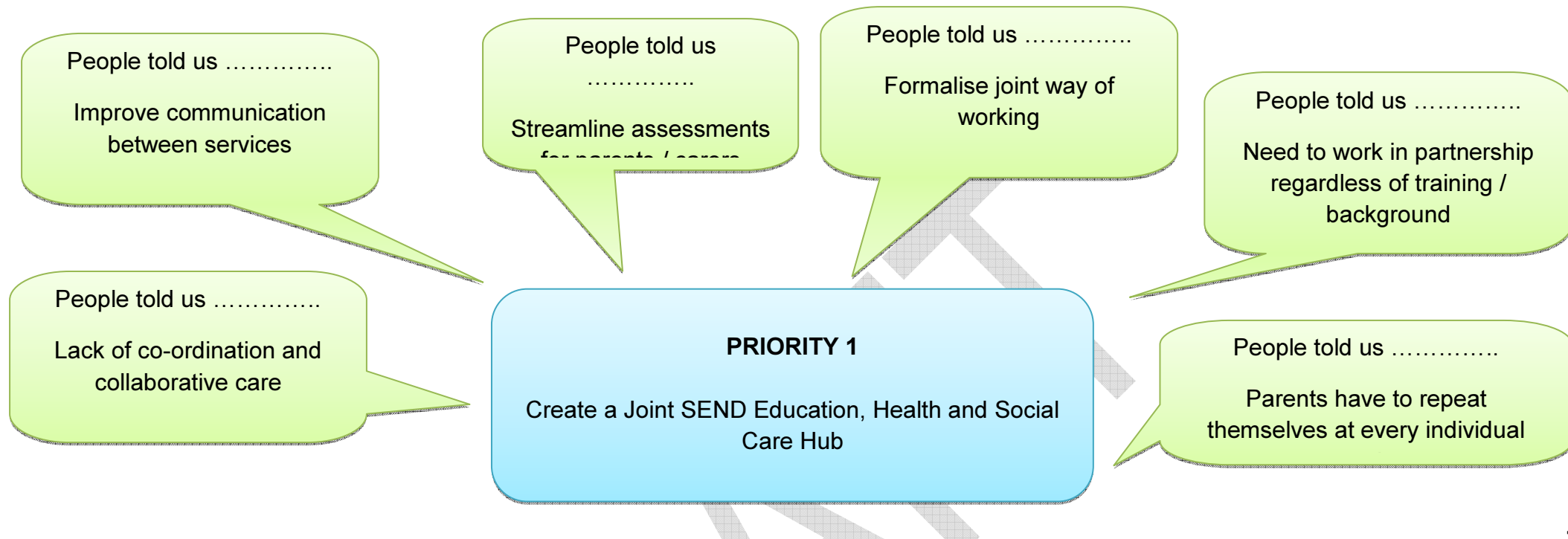
Implementation will require a phased approach to move from the current position, which is a mixture of single, aligned and joint commissioning approaches to more formal, planned and fully coordinated joint commissioning covering the whole of the needs for children and young people with SEND and their families.

The initial focus will be further developing joint commissioning arrangements between the local authority, Rotherham CCG and NHS England. However consideration will be given to how this can be extended to work with schools to understand their potential role and contribution to joint commissioning arrangements.

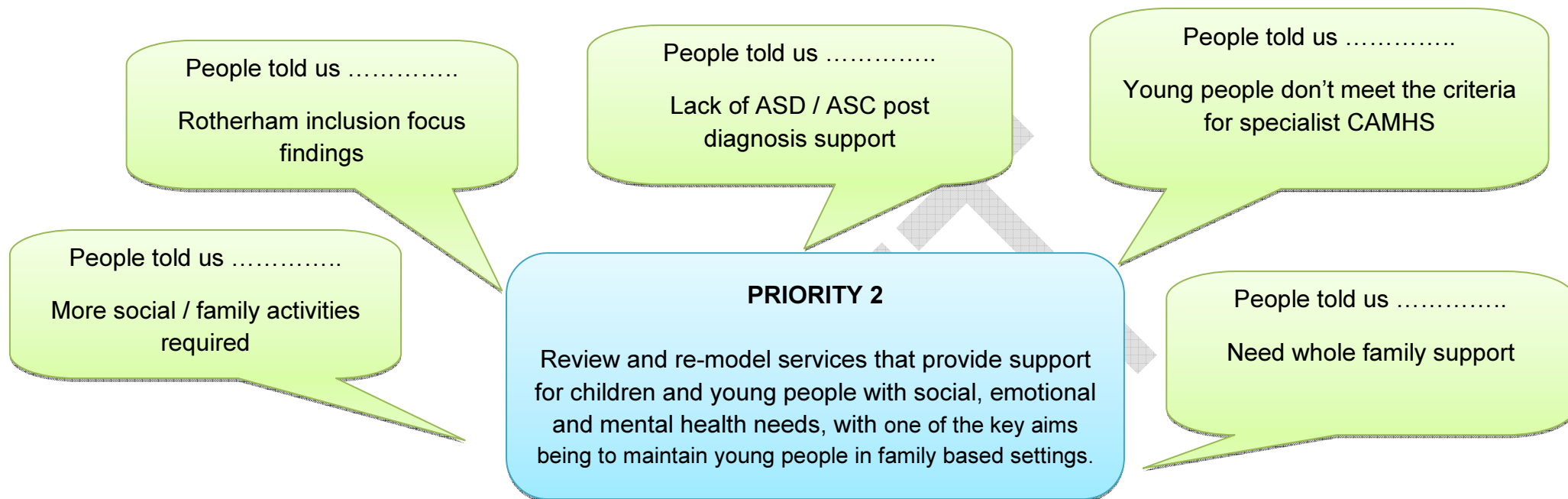
The following list of priority areas of work have been identified through the SEND Mapping exercise and consultation with key staff and will be implemented over the next three years:

