

## **IMPROVING LIVES SELECT COMMISSION**

**Venue: Town Hall, Moorgate  
Street, ROTHERHAM.  
S60 2TH**

**Date: Tuesday, 14th November, 2017**

**Time: 5.30 p.m.**

### **A G E N D A**

**There will be a pre-briefing for all members of the Improving Lives Select Commission at 4.00 p.m.**

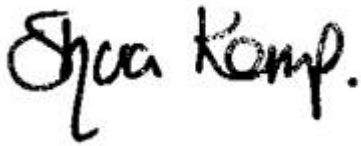
1. To consider whether the press and public should be excluded from the meeting during consideration of any part of the agenda.
2. To determine any item(s) the Chairperson is of the opinion should be considered later in the agenda as a matter of urgency.
3. Apologies for absence.
4. Declarations of Interest.
5. Questions from members of the public and the press.
6. Communications.
7. Minutes of the previous meeting held on 31st October, 2017 (to be circulated)
8. Rotherham Local Safeguarding Adults Board - Annual Report 2016-2017 (herewith) (Pages 1 - 41)
9. Rotherham Local Safeguarding Children Board - Annual Report 2016-17 (herewith) (Pages 42 - 105)
10. Date and time of the next meeting - Tuesday, 12th December, 2017 at 5.30 p.m.

**Improving Lives Select Commission membership:-**

Chair – Councillor Clark  
Vice-Chair – Councillor Cusworth

Councillors Beaumont, Brookes, Cooksey, Elliot, Fenwick-Green, Hague, Ireland, Jarvis, Khan, Marles. Marriott, Pitchley, Senior, Short, Julie Turner and Tweed.

Co-opted members:- Ms. J. Jones (Voluntary Sector Consortium),  
Mrs. A. Clough (ROPF: Rotherham Older Peoples Forum)  
for agenda items relating to older peoples' issues.

A handwritten signature in black ink that reads "Sharon Kemp." The signature is written in a cursive, flowing style.

Sharon Kemp,  
Chief Executive.

## Summary Sheet

### Council Report

Rotherham Local Safeguarding Adults Board – Annual Report 2016-2017

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

Not applicable

### Strategic Director Approving Submission of the Report

Anne Marie Lubanski

### Report Author(s)

Sandie Keene, Independent Chair of the RSAB (from November 2015).

### Ward(s) Affected

All wards

### Summary

The Care Act 2014 requires each SAB to publish an annual report as soon as is feasible after the end of each financial year, a SAB must publish a report on:

- what it has done during that year to achieve its objective,
- what it has done during that year to implement its strategy,
- what each member has done during that year to implement the strategy,
- the findings of the reviews arranged by it under section 44 (safeguarding adults reviews) which have concluded in that year (whether or not they began in that year),

### Recommendations

It is recommended that the Improving Lives Select Commission note the report.

### List of Appendices Included

Rotherham Local Safeguarding Adults Board Annual Report 2016 - 2017

**Background Papers**

None

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

N/A

**Council Approval Required**

No

**Exempt from the Press and Public**

No

## **Rotherham Local Safeguarding Adults Board – Annual Report 2016-2017**

### **1. Recommendations**

It is recommended that the Improving Lives Select Commission note the report.

### **2. Background**

The Care Act 2014 requires each SAB to publish an annual report as soon as is feasible after the end of each financial year, a SAB must publish a report on:

### **3. Key Issues**

This report introduces both the achievements of Rotherham Safeguarding Adults Board (SAB) for 2016/17 and comments on some of the key points of inter-agency working arrangements and positive partnership.

#### **Key priorities for 2017-18**

- All organisations and the wider community work together to prevent abuse, exploitation or neglect wherever possible.
- Where abuse does occur we will safeguard the rights of people, support the individual and reduce the risk of further abuse to them or to other vulnerable adults.
- Where abuse does occur, enable access to appropriate services and have increased access to justice, while focussing on outcomes of people.
- Staff in organisations across the partnership have the knowledge, skills and resources to raise standards to enable them to prevent abuse or to respond to it quickly and appropriately.
- The whole community understands that abuse is not acceptable and that it is 'Everybody's business'.

#### **Contact:**

Sandie Keene,  
Independent Chair, Rotherham LSAB  
[sandie.keene@rotherham.gov.uk](mailto:sandie.keene@rotherham.gov.uk)



Rotherham  
**Safeguarding Adults**

Rotherham **Safeguarding** Adult Board

# 2016 2017 Annual Report

People of Rotherham are able to live a life free from harm  
where all organisations and communities

**Keeping people safe from abuse is everyone's business**

**Work together to prevent abuse**

**Knows what to do when abuse happens**

# Introduction by Sandie Keene CBE

## Rotherham Safeguarding Adults Board Independent Chair



**D**uring 2016/7 all the agencies in Rotherham continued their commitment to improve Adult Safeguarding in the

**Borough and to build on previous progress.**

Our plans remain the same as last year. We wish to:

- engage better with the public and make it easy to report concerns about safeguarding
- ensure that where safeguarding concerns are identified then a personal response will be provided
- communicate well by listening and ensuring good information is available
- have open and clear governance so what we do is widely known
- understand the level of reported abuse and have systems and processes in place to ensure we are responding appropriately and quickly.

During the last year we have achieved many of our goals. We have listened to those who have experienced safeguarding enquiries, agreed our constitution, launched our website accompanied by leaflets and a poster, agreed our performance dashboard where agencies can come together and

hold each other to account, developed policy and procedure for staff to understand what is expected and completed 2 Safeguarding Adult Reviews to enable learning and action planning where we have fallen short of expected standards in the past. This report contained more detail of these and other successes in the year.

Our detailed plans for the coming year include the creation of further opportunities to engage with residents in the Borough, particularly those who may have experienced the need for a Safeguarding response. We want to know how we can improve multiagency safeguarding responses further and hear from a wide range of people including staff and partners. We will also be auditing what we do in order to learn from mistakes and celebrate successes and develop our training strategy to ensure up to date learning from new initiatives. This report outlines our plans in more detail.

We have zero tolerance of any acts of abuse, coercion or violence which impacts on the most vulnerable in society. Our role as a Safeguarding Adults Board is to work with everyone in the Borough to protect those in need of care and support from harm. I look forward to working with you all to this end in the coming year.

**Sandie Keene** CBE

Rotherham Safeguarding Adults Board  
Independent Chair



# Message from Councillor David Roche

Chair of the Health and Wellbeing Board



**This Safeguarding Annual Report for 2016/17 gathers safeguarding information and evidences the true**

**collabrative work from all partners of the Rotherham Safeguarding Adults Board. Strong partnership working ensures that safeguarding is at the forefront of all our agendas.**

The Rotherham Safeguarding Adults Board works continuously to ensure that Safeguarding is everyone's business, we work to safeguard the vulnerable and those who lack the mental capacity to make the right decisions, ensuring help is available to support people and every effort is made to protected people from harm.

Once again I would like to take this opportunity to acknowledge the commitment of all of you including the statutory, independent and voluntary community sector, who have helped us to achieve all that we have in the last twelve months.

**Councillor David Roche**

Adult Social Care and Health





# Keeping people safe from abuse is everyone's business *Recognise – Respond – Report*

**The Rotherham Safeguarding Adults Board works to protect adults with care and support needs from abuse and neglect.**

The RSAB's objective is to ensure that local safeguarding arrangements and partnerships act to help and protect adults at risk or experiencing neglect and/or abuse. The RSAB is a multi-agency strategic, rather than operational, partnership made up of senior/lead officers within adult social services, criminal justice, health, housing, community safety, voluntary organisations.

It coordinates the strategic development of adult safeguarding across Rotherham and ensures the effectiveness of the work undertaken by Partner Agencies in the area. The Rotherham Adult Safeguarding Partnership Board ('RSAB') aims to achieve those objectives whilst supporting individuals in maintaining control over their lives and in making informed choices without coercion.



## Who is at risk?

**An adult at risk is someone who is aged 18 or over who:**

- has needs for care and support
- is experiencing or is at risk of abuse or neglect, and is unable to protect themselves

## What is abuse?

**Abuse can be:**

- something that happens once
- something that happens repeatedly
- a deliberate act
- something that was unintentional, perhaps due to a lack of understanding
- a crime

**Abuse can happen anywhere, at any time and be caused by anyone including:**

- a partner or relative
- a friend or neighbour
- a paid or volunteer carer
- other service users
- someone in a position of trust
- a stranger

**Harm is defined in the Care Act as:-**

**Sexual** – for example; forcing adults to do sexual acts they don't want to or can't consent to (including rape, sexual assaults etc)

**Financial or Material** – for example; taking money or anything of value from adults etc

**Neglect and Acts of Omission** – any action that causes harm or isolates people, for example not supporting them to get washed/dressed etc

**Psychological or Emotional** – for example; threatening to leave them alone or intimidating them etc

**Self Neglect** – is any failure of an adult to take care of themselves that causes serious physical, mental or emotional harm or substantial damage to or loss of assets

**Discriminatory** – to bully someone who has a disability or is "different"

**Physical** – for example; hitting

**Domestic Abuse** – any incident of threatening behaviour, violence or abuse between adults who are or have been intimate partners or family members, regardless of gender or sexuality

**Modern Slavery/Human Trafficking** – the movement: recruitment, transportation, transfer, harbouring or receipt of people



# Rotherham Safeguarding Adults Review of 2016/17

**During 2016/17 Rotherham's Safeguarding Adults Board (RSAB) has been continuing to work to promote and protect vulnerable adults in Rotherham.**