- Priority 1 Create a joint SEND Education, Health and Social Care Assessment hub at Kimberworth Place. *Year 1*
- Priority 2 Review and re-model services that provide support for children and young people with challenging behaviour, with one of the key aims being to maintain young people in family based settings. *Year 1*
- Priority 3 Develop a performance and outcomes framework that will be applied across all local authority and CCG SEND provision. *To be implemented by Year 3*
- Priority 4 Align local authority and CCG specifications for SEND service provision, so as to facilitate commonality of practice and a consistent approach (thus reducing duplication, improving efficiencies and developing clearer pathways). *Year 1*
- Priority 5 Audit the Education, Health and Care Planning (EHCP) process to look at how the assessment process (including the decision making process/panels and allocation of resources) can be streamlined, so as to reduce the multiple assessments that young people and their families have to undertake. *Year 1*
- Priority 6 Ensure that there is a co-ordinated joint workforce development plan. *Year 2*
- Priority 7 Develop and implement Personal Budgets. *Year 1*
- Priority 8 Develop pathways to adulthood *To be implemented by Year 3*
- Priority 9 Develop approaches to improving life experiences *To be implemented by Year 3*

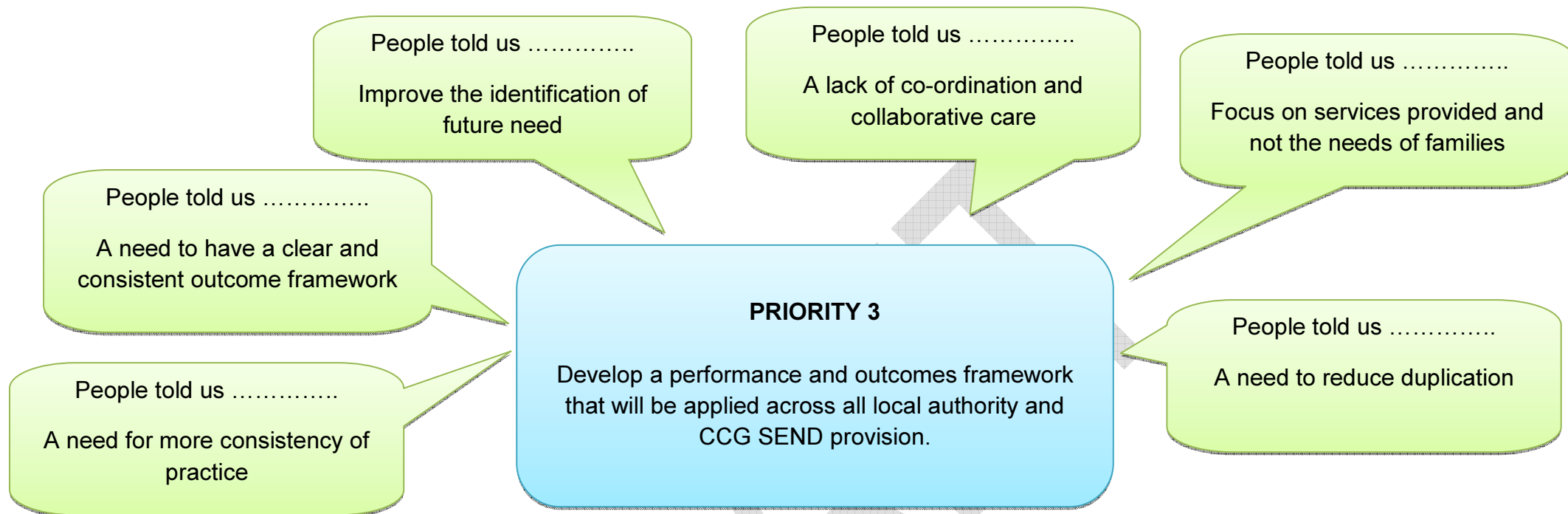
The priorities, along with comments from parents/carers and stakeholders that relate to those priorities, are detailed on pages 11 to 17.