The priorities for the board and its sub groups were:

| Priority  | Resulting Action  |
|---|---|
| <b>Developing a Constitution with agreement from all partners</b> | <p>The RSAB Constitution is complete and published.</p> <p>The document is an agreement from all partners to work strategically together to promote and protect vulnerable adults in Rotherham.</p>   |
| <b>Develop a Safeguarding Adults Board website</b>                | <p>The Rotherham Safeguarding Adults Board website is up and running.</p> <p>The website will continue to develop and be a hub of information for Safeguarding Professionals and the general public.</p>  |
| <b>Facilitate Board Development sessions with all partners</b>    | <p>The first Board Development Day was held in July 2016 and was well attended by all partners, the theme of the day was; What makes a good Section 42 Enquiry?</p> <p>The second Board Development Day will be held in May 2017 and will concentrate on; Communication, Thresholds and the Strategic Plan.</p> |
| <b>Raise the profile of Safeguarding Adults and the RSAB</b>      | <p>The Safeguarding Adults Board has produced a Leaflet and a Poster following consultation with partners.</p> <p>The leaflet gives easy read information on Safeguarding, types of abuse and how to report.</p>  |

# Rotherham Safeguarding Adults Review of 2016/17

The Safeguarding Adults Board has five sub groups to ensure the priorities of board are actioned, the Sub-Groups each have a work plan and during 2016/17 they were able to deliver the following specific pieces of work:

| <b>Performance and Quality Sub Group</b>   |  |
|--|--|
| <b>Develop a performance reporting framework to report Safeguarding activity from all partners</b> | <p>The Performance Dashboard is reported quarterly to the board and has 'performance on a page' information from all partners.</p> <p>The Dashboard continues to develop.</p>  |
| <b>Carry out annual self-assessments and peer challenges of all member organisations</b>           | <p>A self-assessment and challenge was carried out with all partners, recommendations were made and action plans developed.</p> <p>The action plans will be monitored by the Performance and Quality sub group and reported to the board.</p> <p>A Peer Review is planned for May 2017 and Case file audits for August 2017.</p> |

| <b>Training and Development</b>                                    |  |
|--|--|
| <b>Revise and update the Boards Safeguarding Training Strategy</b> | <p>The Sub-group have developed a Training Strategy 2017-2020 to lead and manage training arrangements across Rotherham. The Strategy sets out the vision, goals and principles for training and how these will be taken forward.</p>        |
| <b>Revise and update the Boards Safeguarding Training Plan</b>     | <p>The sub group have developed a training plan that supports and drives forward the Training Strategy's goal: to achieve a confident and capable workforce equipped with the knowledge, skills and expertise to fulfil their job roles.</p> |

# Rotherham Safeguarding Adults Review of 2016/17

| <b>Making Safeguarding Personal</b>                        |   |
|--|---|
| <b>Ensure the 'customer voice' is heard at board level</b> | <p>A survey was carried out with clients and families who had been through the Safeguarding process to gain valuable feedback to how the safeguarding experience could be improved.</p> <p>Work continues to establish a regular customer voice at board.</p> |

A decision was made at board level to rename the Making Safeguarding Personal (MSP) Sub Group to the Policy and Practice incorporating MSP this comes into effect from August 2017.

| <b>Safeguarding Adults Review</b>   |  |
|---|--|
| <b>Commissioning and overseeing Safeguarding Adult Reviews (SAR) and any other reviews agreed by the Chair</b>                        | During 2016/17 1 Safeguarding Adults Review has been completed but unpublished and 1 Safeguarding Adults Review has been commissioned and is due for completion in May 2017. |
| <b>Ensure that recommendations arising from each SAR are communicated to all agencies and are subject to review of implementation</b> | Action plans following the completion of a SAR are developed by the sub group and partners and will be managed through the Performance and Quality Sub Group.                |
| <b>Develop a Safeguarding Adults Review Protocol</b>  | A protocol has been drafted with input from all partners and will be signed of at board.   |



# Rotherham Safeguarding Adults Review of 2016/17

**Rotherham's Safeguarding Adults Board is a multi-agency, statutory partnership whose main objective is to ensure that local safeguarding arrangements and partners act to help and protect adults at risk of abuse and neglect across Rotherham.**

## Mission Statement

People of Rotherham are able to live a life free from harm where all organisations and communities:

- keep people safe from abuse is everyone's business
- work together to prevent abuse
- know what to do when abuse happens



## Objectives

- All organisations and the wider community work together to prevent abuse, exploitation or neglect wherever possible
- Where abuse does occur we will safeguard the rights of people, support the individual and reduce the risk of further abuse to them or to other vulnerable adults
- Where abuse does occur, enable access to appropriate services and have increased access to justice, while focussing on outcomes of people
- Staff in organisations across the partnership have the knowledge, skills and resources to raise standards to enable them to prevent abuse or to respond to it quickly and appropriately
- The whole community understands that abuse is not acceptable and that it is 'Everybody's business'

## Charter

### We will:

- take a zero tolerance approach to abuse and the factors that lead to abuse
- take action to protect vulnerable adults
- listen and respond to people
- investigate thoroughly and in a timely manner any concern that is raised
- pursue perpetrators of abuse
- empower customers
- embed an outcomes focused approach
- learn lessons and improve services as a result



# Looking forward to 2017/18

## The Rotherham Safeguarding Adults Board (RSAB) and its sub groups continue to meet every two months.

We will continue to develop a safeguarding culture that focuses on the personalised outcomes desired by people with care and support needs who may have been abused; this will remain a key operational and strategic goal.

The Safeguarding Adults Board continues to support the embedding of the 'Making Safeguarding Personal' approach across agencies.

Rotherham Safeguarding Adults Board in 2017 have committed to the following actions which we will continue to progress to conclusion in 2017-18.

### These are:

- development of policy and practice in the consistent application of thresholds for safeguarding alerts
- identification of joint work with the Community safety partnership concerning human trafficking/modern day slavery
- consideration of a Rotherham wide initiative to promote the option of Legal Power of Attorney in relation to care and protection of individuals
- increase the voice of users and carers in the work of the Board
- monitor the uptake of Advocacy in Safeguarding enquiries from information provided by RMBC
- development of guidance and training concerning key practice issues such as self neglect, consistent MCA application of the use of restraint and restrictions

The five Safeguarding Sub-Groups have updated their work plans and will develop their actions throughout the coming year to ensure the board are informed and guided in all matters that arise.

## Performance and Quality

- Continue to develop the annual self-assessments and peer challenges of all member organisations
- Continue to develop the performance reporting framework for Safeguarding
- Review the access to advocacy and the quality of service received including outcomes achieved
- Development of an RSAB Risk Register

## Training and Development

- Develop a mechanism to measure the success of Safeguarding
- Continue to identify areas where cross sector training would enhance the application of the safeguarding process and achieve improved outcomes for Service Users

## Making Safeguarding Personal (Policy and Practice)

- Develop guidance, policy and practise in respect of Self-Neglect
- Provide the board with assurance that Learning Disabilities Services and their users have safeguarding fully embedded within their service
- Continue to explore ways to bring the 'Customer Voice to RSAB
- Work across the South Yorkshire Region to develop an easy read guide to Safeguarding Procedures

## Looking forward to 2017/18

### Safeguarding Adults Review

- Making recommendations to the Chair in respect of whether a review should be commissioned
- Commissioning and overseeing SARs and any other reviews agreed by the Chair
- Receiving completed reports to quality assure before presenting to the Chair and Board
- Ensuring that recommendations arising from each SAR are communicated to all agencies and are subject to review of implementation

### Deprivation of Liberty's

- To champion the Mental Capacity Act 2005 practice and implementation
- Provide the RSAB with evidence of a consistent approach to Mental Capacity Assessments and a continuous improvement approach
- Ensure that Children's Services are fully aware of their responsibility around DoL's in respect of children



## Key Partnership Contributions 2016-17

### Rotherham Metropolitan Borough Council

#### Safeguarding Adults Investigation Team:

**Robust safeguarding arrangements are in place in Rotherham to promptly and effectively respond to protect individuals where allegations of a Safeguarding nature are made.**

Rotherham has in place a safeguarding structure covering all user groups. This focuses on section 42 concerns, enquiries and further enquiries, raising standards and quality of residential and nursing homes, domiciliary and all other provider services.

The specialist team of highly qualified social workers track and manage all safeguarding concerns from initial concern, screening, Decision Making Meetings (DMM), further enquiries and outcome meeting, ensuring risk is reduced or removed and individual outcomes are achieved.

The Safeguarding Adults Team remain focused on ensuring the source of abuse is held to account and through appropriate disciplinary actions and referrals to Disclosure Barring Service and appropriate registered bodies.

Adults at risk of harm continue to be protected through appropriate risk assessments, protection plans and support networks. The Safeguarding Adults Team recognises the importance 'of family life', where cases of abuse occur they will conduct investigations with sensitivity and proportionality.

The team have built good strong working relationships with partner agencies such as The Rotherham Foundation Trust, RDaSH and South Yorkshire Police to provide the very best Safeguarding service to the people of Rotherham.

The specialist team are all skilled and qualified workers specialising in their chosen area with experienced workers in the field of financial matters, organisational issues, matters attaining to Court of Protection and workers dedicated to a busy duty response team as well as safeguarding concerns within the community. Robust safeguarding arrangements are in place in Rotherham to promptly and effectively respond to support individuals who are at risk or are experiencing abuse.

The Safeguarding Team manage all first point of contact for Safeguarding concerns raised, which supports with accurate recording and gives a strategic overview of all safeguarding concerns reported. The team also hold and manage all section 42 concerns involving provider services such as domiciliary care, residential and nursing establishments, this has proven valuable as intelligence gathering and supported greatly with preventative work.

Making Safeguarding Personal (MSP) was introduced in to practice in April 2015 after the implementation of the Care Act 2014. This continues to be developed to ensure Safeguarding tailors its approach to the requirements of the individual, focusing on achieving individuals outcomes and reducing or removing risks.

We also work closely with governing bodies, where abuse is substantiated the source of harm are reported to the appropriate professional body such as the Disclosure and Barring Service, the Nursing and Midwifery Council or Health Care Professional Council or dealt with appropriately through employment law. Adults at risk of harm continue to be protected through appropriate risk assessments, protection plans and support networks. The safeguarding adults investigation team recognises

the importance 'of family life', where cases of abuse occur they will conduct investigations with sensitivity and proportionality.

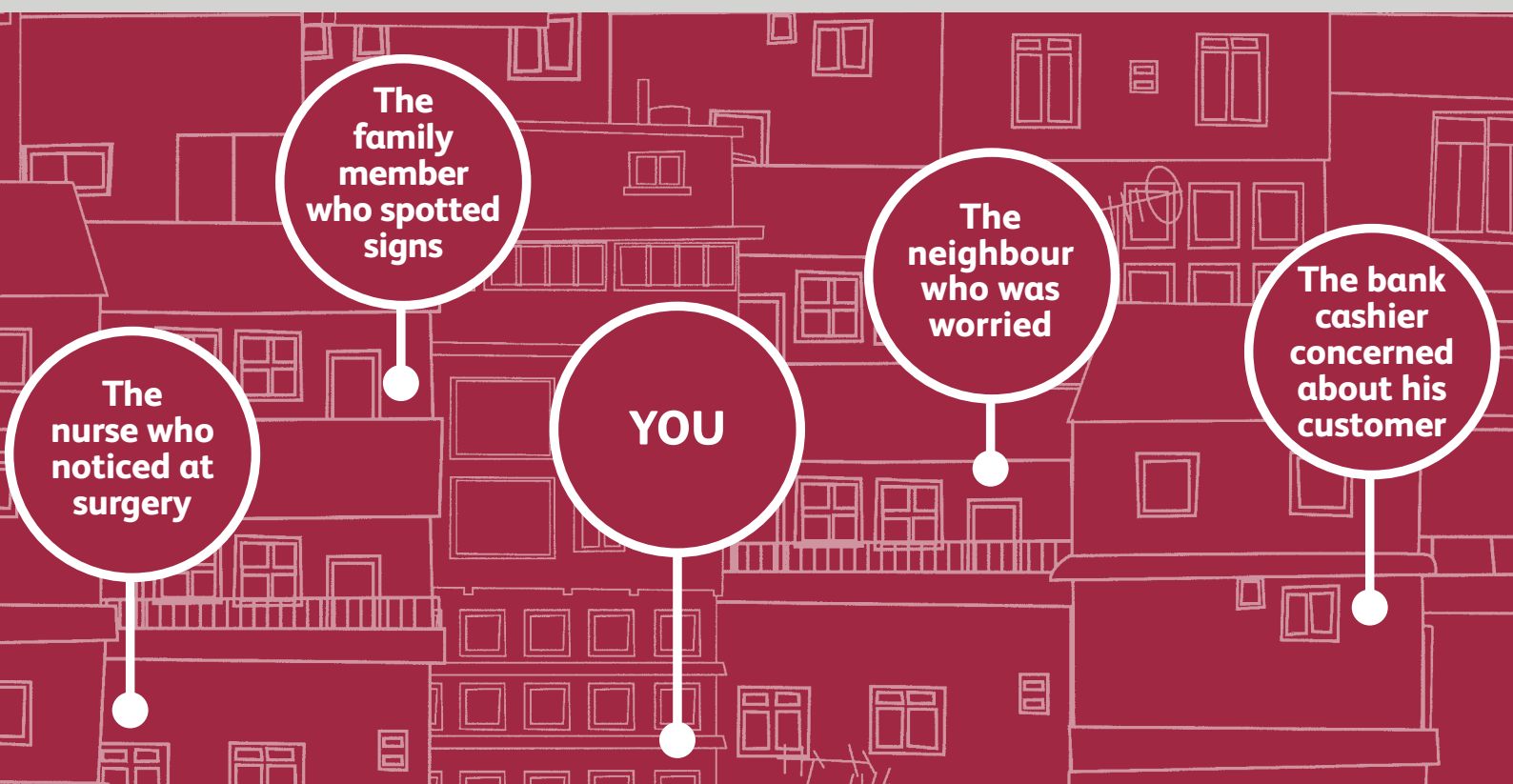
In 2016/17, 2456 alerts were reported to the safeguarding team. 641 of these alerts became section 42 enquires, this is where an investigation begins and further enquires are made. 54 cases continued to an outcome meeting.

The safeguarding adults investigation team seeks to maintain a high expectation in standards of provider services, continue to forge good working relationships with providers and work on preventative measures when low level safeguarding trends occur.

**Case Outcome:**

Mrs S lived in a residential home and although she had capacity she had chosen to use a family member as her financial agent responsible for ensuring her bills were paid and that she had money to buy the things she needed. Following the unfortunate death of the family member, Mrs S assumed that the surviving spouse would take over the role and responsibilities and things would carry on as before but bills went unpaid and Mrs S found herself with no money and being deprived of her assets.

The Safeguarding team became involved and worked with Mrs S to unlock her money and pay all her outstanding bills but ensured that Mrs S's outcomes were achieved and the family member was not prosecuted or investigated for financial misconduct. Mrs S was supported to set up standing orders to ensure bill never went unpaid and that she had access to money to buy the things she needed.





### Contract Compliance Team:

Services contracted from the independent sector and voluntary sector are monitored by the Strategic Commissioning Contract Compliance team for compliance against the quality standards. Any deviation away from the standards specified will result in action to enforced terms and conditions.

During 2016/17 the Contract Compliance Team has maintained its risk based programme of monitoring and inspection. New ways of working have been developed to meet the changing needs of the service with a greater reliance being placed on self-auditing by those providers who are considered to be at low risk.

The Team continues to work closely with the Adult Safeguarding Team and monthly meetings have been established to look at all Safeguarding alerts to determine trends that may require early intervention to prevent a drop in quality and further safeguarding incidents .

A number of multi-disciplinary meetings have taken place to discuss failing providers and agree further actions and six independent residential care providers were placed in contract default.

In 2016/17 the Contract Compliance Team dealt with 432 Contract Concerns which involved providers across all care sectors. This is a reduction of 22% on the previous year. The majority of these concerns had multiple threads which required investigation by the contract compliance officer and the provider.

Of the 432 concerns received approximately 49% (210) were raised against Community Home Care Services (CHCS), 40% (171) related to Adult Residential and Nursing Care Providers, 6% (26) concerned Learning Disability Residential and Nursing Care, with the remaining 5% (22) being spread across the remaining provider groups including the Voluntary and Community Sector (VCS).

The top 5 categories for Contract Concerns reflect those of the previous year;

- **Failure to report Incidents** – 13 concerns reported (Residential/Nursing 7, CHCS 6) a reduction of 46% on 2015/16
- **Late/Missed calls** – 69 concerns reported (all CHCS) - a reduction of 33% on 2015/16
- **Quality** – 100 concerns reported (Residential/ Nursing 50, CHCS 49, VCS 1) - a reduction of 10% on 2015/16
- **Medication** – 47 concerns reported (Residential/ Nursing 31, CHCS 12, Supported Living 3 & Day Care 1) - a reduction of 32% on 2015/16
- **Staffing** – 39 concerns reported (Residential/ Nursing 34, CHCS 5) - a reduction of 38% on 2015/16

Elected members visited three care homes with members of the contract compliance team, each care home had a different registration with the Care Quality Commission. This activity was undertaken to enable elected members to have a better understanding of the different types of 24 hour care provision available in Rotherham, and an insight into the role of the contract compliance officers, monitoring and inspection arrangements, and their working relationships with providers.



## Vulnerable Persons Team:

In response to the reports published and in recognition of the needs of (now adult) survivors of child sexual exploitation, in September the safeguarding adults team developed the vulnerable persons team. Dedicated to working alongside the historic survivors of child sexual exploitation and those individuals who came to the attention of services due to episodes of crisis who require support and specialist services. The vulnerable persons team (VPT) aim was to develop a positive engagement model which would result in reducing multiple negative contacts with services. The ultimate aim is for good outcomes built on a partnership which reduces chaotic lifestyles and subsequent risks to vulnerable people, their families and carers.

By developing this unique team, we are able to work with this customer group to reduce the risk of harm, work with them towards a better quality of life and to provide stability and promote positive engagement in the future to prevent the individual reaching crisis point.

The VPT has already proved itself a valuable resource and has supported many individuals to improve their lives and continues to offer this wrap-around support to the ever increasing number of new referrals.

The Mayor presented two social workers from the VPT with certificates for their work around a recent child sexual exploitation trial (Operation Clover).

Mark Batterley, Becci Hall, received Certificates of Commendation from the Chief Constable of South Yorkshire Police for their role in the investigation of the high profile case, and these were officially presented in front of all councillors as a mark of thanks.

They were part of the team which provided intense support to the victims and survivors who were giving evidence of part of the trial. The multi-agency team helped the young women throughout the whole process (and continue to do so) to allow them to feel able to come forward and give evidence in incredibly tough circumstances. We are very proud of the work that they have all done, which hopefully will give confidence to others to come forward.

## Case Study

Aged 18, Miss R was pushed down the stairs by her partner resulting in a profound brain injury, cognitive impairment and she developed highly impulsive behaviours. She was being sexually exploited and at 27 years old she reported that she had been raped at a house party. Despite numerous attempts to work with Miss R she refused to engage in services.

Aged 30, Miss R was referred to the Vulnerable Persons Team (VPT) via Children's services. Her 4 year old son was placed into the care of her Grandparents as Miss R had begun to 'sofa surf' and was found to be using illicit substances and alcohol to a high degree.

## Actions

The VPT began the process of building a relationship with Miss R facilitated by her Mother. Trust was eventually established and the VPT immediately began to assess current risk of continued sexual exploitation, the CSE Police Team were contacted and discussions took place with VPT, Miss R and Detectives. VPT began to work on a process of "graded exposure" therapy to manage anxieties and a referral to Headways was made to assess level of cognitive impairment, the VPT also sought the advice of a Psychotherapist to help manage the complexity of R's trauma.

## Outcome

VPT supported Miss R successfully over a period of a year and today she is in a strong mutually supportive relationship, after working with Children's services she now has custody of her 5 year old son who she adores. Miss R's problems remain present, but to a far less degree, she presents as a happy individual who goes on regular holidays and has recently purchased a car.



## Mental Capacity Act & Deprivation of Liberty Safeguards (DoLS) Service:

The Mental Capacity Act 2005 came into force in October 2007 and for the first time provided a legal framework for acting and making decisions on behalf of vulnerable people who lack the mental capacity to make specific decisions for themselves. In 2007 the Deprivation of Liberty Safeguards followed as an amendment to the Mental Health Act 2007 and was implemented in April 2009. The deprivation of Liberty Safeguards provided additional protection to vulnerable people living in residential homes, nursing homes or hospital environments.