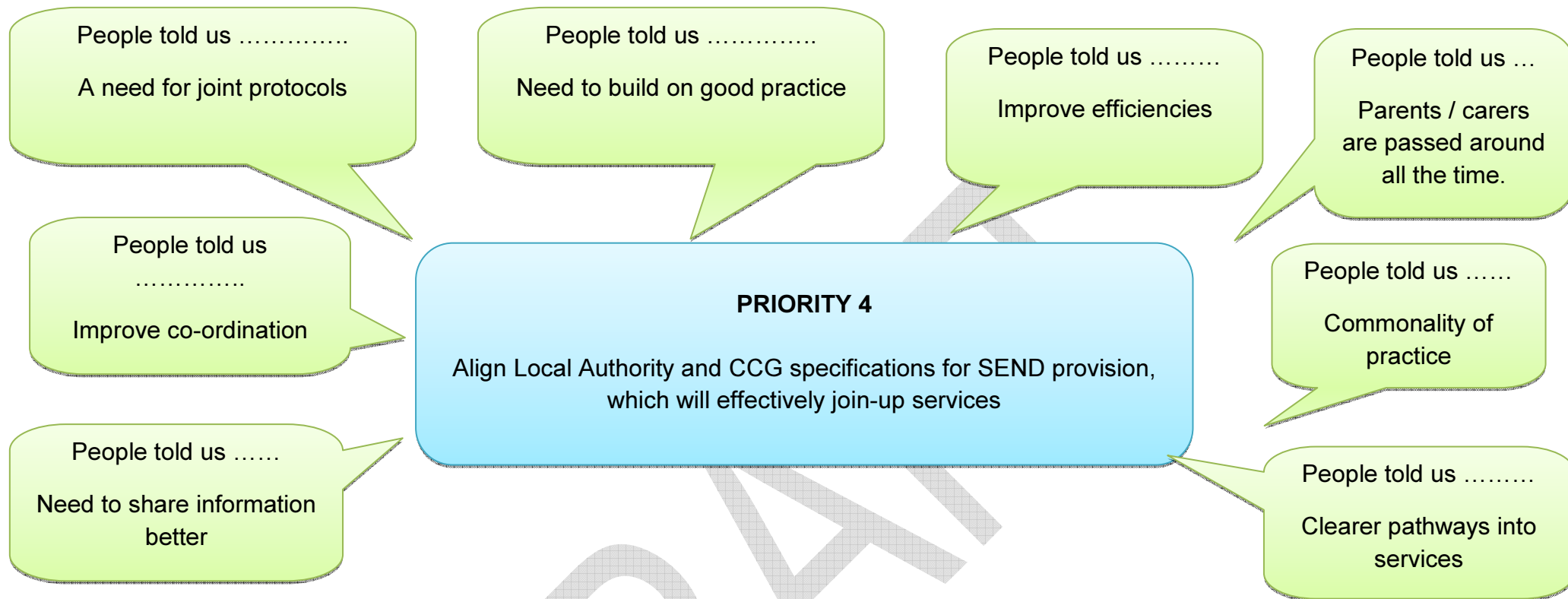
This is how we get there	This is where we want to be
Map services and relationship between services	<ul style="list-style-type: none"> Individually commissioned plans for children and young people and families are co-ordinated in one place Streamlined decision making process / panels (Continuing Care, Education Health and Care Plans, Short Breaks, Equipment and transitions) Hub for personal budgets Services understand the offer for partner agencies and have shared values and priorities Education Health and Care Team work in strong collaboration and families Plans are quality assured Locality assessments feeds into the assessment hub
Develop shared values and principles for staff to be co-located at SEND Hub	
Consider benefits of moving Education, Health and Care staff together and identify the staff involved and audit use of building space.	
Identify co-ordinator of provision at the SEND Hub	
Consider solutions for information sharing	
Co-ordinate decision making processes	
Develop a robust quality assurance process	
Establish a hub for personal budgets	



This is how we get there	This is where we want to be
Use the CAMHS / Schools Pilot Project to develop new ways of working and increase understanding of social, emotional, mental health.	<ul style="list-style-type: none"> • Collective responsibility for C&YP with social, emotional, mental health issues. • Clusters of learning communities work in partnership to meet needs locally. • Strong collaboration with partners, including CAMHS, schools and Early Help who are linked into school clusters. • Build school resilience • Develop alternative provision • Young people are included and rarely excluded • C&YP mental health needs supported locally in a trusted environment and young people are kept in family based environments. • Schools develop a graduated response • Schools have a whole school approach
Early Help Offer clearly understood	
Develop training package and information and advice	
CAMHS restructure to align provision against school clusters	
School support will have a graduated response to meeting the social, emotional and mental health needs of young people with SEND	
Pathways into specialist interventions shared and understood	
GP's, social care and other services will be aware of and influence social, emotional and mental health developments.	

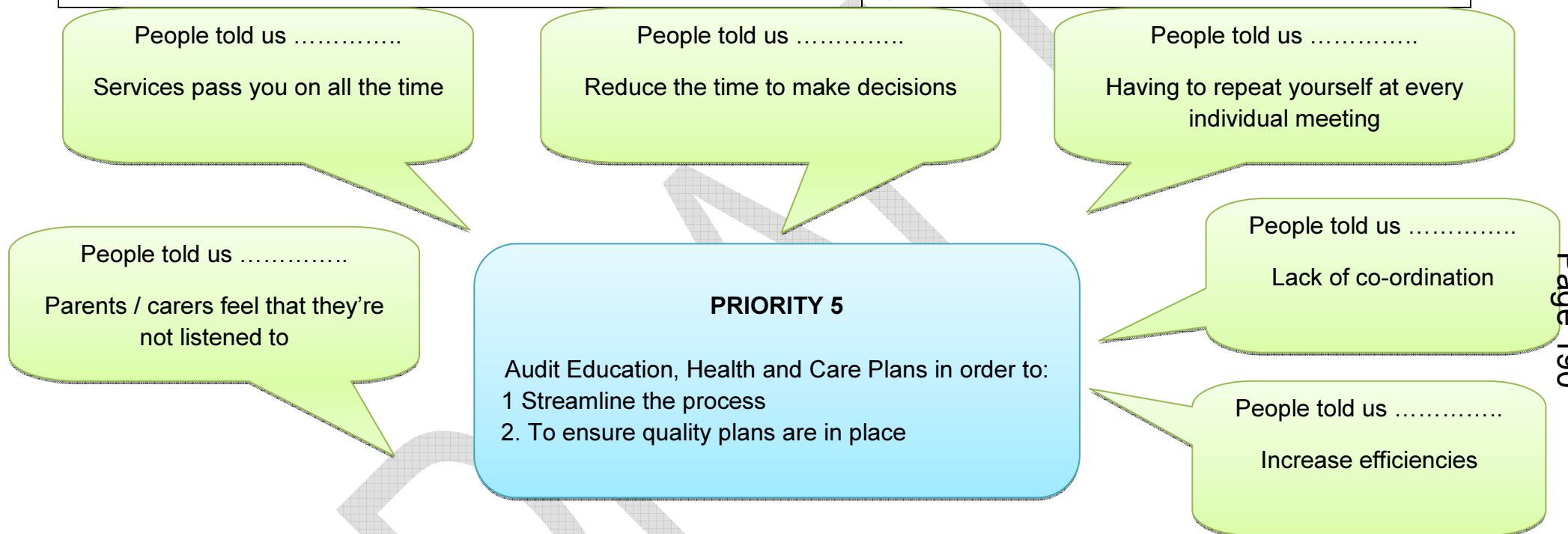


This is how we get there	This is where we want to be
Involve young people and families in determining what the performance measures should be	<ul style="list-style-type: none"> To understand employment / education destinations for C&YP with SEND. To understand if outcomes in Education, Health and Care Plans are achieved. To understand learning outcomes for SEND. To understand number of exclusions. Use surveys to understand the views of families and providers e.g. POET and Making It Real
Create an SEND dashboard, including quantitative and qualitative data	
Quality assure Education, Health and Care Plan	
Audit a sample of Education, Health and Care Plans on a 12 month basis	
Review data of learning outcomes (Closing the Gap)	
Monitor and collate data on exclusions	
Introduce POET and analysis data	
Link with performance team quality assurance framework	



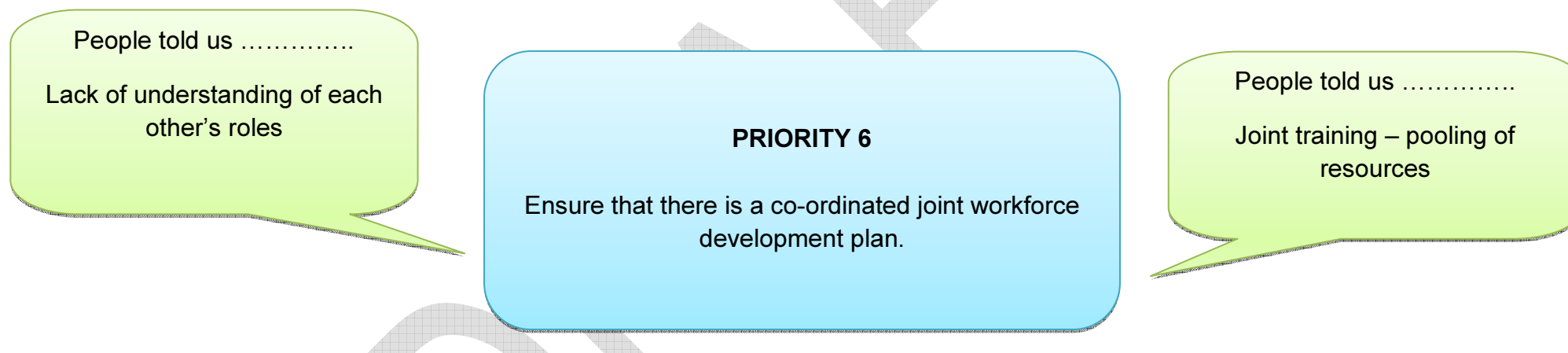
This is how we get there	This is where we want to be
Identify common working practices (golden thread) and align across all SEND services linked to the digital roadmap strategy.	<ul style="list-style-type: none"> Families will influence, shape services and be assured that services work collaboratively Shared values and priorities that underpin SEND services. Clear communication of joint intentions and expectations Clear pathways Service specifications reference new duties and
Identify dates of review of service specifications and include the principles and priorities	
Issue service specifications for in-house services	

Include quality control process to Education, Health and Care Plans	responsibilities eg joint assessment and collaboration. <ul style="list-style-type: none"> • There are specifications for in-house and external services • A golden thread runs through the commissioning strategy to individual service specifications in all areas • Service specifications have SEND non-negotiables
---	--