In March 2014, the House of Lords Select Committee published a detailed report concluding that the Deprivation of Liberty Safeguards were “not fit for purpose” and recommended that they be replaced. One week later the Supreme Court laid down its Judgement in the case of P&Q and Cheshire West. The Cheshire West Judgement as it has widely become known significantly extended the numbers of people who were considered to be deprived of their liberty and subsequently require the additional safeguards. This decision has understandably produced much debate and controversy and the implication have been enormous for Local Authorities and applications have increased exponentially and councils nationally have been unable to meet the demand in a timely way, if at all.

The official figures indicate that hospitals and care homes in England made 195,840 DoLS applications in 2015-16 (the highest number since the Deprivation of Liberty Safeguards were introduced in 2009), 30% more than the 137,540 applications the previous year and more than 14 times the 13,700 applications in 2013-14 (the year prior to the judgment. The official figures also show an increasing number of Deprivation of Liberty Safeguards referrals being left unassessed

and statutory time-scales being routinely breached; in England, only 43% of the 195,840 Deprivation of Liberty Safeguards cases referred to local authorities during 2015-16 were completed during the year, and of those only 29% were completed within the 21-day time limit set in regulations.

In Rotherham over the same timeframe the total number of applications from Managing Authorities for Deprivation of Liberty Safeguards authorisations increased from 52 in 2013/14 to:

- 565 in 2014/15
- 957 in 2015/16
- 1128 in 2016/17

In response to these challenges Rotherham continues to work with Association of Directors of Adult Social Services (ADASS) who continue to ‘provide guidance which contains practical measures to alleviate the pressure on Councils and provide necessary additional safeguards for vulnerable people in a proportionate way.’

On the 13 March 2017, the Law Commission published the final report and draft Bill which recommends that the Deprivation of Liberty Safeguards be repealed with pressing urgency and sets out a replacement scheme for the Deprivation of Liberty Safeguards, which they have called the Liberty Protection Safeguards. The draft Bill also makes wider reforms to the Mental Capacity Act to ensure greater safeguards for persons before they are deprived of their liberty.

However, the Law Commission is still awaiting a formal response from the Government to its proposals and given that these proposals did not appear in the Queen’s speech (June 2017) it is envisaged that any changes are years away from implementation; therefore, in response to the ever increasing demand Rotherham is currently undertaking a comprehensive review of the service and its processes to ensure it continues to provide assurances that vulnerable people are safeguarded.

## Domestic Abuse Service:

The Independent Domestic Violence and Advocacy Service (IDVAS) are integrated within safeguarding adults in Rotherham. This has ensured that domestic abuse is seen as a local safeguarding priority, also reflecting that domestic abuse has been added under the new category of abuse in The Care Act 2014.

Between April 2016 and March 2017 the service received 467 referrals and supported 502 Multi Agency Risk Assessment Conference cases (MARAC).

The Independent Domestic Violence Advocates (IDVA's) have 4 Safe Lives qualified IDVA's and for a full-time domestic abuse support worker who will undertake his Safe Lives qualification in October. Furthermore, the IDVA team hold trainer qualifications and are looking to enhance the skills of the service in affording the opportunity for some of the IDVA's in the future to undertake the Young Person's Domestic Violence Advocate (YPDVA) and Independent Sexual Violence Advocate (ISVA) qualifications.

The IDVAS has developed a new training package which is now being delivered. This is to raise awareness of what domestic abuse is and its impact on its victims, to introduce good practice and risk assessment, to explore and challenge some commonly held beliefs, attitudes and assumptions about domestic abuse and to increase understanding of domestic abuse services in Rotherham, domestic abuse risk assessment and the MARAC process. Additionally, a continuous effort is made from the IDVAS in Rotherham in visiting services and offering advice, guidance and support to other agencies to recognise domestic abuse and complete risk assessments.

## Case Study

Mr. L is a 39 year old gay man who had been physically and emotionally abused by his partner. Mr. L has a diagnosis of schizophrenia and a physical disability causing brittle bones and he and his partner both had an addiction to heroin. Mr. L's partner was arrested after physically assaulting him and it emerged that Mr. L was regularly physically abused and his partner was using heroin to control him.

Mr. L was warned by South Yorkshire Police that his abuser had been released by the courts on bail. The Police contacted the IDVA team to request support in finding emergency accommodation, refuges were contacted but a bed could not be found for that night, so Mr L was placed in an emergency crash pad. Transport and an emergency food parcel were arranged for Mr. L and support was given to ensure that he was able to access his GP the following day.

Mr. L also needed an appointment with The Substance Misuse Service as he wished to resume his methadone program; his partner had stopped him from taking part in drugs rehabilitation in the past. The IDVA assisted with re-arranging appointments with The Substance Misuse Service, so that he could attend until a refuge could be found. Mr L was found a refuge in another area after the IDVA had assisted him with the refuge's assessment. The IDVA liaised with the out of borough refuge staff to ensure Mr L received the support he needed with his rehab and ensured his case was picked up by the support services in his new area.

## Rotherham NHS Foundation Trust:

In March 2016 The Rotherham NHS Foundation Trust (TRFT) launched a new vision:

***To be an outstanding Trust, delivering excellent healthcare at home, in our community and in hospital.***

Achievements to support this within TRFT:

### Training

- Adult Safeguarding Training is a mandatory requirement and is part of a robust training programme for all colleagues throughout the Trust which includes Mental Capacity Act & Deprivation of Liberty Safeguards (DoLS) service, Learning Disability (LD), Dementia and the Mental Health Act
- The Prevent Strategy continues to be implemented and compliance with training is above trajectory

### Partnership Working

- TRFT have been working in partnership with Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH) to ensure the safe and lawful application of the Mental Health Act within the Trust
- TRFT provides representation at MARAC and is a partner in the Safer Rotherham Partnership
- Work is ongoing to embed the Care Act 2014 and the Making Safeguarding Personal agenda throughout the Trust

### Support

- The Adult Safeguarding Team was extended to ensure that the Trust can continue to offer timely advice and support to all staff where there are identified or suspected concerns about vulnerable people

### Governance

- Over the last twelve months a significant amount of work has been undertaken to ensure there is a robust Trust safeguarding and external governance structure
- Policies have been developed which clarify the responsibilities of all TRFT staff and volunteers
- Key Performance Indicators (KPI) is shared with our partner agencies quarterly

### Development

- The positions of Lead Nurse in Dementia Care and Lead Nurse in Learning Disability are now embedded and have led to improvements in those service areas
- The Adult Safeguarding Team was extended to include increased provision of an Adult Safeguarding/MCA Nurse Advisor to ensure sufficient support was available to meet the needs of TRFT staff and to improve the implementation of the MCA & DoLS agenda
- TRFT have completed several projects designed to improve the implementation of the MCA throughout the Trust
- TRFT have embedded the Dementia Care strategy including dementia screening which aims to achieve screening of all patients aged over 65 who are in hospital for more than 72 hours and have established a network of Dementia Link Nurses and Dementia Champions based in clinical areas.
- Embedded the 'Forget Me Not' carer passport and continues to work towards improvements driven by the Dementia Friendly Hospital Charter launched by the Dementia Action Alliance and supported by the Alzheimer's Society. Implemented the 'Traffic Light System', a person-centred assessment for patients who have a learning disability and established learning disability champions

- The learning disability lead nurse has worked in partnership with a local advocacy group for people with learning disabilities and is developing e-training to make information more accessible to all
- TRFT has fostered excellent links with the community Learning Disability service providers and General Practitioners and the learning disability lead nurse attends local parent/carer groups



### Case Outcome:

Mrs A attended RGH following a collapse at home. She was noted to be in a very unkempt condition with her hair matted and dirty. She disclosed to the nurse that she hadn't been caring for herself, and hadn't been taking her (essential) medications for a while as she felt 'very down'.

Mrs A was admitted and her medical needs tended to. During her stay on the ward, the nurse met with her several times to explain that she was worried about 'self-neglect' and to ascertain what Mrs A's views on this were.

Mrs A said that she knew she wasn't looking after herself, but that she didn't seem to have any motivation to make things better. She identified that all she wanted was to be able to look after herself like she always had before.

Between them, they agreed that Mrs A should be referred to the Mental Health professionals for an assessment of her mental health. A care package was agreed to ensure that there would be some practical support for Mrs A on her discharge, until she was able to manage independently again.

The nurse explained to Mrs A that she would complete a 'safeguarding concern' to share this information with other professionals. This process is consistent with the principles laid out in the Care Act 2014 which highlights the Making Safeguarding Personal approach. As a result of achieving Mrs A's stated outcome, this case was able to exit safeguarding.



## NHS England Yorkshire and Humber

### NHS England responsibilities in relation to direct commissioned services

NHS England ensures the health commissioning system as a whole is working effectively to safeguard adults at risk of abuse or neglect, and children. NHS England is the policy lead for NHS safeguarding, working across health and social care, including leading and defining improvement in safeguarding practice and outcomes. Key roles are outlined in the Safeguarding Vulnerable People Accountability and Assurance Framework 2015.

Yorkshire and the Humber has an established safeguarding network that promotes shared learning across the safeguarding system. Representatives from this network attend the national Sub Groups, which have included priorities around Female Genital Mutilation (FGM), Mental Capacity Act (MCA), Child Sexual Exploitation (CSE) and Prevent. NHS England Yorkshire and the Humber works in collaboration with colleagues across the North Region on the safeguarding agenda and during 2016/17 a Clinical Commissioning Group (CCG) peer review assurance process was undertaken covering all 44 CCGs in the North Region.