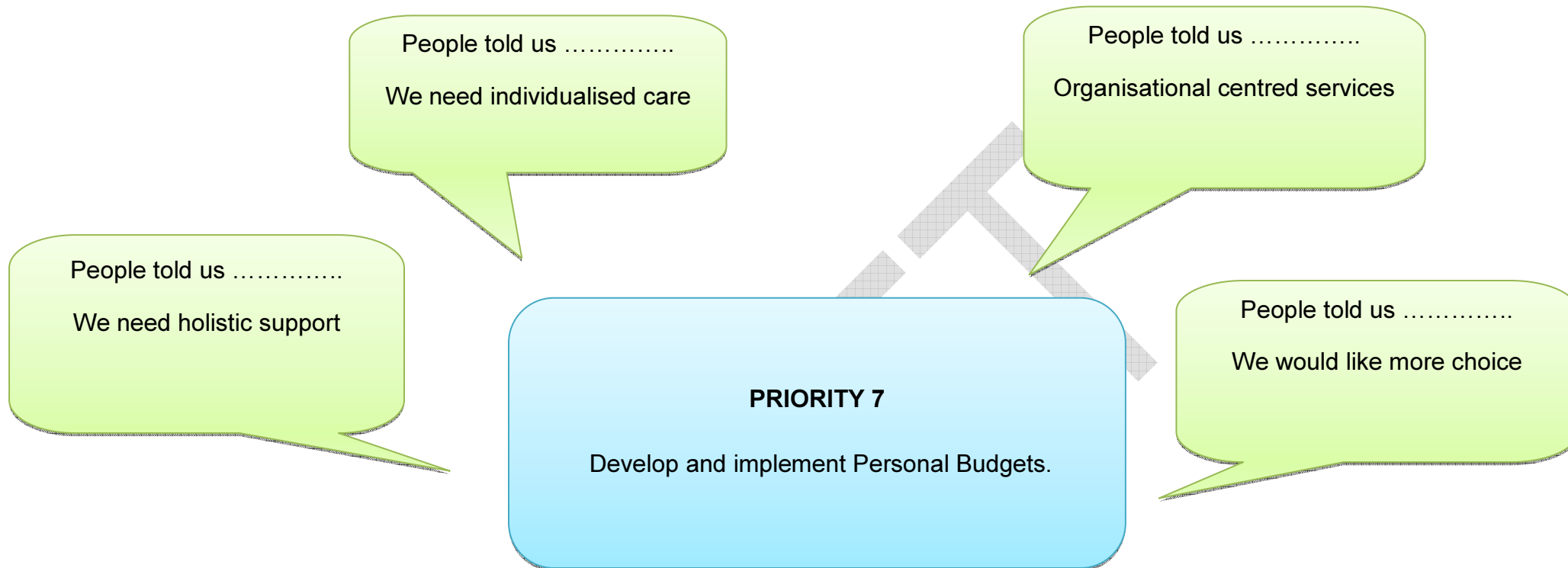


This is how we get there	This is where we want to be
1. Audit the SEND assessment process , so as to look at merging processes	<ul style="list-style-type: none"> • Families do not have to tell their story a number of times • All Education, Health and Care Plan partners make quality contributions to the process • Completed Education, Health and Care Plans are signed off
2. Review a sample of 20 completed Education, Health and Care Plans, to look at quality, outcomes, contribution from partners and C&YP and parental contribution	

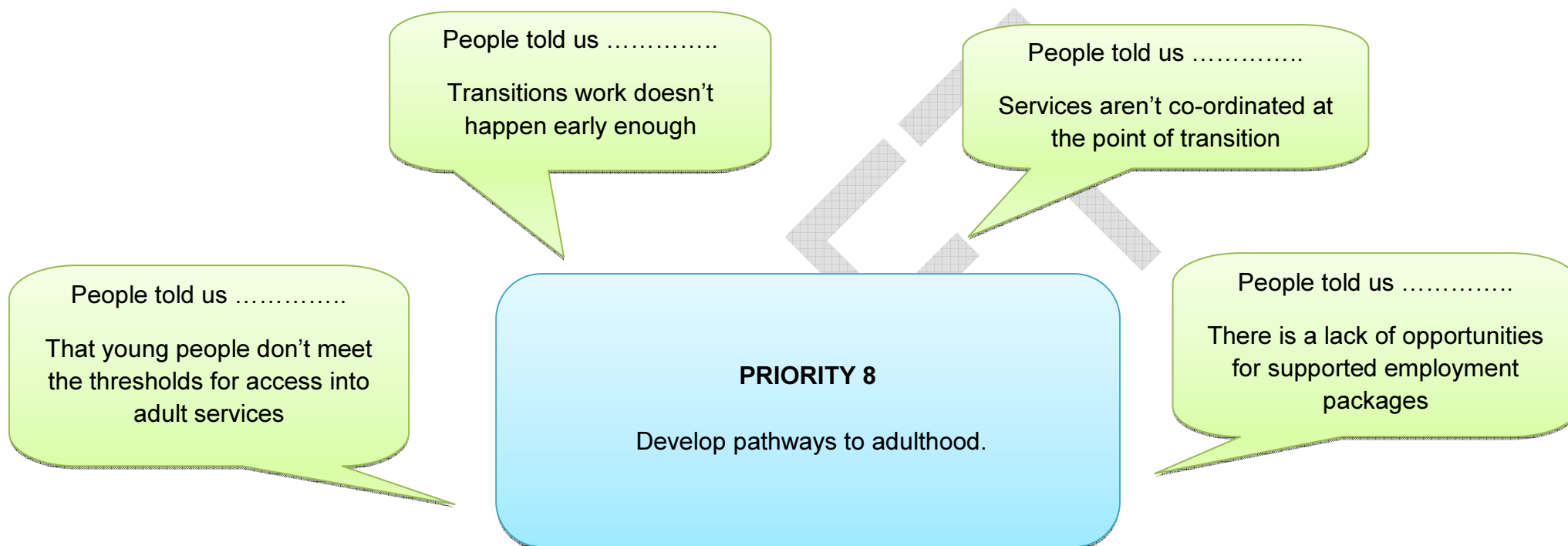
2. Identify learning from the review and	People told us Avoid mixed messages	by the Care, provis	People told us Shared understanding of the SEND agenda and process	nd Social ort or
2. Build in to service specifications the Care process				
2. Explore sign off procedure for Education, Health and Care Plans (two tiered approach)				