### Sharing learning from safeguarding reviews

In order to continuously improve local health services, NHS England has responsibility for sharing pertinent learning from safeguarding serious incidents across Yorkshire and the Humber and more widely, ensuring that improvements are made across the local NHS, not just within the services where the incident occurred. The NHS England Yorkshire and the Humber Safeguarding Network meets on a quarterly basis throughout to facilitate this. Learning has also been shared across GP practices via quarterly Safeguarding Newsletters, a

safeguarding newsletter for pharmacists has been circulated across Yorkshire and the Humber and one for optometrists and dental practices was developed and sent out in March 2017.

### Safeguarding Serious Incidents

All safeguarding serious incidents and domestic homicide's requiring a review are reported onto the national serious incident management system – Strategic Executive Information System (STEIS). During 2016/17 a review of current systems for recording safeguarding incidents and case reviews across the North Region was undertaken to support the identification of themes, trends and shared learning. The Yorkshire and the Humber process to jointly sign off GP IMRs, as CCGs responsibilities for commissioning of primary care services is increasing, has been adopted across the north of England region to ensure consistency. NHS England works in collaboration with CCG designated professionals to ensure recommendations and actions from any of these reviews are implemented. Prior to publication of any child serious case reviews, serious adult reviews or domestic homicide reviews NHS England communication team liaise with the relevant local authority communications team regarding the findings and recommendations for primary care medical services.

### Training & Development

Designated safeguarding professionals are jointly accountable to CCGs and NHS England and oversee the provision of safeguarding training for primary care medical services. The main source of training for other primary care independent contractors is via e-learning training packages.

NHS England Safeguarding Adults: Roles and competencies for healthcare staff – Intercollegiate Document has been awaiting final publication following review by – The Royal College of Nursing, The Royal College of Midwifery, The Royal College of General Practitioners, National Ambulance

Safeguarding Group and The Allied Health Professionals Federation. The purpose of this document is to give detail to the competences and roles within adult safeguarding and the training guidance for healthcare professionals.

NHS England North hosted a safeguarding conference on 10 December 2016 which included presentations on forced marriage, honour based abuse, FGM and domestic abuse and adult safeguarding. The conference aimed to provide level 4 training for healthcare safeguarding adults and children professionals and leads in the North Region. A conference was held on 11 November in York for named safeguarding GPs in Yorkshire and the Humber attended by Bradford named GPs, it was well evaluated and plans for a North Region named GP conference are in place for 2017/18.

NHS England has updated and circulated to health colleagues the Safeguarding Adults pocket book which is very popular amongst health professionals and has launched the NHS Safeguarding Guide App and a North Region Safeguarding Repository for health professionals.

### **Assurance of safeguarding practice**

NHS England North developed a Safeguarding Assurance Tool for use with CCGs across the North Region, which was implemented in 2016/2017. NHS England North Regional Designated Nurses undertook the review which was intended to be supportive, they reviewed all action plans to identify key themes and trends across the North Region with a view to identifying common areas requiring support. Themes from this process have influenced the commissioning of leadership training for safeguarding professionals and there are future plans for a national assurance tool for CCG's.

### **Learning Disabilities Mortality Review (LeDeR) Programme**

Over the last two years a focus on improving the lives of people with a learning disabilities and/or autism (Transforming Care) has been led jointly by NHS England, the Association of Adult Social Services, the Care Quality Commission, Local Government Association, Health Education England and the Department of Health. In November 2016 the national LeDeR Programme has been established following the Confidential Enquiry into the Premature Deaths of People with Learning Disabilities (CIPOLD).

All NHS regions have been asked to establish the LeDeR process locally to undertake the reviews. LeDeR also complements the NHS Operational Planning and Contracting Guidance for 2017/19 which contains 2 'must-dos' for people with learning disabilities:

- improve access to healthcare for people with a learning disability so that by 2020, 75 % of people on a GP register are receiving an annual health check
- reduce premature mortality by improving access to health services, education and training of staff, and by making reasonable adjustments for people with a learning disability and/or autism

### **LeDeR involves:**

- Reviewing the deaths of all people aged 4 – and over
- Identify the potentially avoidable contributory factors related to deaths of people with learning disabilities
- Identify variation in practice
- Identify best practice
- Develop action plans to make any necessary changes to health and social care service delivery for people with learning disabilities



A national database has been developed and anonymised reports will be submitted. This will allow, for the first time, a national picture of the care and treatment that people with learning disabilities receive.

The LeDeR Programme is not a formal investigation or a complaints process and will work alongside any statutory review processes that may be required.

The LeDeR Programme recognises it is important to capture the extent of personalised services, including the use of reasonable adjustments, choice and control and the well-being of people with learning disabilities. Good practice examples will be written up and shared nationally.

### Prevent

Across NHS England North there are a number of priority areas which are designated by the Home Office, who fund two Regional Prevent Coordinator posts. These posts support the implementation of the Prevent Duty and ensure that Health embeds the requirements of the Contest strategy and specifically Prevent into normal safeguarding processes. Funding to support this work was secured from the North Region Safeguarding budget which has facilitated a number of projects including supporting partnership working with the North East Counter Terrorism Unit, delivering a conference in October on 'Exploitation, grooming and Radicalisation' and an Audit of referrals to Prevent /Channel where Mental Health concerns are understood to be a contributing factor.

A research project to scope the current, attitudes, awareness and practice amongst GP colleagues has also been commissioned in the Region.

In December 2016, a North Regional Prevent conference was held to raise awareness of Prevent, delegates found this event a good opportunity to increase their knowledge and confidence in the role of the health sector in Prevent. Feedback received supported that there was an overall improvement in understanding the requirements of health

organisations e.g: CCGs under the new statutory duty.

### Pressure Ulcers – “React to Red”

React to Red was launched on 1 February 2016 at the Pressure Ulcer Summit in Leeds. It is a bespoke training package for pressure ulcer prevention which is competency based and designed specifically for care home staff and care providers. Since its launch in February 2016, there has been significant interest in this resource from CCGs: private organisations; secondary care; hospices; domiciliary care providers; tissue viability nurses and care homes. During 2017/18 this work will continue to be a priority across NHS England North and will focus on embedding the programme as a quality improvement initiative using a focused approach co-ordinated by CCG's and robust evaluation by NHS England North.



## NHS Rotherham Clinical Commissioning Group – RCCG

NHS Rotherham Clinical Commissioning Group (NHSR CCG) firmly believes that every person has the right to live a life free from abuse and neglect. With this in mind the CCG will continually develop the organisations Safeguarding agenda, with Safeguarding Adults high on that agenda.

Legislation of The Care Act 2014 has afforded Adult Safeguarding a statutory framework. This has resulted in the CCG reaffirming its commitment, at a senior and executive level, to Rotherham Safeguarding Adults Board (RSAB). RSAB in turn has undergone significant changes and developments resulting in improved partnership working across the borough.

NHS RCCG continues to work within NHS England's key documents which underpin the CCG's responsibilities for Adult Safeguarding - "Safeguarding Vulnerable People in the NHS Accountability and Assurance Framework (2015)" and the much awaited Safeguarding Adults: Roles and competences for health care staff – Intercollegiate Document which is to be published later this year.

### Achievements for NHSR CCG have been:

The sub groups of the Safeguarding Adult Board have grown and developed over the past year with the CCG remaining a committed member. NHSR CCG chairs the Training and Development Sub - Group. And together have faced the challenge of aligning multi agency safeguarding training across health and social care.

NHSR CCG has commissioned a bespoke training package by DAC Beechcrofts Solicitors in regards to the CCG's responsibilities for Continuing Health Care clients within their own environment who may be Deprived of their Liberty. Work continues to progress in this area.

October 2016 saw NHSR CCG hold a 3 Step Approach (self- assessment tool, facilitated peer review and safeguarding supervision sessions) for the national Bradbury Independent External Review and the Goddard Inquiry (now known as the Independent Inquiry into Child Sexual Abuse IICSA). This approach significantly supported all Rotherham GP Practices in providing assurance to the CCG, that as Independent Providers, they have taken steps to safeguard vulnerable people in their care and that records relating to the Goddard Inquiry are not 'lost' or destroyed.

The Safeguarding Policy was revised and updated in line with renewal date and legislation. Significant changes were made with the policy including procedures added to reflect and meet the needs of both clinical and non-clinical staff members of the CCG.

January 2017 saw the CCG launch its Safeguarding Leaflet level 1 and 2 – What you need to know? The leaflet was sent electronically to all NHSR CCG staff to cover training requirements for a yearly update and recorded by HR in the CCG central training record.

The Prevent Duty remains a high priority for NHSR CCG with mandatory Healthwrap training for all staff. The CCG will continue to be an engaged partner with The Safer Rotherham Partnership to ensure that we are meeting our statutory duties.

The past year has seen NHSR CCG involved with two Safeguarding Adult Reviews (SAR's) and one Domestic Homicide review (DHR). The CCG was highly commended for the support given to the second SAR by the Independent Author.

Robust governance arrangements are in place to ensure that the CCG's own safeguarding structures and process are in place and that the agencies from which they have commissioned services meet the required standards. A plethora of measures are in place for monitoring NHSR CCG commissioned services including Safeguarding Standards and KPI's (Key Performance Indicators).



NHSR CCG continues to publish an annual safeguarding report which demonstrates how the CCG continues in its commitment to safeguarding and promoting the welfare of all residents in the Borough. The CCG also strives towards the highest possible standard of care, taking on board the national and local drivers for change in safeguarding. It provides assurance that commissioned health services are working collaboratively to safeguard those at risk. More so it provides assurance of how NHSR CCG carries out its safeguarding roles and responsibilities.

The world of Adult Safeguarding is constantly developing not only in the way of case law and legislation but in terms of new categories of abuse. The next year will see the CCG undertake work to address Domestic Abuse, Hate Crime and Modern Slavery. The embedding of the Mental Capacity Act and application of Deprivation of Liberties will continue to be developed in line with national and local expectations of CCGs.

NHSR CCG will continue to work closely with statutory partners and be continually responsive to changes and developments learning from SAR and DHRs. The CCG will not be complacent in its commitment to safeguarding which is demonstrated by including Safeguarding as one of the four priorities in the commissioning plan 2015-2019 – Your life, Your health.