This is how we get there	This is where we want to be
Pool CPD resources	Have joint CPD around key areas of development eg: <ul style="list-style-type: none"> • Young people and parental engagement • Social, Emotional and Mental Health • Education, Health and Care Planning Process • Personal budgets • Safeguarding disabled children • SEND support • Local Offer • Outcome focussed planning • Other identified needs
Develop and renew an annual training schedule	
Focus CPD on joint issues	
Invite colleagues from other service areas to multi-agency training events	
Work with staff and families to identify what matters most in terms of training needs	
Ask families what matters most	



This is how we get there	This is where we want to be
Develop a Personal Budget policy and strategy	<ul style="list-style-type: none"> Families have choice and control through personal budgets Personal Budget strategy developed and included on the local offer.
Personal Budgets Working Group to develop and implement a process for providing personal budgets around areas such as transport, specialist equipment, Short Breaks and specialist Short Breaks	
Undertake a personal budgets pilot with 20-40 families	



This is how we get there	This is where we want to be
Education Health and Care planning team have input from children's and adult's social care	<ul style="list-style-type: none"> • Young people have a plan that takes them into adulthood • A planned approach for transition to adult services. • Education, Health and Care provide a 0-25 plan • Good connections between Education, Health and Social Care • A clear criteria for transition into adult services
Develop links with Young Adults Transitional Team	
Implementing the recommendations of the Transitions Review	
Develop opportunities for semi-independent living and supported employment	



This is how we get there	This is where we want to be
Audit services that provide information, advise and support and consider re-commissioning (possibly managed by the voluntary sector)	<ul style="list-style-type: none"> Families know where to go for information, advice and support. SEND independent information and advice service should be linked to other information services. Young people have support in moving towards independent living Young people have access to enriching leisure activities Appropriate levels of family support available
Work with housing to ensure that housing is on the local offer	
Ensure that the local offer is populated with services that provide leisure activities	
Link with Early Help to support the development of positive activities	
Research and develop a model of support for families post Autism Spectrum Condition diagnosis	

How will we know we have made a difference?

The SEND Joint Commissioning Sub Group will lead on the implementation of this strategy and pending work plan. As joint commissioning projects are implemented, agencies will provide information to measure progress regarding the impact of services and interventions. Performance reports will be shared through the necessary governance routes within agencies.

The Sub Group will also actively receive feedback from children, young people and their families, as well as from practitioners working with children and young people with SEND, to help further assess needs and challenges. This, along with the performance management will inform future joint planning, commissioning and decommissioning of SEND services within Rotherham.

Joint Commissioning Plan 2016/17

Priority action	Milestones	Resources	Lead	Risk
1. Create a formalised joint SEND Education, Health and Social Care Assessment hub at Kimberworth Place	<ul style="list-style-type: none"> • Visioning event - March 2016 • Plans in place for move – June 2016 • Teams to move - August 2016 • All teams in Kimberworth Place - September 16 	Estates support to relocate	Paula Williams	<p>A number of teams moving at the same time may cause some service disruption.</p> <p>If all team leads and staff are not actively engaged the move will be location only and not result in the creation of an SEND Hub</p>
2. Review and re-model services that provide support for children and young people with challenging behaviour, with one of the key aims being to maintain young people in family based settings.	<ul style="list-style-type: none"> • Initial discussions with School Partners – September 2015 • SEMH Strategy written – November 2015 • Schools Forum to agree new funding structure – December 	<p>Chris Harrison time</p> <p>Estates support for relocations</p> <p>Dedicated CAMHS support to PRUs</p>	Paula Williams/Chris Harrison	<p>Rising exclusions</p> <p>Limitations on places available at PRUs leading to capacity issues</p> <p>Statutory duty not met</p>

Priority action	Milestones	Resources	Lead	Risk
	<p>2015</p> <ul style="list-style-type: none"> • SEMH Partnerships established – January to March 2016 • Reconfiguration of Aspire PRU for September – April to July 2016 • New admissions policy for Rowan PRU and reconfiguration for person centred approach – April to July 2016 • Establish Emotional Wellbeing & Mental Health Whole School Approach pilots – March 2016 • Whole School Approach pilots operational and evaluation undertaken – September 2016 to July 2017 	<p>Staff time CAMHS Transformation monies</p>	<p>Ruth Fletcher Brown/ Paul Theaker</p>	