## **Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH):**

To support the delivery of adult safeguarding, within RDaSH and across the wider partnership arena, there is a clear governance and accountability framework in place, specific to each of the localities that the Trust covers. The framework provides assurance to the RSAB and commissioner's that whilst the ultimate responsibility and accountability for adult safeguarding lies firmly with the Trust Board, every member of staff is accountable and is responsible for safeguarding and protecting adults at risk

As a multi-agency partner working with the RSAB, the RDaSH safeguarding adult team has been able to act as a link between strategic and operational objectives and share the learning and development across all areas of the Trust.

A comprehensive workforce development programme is in place and staff are able to access both single and multi-agency training that allows them to meet their safeguarding competency framework. A model of clinical supervision is in place and embedded across the Trust to ensure safeguarding cases are managed in line with the Care Act 2014 and Making Safeguarding Personal.

## Responsibility for Safeguarding

Overall responsibility for safeguarding adults at risk within the organisation rests with the Board Executive Lead Dr Deborah Wildgoose, A detailed safeguarding report is received by the RDaSH Quality Committee every 3 months where detailed scrutiny is given to the activities taking place to keep children and adults safe, including the impact of effective practice, the challenges and the solutions being sought to address these, including the effectiveness of multiagency partnership working”

## Safeguarding Adult Board Contribution

RDASH contribute to the workings of RSAB through Board and Sub group membership.

## Governance arrangements

The following governance arrangements are embedded within the organisation;

- South Yorkshire Multi-agency Safeguarding Adults Procedures
- RDaSH Safeguarding Adults Policy
- RSAB Safeguarding Adults Process for Health Staff
- Mental Capacity Act and DoLS Policy
- Making Safeguarding Personal
- risk assessments
- an RDaSH Local Authority Designated Officer (LADO) process in place
- reports to Safeguarding and Quality Group and Trust Board
- results an actions of any inspections or audits undertaken within the year i.e. Trust clinical records audit, Quality Reviews.

The Safeguarding governance structure and reporting arrangements are shown below





## Oversight of safeguarding cases

Safeguarding Adult Lead Professionals review and quality assure cases and escalate to the Head of Safeguarding (Associate Nurse Director, Children's Care Group) for complex and sensitive cases.

## Safeguarding Adults Training

Safeguarding adults training is embedded within the organisation through the Trust Safeguarding Adult Policy through;

- multi agency training
- single agency training
- clinical supervision

In addition through raising awareness and understanding of safeguarding adults, proactive risk assessments and planning for individuals and services and reporting and review of incidents (IR1's and SI's).



## Prevention in Safeguarding Adults

Preventative safeguarding adults work is undertaken in RDaSH through safeguarding adults information being made available to staff and patients, the application of robust risk assessments, planning and the monitoring of low level concerns. Low level concerns are managed through the organisations Incident Management Policy. These concerns are reviewed by the safeguarding adult lead Professionals and those identified as potential safeguarding adults concerns are reported as appropriate. Senior managers also review all safeguarding adults concerns.

Action plans are devised following recommendations from:

- Safeguarding Adults Review (SAR)
- Learned Lessons Review (LLR)
- Serious Case review (SCR)
- Domestic Homicide Review (DHR)

As a team safeguarding has adopted the holistic approach 'think family' to identify triggers and prevent escalation.

Supervision forums where potential safeguarding problems are discussed and management plans identified, to reduce risk of intensifying.

## Future intentions

The organisation will continue to embed the changes with regard to Care Act 2014 and the principles of Making Safeguarding Personal.

Moving forward it will develop a safeguarding strategy and support the organisational transformation agenda to ensure safeguarding remains a high priority.

To develop a joint safeguarding team for children's and adults at risk

Expanding on the holistic approach of 'think family'

## South Yorkshire Fire and Rescue Service (SYFR):

### Governance

In the last 12 months South Yorkshire Fire & Rescue have introduced an internal Safeguarding Executive Board and Reference Subgroup. The purpose of these new arrangements, are to strengthen governance, through scrutiny and challenge across departments and to learn and improve in areas relating to multiagency working and information sharing.



### Case Management & Policy

Safeguarding concerns are triaged by the designated safeguarding advisor and out of hours by the group managers and data relating to this is published in the Prevention & Protection Quarterly report. The cases are predominantly related to self neglect, often in association with fire risks and concerns about health and wellbeing. The high risk coordinators (2) manage the high fire risk cases locally. Policies, relating to safeguarding, are updated annually together with an equality analysis and for adult safeguarding Making Safeguarding Personal is included and for child protection a strengths based approach “Signs of Safety”.

### Safeguarding Boards

South Yorkshire Fire & Rescue continues to be represented at both Local Authority Safeguarding Children and Safeguarding Adult Boards across the county (and SYP County Wide Safeguarding Board) and has contributed to a number of initiatives in policy development relating to self neglect and hoarding.

### Developments

In addition to the Fire Risk Assessment and Fire Safety advice given during the Home Safety Check, additional screening questions and signposting have been incorporated as a “Safe & Well Check”. This now includes “Falls”, “Crime Prevention” and “Sight testing” and has been piloted in Doncaster and now being rolled out across South Yorkshire.

### Training

The SYFR internal training programme includes a face to face Safeguarding Induction for all frontline staff (this includes volunteers) and then dependent on role and responsibility additional and bespoke Introductory and Refresher. The latter may be blended learning and/or external trainers are invited in for e.g. Domestic Abuse, Modern Slavery, Tele-care training. Community safety staff also attend multiagency training in their respective districts.



### Case Study: John

In 2016 the gentleman with Dementia/ Alzheimer's Disease by his GP and recommended that he would be best placed in 24 hour care. It was not until he was found at a bus stop incapable of moving his legs that the case was highlighted to SYFR again, after numerous attempts to support the occupier.

The Life Team visited the property after a referral from the Police, this case was then referred onto the high risk co-ordinator who attended a multi-agency meeting where they discussed the occupier returning to the property as he had been placed in a Care Home while a decision was reached on where he should reside. At the multi-agency meeting, it was clear that Adult Services wanted the occupier to return back to the property although all other services at the meeting presented their case as to why he should not return.

Environmental Health Services had cleared the property again and had thrown all household items away; even carpets had been removed. The occupier had no bed, clothes or bedding, the only clothes that he had were clothes that had been donated to him by the Care Home. The gentleman attended the multi-agency meeting

and it was agreed by all that his health had greatly improved he had put on weight and was no longer as frail as he previously had been in addition to this he had abstained from drinking alcohol and was now socialising with other residents.

It came to light that he was a victim of Anti-Social Behaviour and was also being financially abused and it was agreed that further assessments would need to take place, another multi-agency meeting was arranged and the Occupational Therapist assessment concluded that the gentleman would not be able to return to his property.

Due to the involvement of the High Risk Co-ordinator and Safeguarding Officer plus other partner agencies, an agreement was made with the gentleman that he would remain in the Care Home while options around housing are explored with the possibility of sheltered accommodation. This shows that a holistic multi-agency approach has proved to be a much better way of working when addressing individuals with complex needs and risks that are associated with those needs, to achieve the best possible outcome for individuals.



## South Yorkshire Police:

In January 2017 new, dedicated Safeguarding Adult Teams were introduced within South Yorkshire Police. In Rotherham, the team is ten, a mixture of dedicated Detective Sergeants, Detective Constables and specialist staff investigators. There is a Detective Inspector who provides more strategic leadership, she is shared between Rotherham and Sheffield.

South Yorkshire Police's Safeguarding Adult Teams have in the short time they have been operational, become very industrious and productive teams. Since January, the team have been able to investigate 263 reported crimes (up until 26/07/17). Of which, 82 have been rape offences, or associated to rape investigations. The team have also evaluated and acted upon 1,400 recorded Case administration and tracking system (CATS) entries which have been identified as relating to vulnerable adults within the Rotherham area.

From an SYP perspective, our SAT is engaged with our partners via the newly introduced Multi agency domestic abuse (MARDA) and the established Multi agency risk assessment conference (MARAC) processes. Through these vehicles, the partners interact to co-operate over victims and offenders to achieve better outcomes.

The SATs approach has undoubtedly brought benefits to victims and to clarity internal from clear understanding of roles and responsibilities. Recent successes, achieved by the team on behalf of victims at high risk, include,

- a dangerous predatory sex offender was found guilty at Sheffield Crown Court of one count of rape in November 2016 and sentenced to 24 years imprisonment on Wednesday 13 April 2017
- two separate offences of domestic rape against two separate partners. Perpetrator was sentenced to 6 years imprisonment



- domestic assault on a male victim of rape. Victimless prosecution where the suspect was sentenced to 3 years imprisonment

Our SAT sits within the much wider force-wide Public Protection portfolio. In the last two years, our investment within Public Protection has grown markedly, in financial times, via an uplift of £5 million p.a. enabling the unit to have 300 staff. This is set against overall budget reductions of over 20% which has led to the number of police officers declining from 3,600 in 2007 to around 2,450 today. The Public Protection Unit delivery model, is based upon specialism of role and geographic accountability. Thus we have a SAT for Rotherham, Doncaster, Sheffield and Barnsley. A Child Sexual Exploitation (CSE) team for each borough etc. Each and every area is operating in a challenging environment where demands continue to increase. Since the uplift described above, staffing levels have remained constant, meaning those officers and staff are having to deal with more demands upon them.

Across the force, the impact of the austerity era is taking its toll. The force is mid-way through a whole force review of our operating models. Criminal Investigation, Local Uniformed Policing (including Neighbourhoods Policing, Contact management and Public Protection are all subject to review by teams comprising business specialists and subject matter experts. These reviews are charged with developing the most appropriate ways of working as we move forward. The reviews have not reported back yet. There is a possibility that the current Public Protection model, including the work around safeguarding adults may change in the coming year.