Priority action	Milestones	Resources	Lead	Risk
3. Develop a performance and outcomes framework that will be applied across all local authority and CCG SEND provision.	<ul style="list-style-type: none"> • Scope out the services to be included in the framework – May 2016 • Develop the performance and outcomes framework – August 2016 • Implement the performance and outcomes framework – September 2016 • Ongoing monitoring of the performance and outcomes framework, including the assessment of demand. 	CYPS Performance Team time	Nicole Chavaudra/ CYPS Performance	<p>There is a lack of co-ordination</p> <p>There is not a consistency of practice</p> <p>There is a duplication of work</p> <p>Future need is not fully identified</p>
4. Align local authority and CCG specifications for SEND service provision, so as to facilitate commonality of practice and a consistent approach (thus reducing duplication, improving efficiencies and developing clearer pathways).	<ul style="list-style-type: none"> • Scope out the services to be included and review existing specifications – June 2016 • Align specifications – August 2016 • Re-issue amended specifications – September 2016 	Staff time	Emma Royle/ Paul Theaker	<p>There isn't a commonality of practice</p> <p>Information sharing is not improved</p> <p>There aren't clearer pathways</p>

Priority action	Milestones	Resources	Lead	Risk
5. Audit the Education, Health and Care Planning (EHCP) process to look at how the assessment process (including the decision making process/panels and allocation of resources) can be streamlined, so as to reduce the multiple assessments that young people and their families have to undertake.	<ul style="list-style-type: none"> Establish leadership of EHCAT – March 2016 Team structure agreed – May 2016 May 16 Conversion Plan finalised Additional staffing secured – May 2016 Quality Assurance with SENCos – September 2016 Panel observations to take place (EHC, Continuing Care, Short breaks, Specialist Equipment) – March 2016 Further strategic work is to take place to create a complex needs panel – September 2016 Devise a framework/ protocol regarding joint funding decisions for cases where needs are identified that are not part of routinely 		<p>Paula Williams/Jackie Parkin</p> <p>Nicole Chavaudra</p>	<p>Young People not having needs met</p> <p>Statutory duties unmet</p>

Priority action	Milestones	Resources	Lead	Risk
	commissioned services – September 2016			
6. Ensure that there is a co-ordinated joint workforce development plan	<ul style="list-style-type: none"> Area Inspection Group established – December 2015 Area Inspection self-evaluation completed – April 2016 SEND training plan devised – May 2016 SEND Communication Plan devised – May 2016 		Paula Williams	Children and Young People's needs not met Poor identification and provision Poor joint working
7. Develop and implement Individual Budgets	<ul style="list-style-type: none"> Personal Budgets Strategy approved – April 2016n eligibility process and mechanism for administering personal budgets Develop an eligibility process and mechanism for administering personal budgets – April 2016 Short Breaks and Transport Personal 	Staff time	Jackie Parkin	Less choice for parents and young people

Priority action	Milestones	Resources	Lead	Risk
	Budget Pilots undertaken – May 2016 to March 2017			
8. Develop pathways to adulthood	<ul style="list-style-type: none"> Develop an Integrated Transition Partnership – June 2016 Identify key transition priorities to take forward – April 2016 Implement the recommendations of the Transitions Review 	Staff time	Linda Harper	Transition work doesn't happen early enough Services aren't co-ordinated
9. Develop approaches to improving life experiences	<ul style="list-style-type: none"> Research the most appropriate model of support for post diagnosis ASD – January to March 2016 Implement model of service – April 2016 	Staff time CAMHS Transformation Grant	Paula Williams	Limited out of school ASD support

Briefing note for: Health and Wellbeing Board**Subject: Board Development Session****Date: 21 September 2016****Background**

During June 2016, Rotherham Health and Wellbeing Board members completed a self-assessment questionnaire, which looked at the vision and role of the board, system leadership, partnership working and communication and engagement. The questionnaire was part of the Local Government Association (LGA) board development toolkit.

The outcome of this questionnaire culminated in a development workshop session in July, facilitated by John Deffenbaugh (Frontline) and the LGA. The session was used to:

- provide time and a safe space for the board to reflect on the journey it has been on to arrive at its current position
- position the board in a role of local leadership of health and wellbeing across Rotherham so that it can drive change instead of being the messenger of change

The Force Begins to Awaken

The Force Begins to Awaken report has been developed by the LGA to explore the current position of health and wellbeing boards in more detail; seeking to understand the features of the more effective boards and to identify the factors that are influencing whether or not a board makes significant progress. This report has been used as part of this process as a benchmark for success. The drivers and barriers to effective boards were identified as:

- **Committed leaders**, both political and managerial;
- **Collaborative plumbing**, often reflecting a history of partnership working;
- **Clarity of purpose**, being clear about the primary task of the board;
- **A geography that works**, or has been made to;
- **A focus on place**, with local priorities that drive collaboration;
- **A director of public health**, who gets it;
- **High quality support**, and a flexible approach to the “council committee thing”;
- **Churn in the system**, within health and local government;
- **Getting the basics right**, to enable effective systems leadership.

Development workshop

On 13 July, board members came together to discuss the responses to the questionnaire, looking at the strengths, weaknesses and challenges, a summary of which can be seen in appendix A. Board members then worked together to produce an action plan to take forward the agreed issues and challenges.