## Rotherham Voluntary and Community Sector:

### Achievements:

- The Voluntary and Community Sector, through the Adult Services Consortium, has continued to show its commitment to Adult Safeguarding across the Borough by contributing to the work of the Adult Safeguarding Board via its nominated representatives.
- The nominated representative, who is the Chief Executive of Age UK Rotherham, attends the Safeguarding Adults Board to provide a voluntary and community sector perspective on developments. They also provide a liaison function between the wider sector and the Board to keep VCS organisations up-dated on safeguarding issues and encourage and support their contribution to this important area of work.
- Each of the safeguarding adults sub-groups has representation from the voluntary and community sector.
  - RSAB – Lesley Dabell
  - Training – Liz Bent
  - MSP – Karen Smith.
- VCS organisations have contributed to the Safeguarding Board and Development Days as partners and as an alerter and referrer where concerns are identified.
- Individual VCS organisations have also continued their work internally in respect of their own policies and procedures for safeguarding, linking in to the wider safeguarding procedures in the borough.

## Learning and development

In 2016/17 the training sub-group ran a rolling programme of supportive multi-agency and specialist training opportunities for staff, managers and volunteers on local policy, procedures and professional practice so that adults across Rotherham are protected from abuse and neglect and their wellbeing is promoted.

1,907 learners attended training courses, as detailed by agency in table the below. The increase in number of learners of 343 from 2015/2016 is due in part to the 177 operatives from Fortem and Mears, the Council's housing partners, who completed their biennial refresh of training.

|                               |             |
|-------------------------------|-------------|
| Local authority               | 364         |
| Independent/ Voluntary sector | 1244        |
| Health                        | 105         |
| Police/Probation              | 0           |
| Service Users / Carers        | 7           |
| Students                      | 1           |
| Other/Housing Partner         | 186         |
| <b>TOTAL</b>                  | <b>1907</b> |

The training sub-group started to develop a Training Strategy and Training Plan for 2017/2020 to lead and manage training arrangements across Rotherham. The strategy will provide the framework for establishing priorities and plans for multi-agency and specialist safeguarding adults training and resources in support of achieving the Strategic Plan of Rotherham's Safeguarding Adults Board. The strategy will set out the vision, goals and principles for training and how these will be taken forward. The plan will support and drive forward the Training Strategy's goals where training equips the workforce with the knowledge, skills and behaviours to carry out their role to safeguard adults from abuse and/or neglect.

## Safer Rotherham Partnership:

The Safer Rotherham Partnership is the borough's Community Safety Partnership with statutory responsibilities established under the Crime and Disorder Act 1998. The partnership has a legal responsibility to tackle crime, anti-social behaviour, drug and alcohol misuse and to enhance feelings of safety.

There are currently five responsible authorities on the SRP, who have a legal duty to work in partnership to tackle crime, disorder, substance misuse, anti-social behaviour and other behaviour adversely affecting the environment and to reduce re-offending.

The six responsible authorities are:

- Rotherham Metropolitan Borough Council
- South Yorkshire Police
- South Yorkshire Fire and Rescue Service
- National Probation Service
- Rotherham Clinical Commissioning Group

The SRP also brings together a range of interested parties from the public, private, community and voluntary sectors to help deliver the outcomes in the SRP Partnership Plan through our strategic and operational structures, as well as representation from the Office of the Police and Crime Commissioner.

The SRP has a statutory duty to develop an annual Joint Strategic Intelligence Assessment of the risks and threats that crime and disorder poses to the communities of Rotherham. The purpose of the assessment is to:

- identify the partnerships priorities for the forthcoming year
- highlight performance, progress and achievements against the commitments made in the 2014/16 Partnership Plan
- identify key crime and disorder risks and threats to the community

## Achievements

Throughout 2016/17, the Partnership continued to make progress in tackling Crime and Anti-social Behaviour across the borough, although in line with both the local and national position, overall total recorded crime showed an increase on the previous year, complaints of anti-social behaviour reduced.

During the period 22,000 crimes were recorded across Rotherham, which was a 15% (2,881 crimes) increase on the previous year. During the same period a total of 12,752 incidents of anti-social behaviour were recorded, a reduction of 6% (767 incidents) on the previous year. Sexual Offences and Violent Crime continued to increase, with the increase in sexual offences being attributable to increased current and historical reporting of crimes post the Jay and Casey reports. As in the previous year a contributory factor to the increase in violent crime was attributable to national changes on how those crimes are recorded resulting in all areas seeing increases.

## Key Indicators

- Total recorded crime increased by 15% (+2,881)
- Anti-Social Behaviour incidents reduced by 6% (-767)
- Violence with injury increased by 11% (+237)
- Public order offences increased by 55% (+424)
- Sexual offences increased by 25% (+176)
- Racially or religiously aggravated crimes increased by 38% (+48)
- Domestic burglary increased by 28% (+293)
- Vehicle crime increased by 13% (+273)
- Criminal damage increased by 1% (+32)
- Arson increased by 23% (+35)
- Drug offences reduced by 24% (-118)

# Appendix 2

## Key Facts and Figures

### A Concern

A Concern is a feeling of anxiety or worry that a Vulnerable Adult may have been, is or might be, a victim of abuse. An alert may arise as a result of a disclosure, an incident, or other signs or indicators.

A total of **2456** concerns were reported through the new Safeguarding Adults Collection (SAC).

Each concern is looked at and the 3 point test is applied.

The safeguarding duties apply to an adult who:

1. Has needs for care and support (whether or not the local authority is meeting any of those needs)
2. Is experiencing, or at risk of, abuse or neglect
3. As a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

If the concern does not meet the criteria of the 3 point test the case may be signposted to a different team such as the vulnerable person's team or maybe a care assessment is needed. We will always ensure the person is safe and not in any danger.

### Section 42 Enquiry

A Section 42 Enquiry is the same as an Alert however it becomes an enquiry when the details progress and an investigation/assessment relating to the concerns begins.

At any point during this investigation a case can exit the safeguarding process.

The subject of the investigation must be aware and in most cases agree to the safeguarding enquiry unless capacity is lacking or a crime has been committed.

**641** Section **42** enquiries began 2016-17

### Decision Making Meeting (DMM)

The DMM will bring all relevant people together to ensure that, if the investigation continues, the right questions will be asked of the right people. The voice of the person at risk of harm must be heard. Plan the way forward, look at who is best placed to investigate the concern.

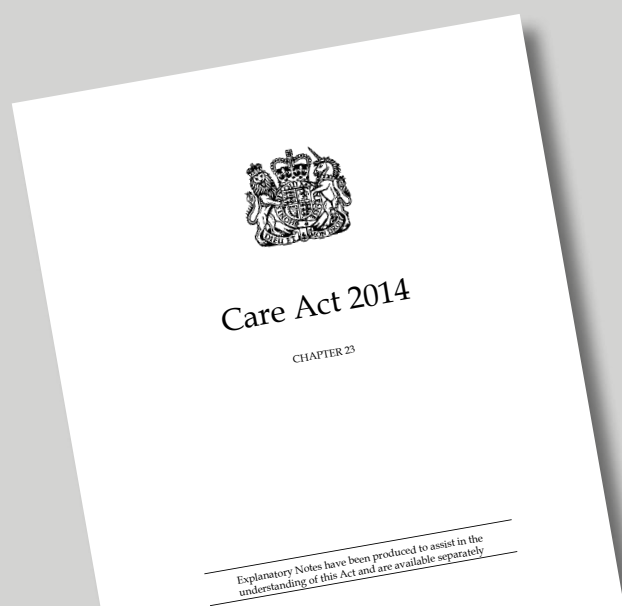
This meeting may be held virtually, to ensure it happens in a timely manner.

### Outcomes Meeting

The Outcome meeting will bring all interested parties together including the individual if they wish to attend. Support from friends, advocacy or family is also encouraged. The voice of the person at risk of harm must be heard throughout the meeting and they must be given the opportunity to tell their story.

The meeting will bring the investigation to a conclusion and recommendations must be agreed by all interested parties and timescales and expectations clearly identified.

**54** Outcome Meetings Convened 2016-17





## Safeguarding Adults Review (SAR)

A Safeguarding Adults Review must be carried out if

- A vulnerable adult dies (including death by suicide) and abuse or neglect is known or suspected to be a factor in their death. In such circumstances the SAB should always conduct a review into the involvement of agencies and professionals associated with the vulnerable adult.
- A vulnerable adult has sustained a potentially life-threatening injury through abuse or neglect, serious sexual abuse, or sustained serious and permanent impairment of health or development through abuse or neglect, and the case gives rise to concerns about the way in which local professionals and services work together to safeguard vulnerable adults.
- Serious abuse takes place in an institution or when multiple abusers are involved, the same principles of review apply. Such reviews are, however, likely to be more complex, on a larger scale, and may require more time. Terms of reference need to be carefully constructed to explore the issues relevant to each specific case.

The SAR is commissioned by the SAB and all partners who have had involvement with the subject of the enquiry will be required to participate in the review. The results of the review are published by the SAB in the form of a final report.

### Number of SAR's Commissioned 2016-2017

1 SAR was commissioned in 2016/17.  
Unpublished. (A/2016 Margaret)

### Number of SAR's Completed 2016-2017

1 SAR was completed in 2016/17.  
Unpublished. (Phyllis)

## SAR Phyllis

The SAR that was completed during 2016/17 had been commissioned the previous year and concerned a lady called Phyllis (the family wanted the review to be named after their mother) who was a resident of a Care Home from late in 2012 until she died on 9th June 2013. Phyllis was a 90-year-old woman with a diagnosis of mixed type dementia and a recent history of depression, and agitation. During the period from February – May 2013 the level of falls was significant and ultimately led to the death of Phyllis on 9th June 2013 following a fall that resulted in a head injury.

A safeguarding investigation carried out at the time, concluded that neglect was substantiated and a subsequent coroner's inquest concluded in July 2015 that Phyllis died from traumatic head injury. The coroner raised concerns related to the care and treatment Phyllis received regarding the falls and issued a Regulation 28 report to prevent future deaths to which the Local Authority duly responded.

## Findings/Recommendations

The author of the Review made recommendations to the RSAB which included.

- RSAB should be assured by a review of policies across all sectors ensures that the focus on falls reduction and management in cases where falls prevention is not possible.
- RSAB should assure itself and test out using auditing processes that communication between professionals, service users and their families is robust.
- RSAB should look at a range of mechanisms and develop protocols for the use of care coordinators in complex cases in the community setting.