One of the challenges identified in the analysis was ‘communication’, the workshop focused on this in developing the plan – both communication to stakeholders and the public about the work of the board, and improving communication of health messages to the Rotherham population. The draft action plan can be seen in appendix B.

Recommendations:**That board members:**

- **Consider the actions set out in the draft plan and whether they are achievable,**
- **Identify what resources may be required, leads and timescales.**

<p>Strengths</p> <ul style="list-style-type: none"> - 100% agree there is a real determination to secure change - 100% confidence that the chair and the vice chair share this determination - Senior officers and elected members within the council recognise the importance of the HWB - There is a strong sense of shared leadership across the local authority and the CCG - There is agreement that the board forms part of a good collaborative landscape between health and local government - There are effective mechanisms in place for collaboration - Personal relationships between board members are strong - Members feel there is parity of esteem across the membership of the board - Partner organisations at the health and wellbeing board understand each others' constraints - Board members are able to be challenging with one another to reach solutions to disagreements - Everybody understands the role and purpose of the health and wellbeing board - Board members see the board as a key driver for change - Most people found the board understands its role in relationships to other partnerships in the system - Better care fund overseen well - The board is seen to have effective sub-structures - Mostly coterminous geography - Meetings not just held in the council - Good collective working on integration - Most agree that the board pursues a local agenda and balances this with national requirements e.g. bcf, NHS targets etc. - Locality pilot - Prevention is a key theme in the strategy and the STP 	<p>Areas for Consideration</p> <ul style="list-style-type: none"> - Engagement – does the HWB engage with the public as a partnership body? Or is engagement done by separate organisations? - Are you able to attribute tangible change to the efforts of the board? - Is there an effective mechanism in place to monitor progress and the board's impact on key metrics and outcomes? - Is there a road map in place to guide what your strategy wants to achieve? - Do board members feel they represent the board when they are back in their own organisations? - Is the delivery of your strategy as effective as you would like? - Does the board challenge partners enough on progress made to its workstreams? - Are your organisations using the JSNA effectively enough to ensure services are commissioned in-line with JSNA priorities? - Is your strategy clear enough on what you want to achieve and how you want to achieve it? - Does the board's agenda reflect only items that will help achieve what you are aiming for in your strategy and is the agenda planning structured well in advance? - Is the board able to have challenging conversations around £ and risk sharing? - Is there a balance between formal and informal board meetings? Does the board hold workshops? Theme discussions? Round tables? Public stories?
<p>Opportunities</p> <ul style="list-style-type: none"> - Public engagement – the board could brand itself and take the strategy and workstreams out into the public - The board is now ready to press on with achieving what it has set out to do – all partners are signed up – just need to ensure this happens 	<p>Challenges</p> <ul style="list-style-type: none"> - Board's role in relation to the STP – short timescales now but an iterative process ongoing how does the board see its involvement?

DRAFT Health and Wellbeing Board – development session action plan

July 2016

What?	How/Who?	When?	Resources	Outcome
Commitment to MECC (Making Every Contact Count). Look at re-training staff and pick up the momentum again.	Use MECC to focus on one key issue to begin with e.g. smoking / physical activity		Cost implications to be included in the draft plan – ‘invest to save’ idea.	
Placing ‘Navigators / Champions’ in 2 GP Practices initially to signpost with basic information – referral pathways. Pilot programme initially to be monitored and evaluated within an agreed timescale with a view to rolling out across the borough	<p>Task and finish group to be formed to take forward development of a Navigator / Champion pilot initiative.</p> <p>Need commitment from key people to give initiative credibility:</p> <ul style="list-style-type: none"> • On-site commitment • Practice Manager / Nurse • clinical expert 	<p>Draft plan to be pulled together and brought to November HWB Board Meeting.</p> <p>Possibility of pilot being up and running by January 2017.</p>	<p>Who will be ‘Navigators / Champions’?</p> <p>Budget implications</p> <ul style="list-style-type: none"> - Staff / training etc. – skill set very important - Plan A – with budget - Plan B – without budget. <p>Involve in T&F group:</p> <ul style="list-style-type: none"> • Councillor/s • Public Health • PPGs • Healthwatch • CCG 	<p>Care navigators in all GP surgeries.</p> <p>Changes in rates of smoking/physical activity/drinking etc</p>
Board to consider where existing arrangements are in place to engage with the public on	Task and finish group to be formed, with key officers from each organisation, to develop	Group to be established by end September, with a draft plan shared at the board in November.	Plan to consider how existing arrangements can be utilised more effectively to engage,	

Appendix B

specific issues/agendas, external to formal meetings, rather than expecting the public to attend meetings.	a communications plan for the board.		within existing budgets.	
Board member commitment to go to another group/place outside of own organisation to talk about the board and engage a wider range of people in key activities and agendas.	One board member to commit to doing this at each formal meeting.	Rolling programme of activity starting from September. (to be included in the communications plan)	No budget required.	
Board to consider holding an 'engagement event' once/twice per year, to inform about the HW Strategy and key areas of work.	Public engagement event programme to be developed (as part of communications plan), to be led by board members.		Budget to be considered for venue costs.	
Engage the public on issues, rather than just the 'board' itself.	CCG will produce a series of information documents including slide packs for professionals, slide packs for public and managerial documents.	Pack developed by mid-September.		