The recommendations have formed an action plan that was signed off by partners and will be monitored and managed through the Performance and Quality Sub Group.

## Mental Capacity Act and Deprivation of Liberty Safeguards

The MCA DoLS team has been strengthened with 5 dedicated Best Interests Assessors through the recent Directorate restructure. The table below reflects the increase in assessments completed during 2016/17 period.

The additional activity is having a detrimental impact on other areas of the team in terms of the use of Mental Health Assessors, the business support and legal support functions. A review of procedures and processes is being undertaken to make sure the necessary infrastructure is in place.

Mental Capacity Act and Deprivation of Liberty Safeguards

| Year    | No. of Applications | Authorised | Not Authorised | Not Assessed | Total Backlog |
|---------|---------------------|------------|----------------|--------------|---------------|
| 2012/13 | 46                  | 30         | 16             | 0            |               |
| 2013/14 | 56                  | 44         | 12             | 0            |               |
| 2014/15 | 565                 | 165        | 111            | 289          |               |
| 2015/16 | 957                 | 190        | 350            | 306          |               |
| 2016/17 | 1128                | 452        | 524            | 152          | 480           |

# The Context of Safeguarding in Rotherham – 16/17 data

## Demographics

**19%**

of population aged over 65.

**41%**

increase in 85+ population in past 15 years.

**59%**

of safeguarding concerns relate to people over 65.

**62%**

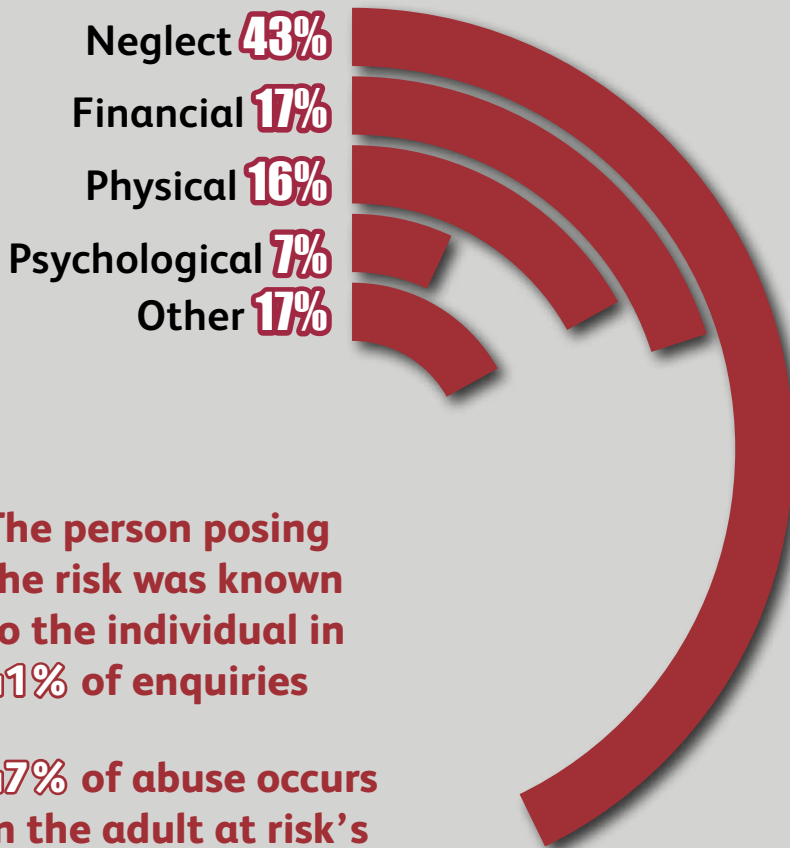
of safeguarding enquiries relate to female adults.

**37%**

of safeguarding enquiries relate to younger adults.

## Abuse and Location Analysis

The pattern of abuse:



**The person posing the risk was known to the individual in 41% of enquiries**

**47% of abuse occurs in the adult at risk's own home**

**42% of abuse occurs in care homes**

## Risk Assessment

Risk was reduced or removed in **97%** of enquiries.

**26%** of adults at risk did not have the mental capacity to make decisions relating to their enquiry.

**41%** of adults lacking mental capacity supported by an advocate. (\*includes informal family/friend/carer).

**1128** DoLS applications received.

## MSP



**366** adults at risk supported in setting the desired outcomes of their enquiry.

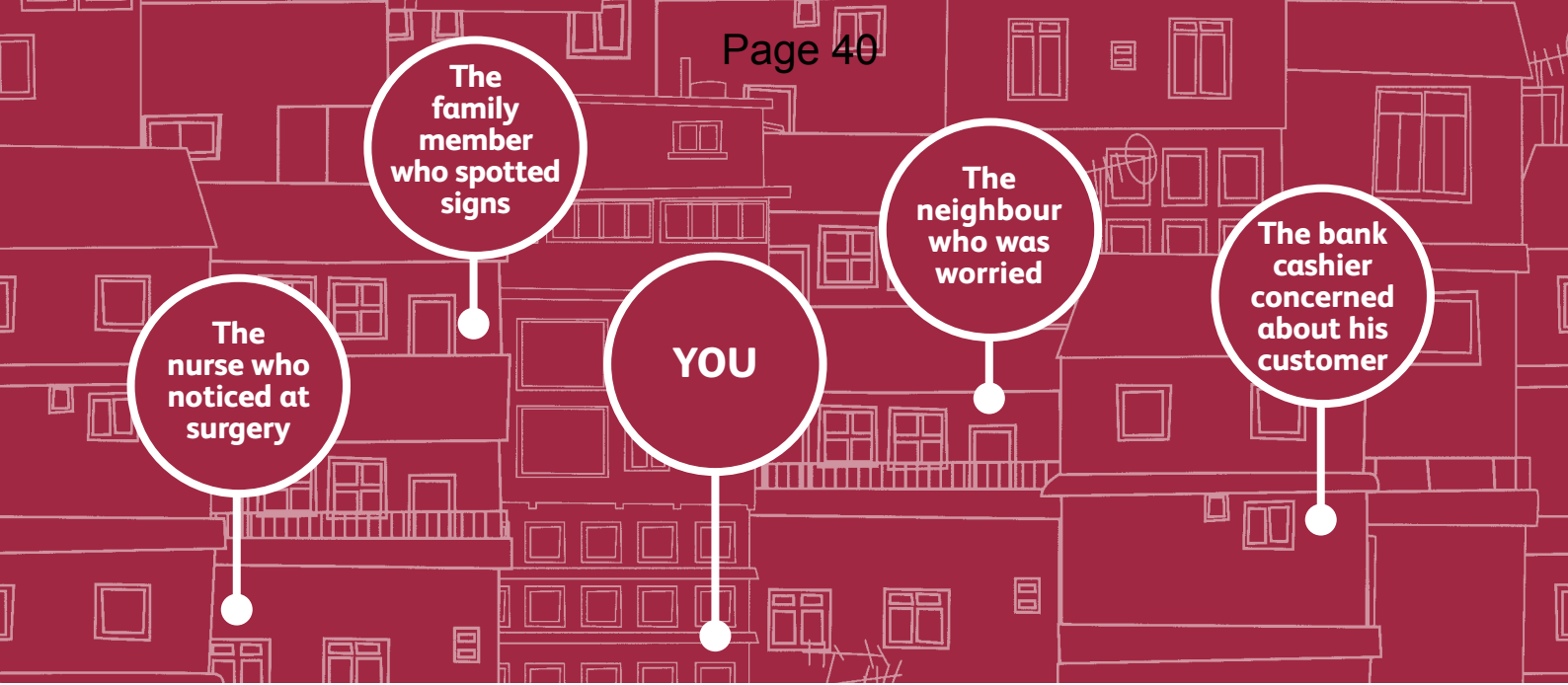


**94%** of adults at risk who responded indicated that they felt their outcomes were met.

# Rotherham Safeguarding Adults Board Attendance

| Date of Safeguarding Adults Board Meeting (excludes e-learning) |            |            |            |            |            |            |
|---|------------|------------|------------|------------|------------|------------|
|   | May 2016   | July 2016  | Sept 2016  | Nov 2016   | Jan 2017   | March 2017 |
| South Yorkshire Police  | Appologies | ✓          | ✓          | ✓          | Appologies | ✓          |
| The Rotherham Foundation Trust                                  | ✓          | Appologies | ✓          | ✓          | ✓          | ✓          |
| Clinical Commissioning Group                                    | ✓          | ✓          | ✓          | ✓          | ✓          | ✓          |
| RMBC Director of Adult Social Services                          | ✓          | ✓          | ✓          | ✓          | ✓          | ✓          |
| South Yorkshire Ambulance                                       | ✗          | ✗          | ✗          | ✗          | ✗          | ✗          |
| South Yorkshire Fire and Rescue                                 | ✓          | Appologies | Appologies | ✓          | Appologies | Appologies |
| NHS England   | ✓          | ✓          | ✓          | ✓          | ✓          | Appologies |
| RDASH   | ✓          | ✓          | Appologies | Appologies | ✓          | ✓          |
| RMBC Children Services  | ✓          | ✓          | ✓          | ✓          | ✓          | ✓          |
| Healthwatch   | ✓          | ✓          | ✓          | ✓          | Appologies | Appologies |
| Voluntary Sector  | Appologies | Appologies | Appologies | ✓          | Appologies | Appologies |





# Do you know the signs of adult abuse?



Physical



Emotional



Financial



Institutional

# Recognise • Respond • Report

**Rotherham Council 01709 822330**

**Police** non emergency: **101** or emergency: **999**

**Keeping people safe from abuse is everyone's business**

**For more information about types of abuse**  
**[www.rotherham.gov.uk/abuse](http://www.rotherham.gov.uk/abuse)**





Rotherham Doncaster and South Humber   
NHS Foundation Trust

  
Rotherham  
Clinical Commissioning Group

  
England

 Rotherham  
ageUK

 healthwatch  
Rotherham

  
Rotherham

 South Yorkshire  
POLICE

 South Yorkshire  
FIRE & RESCUE

 CROSS  
ROADS  
CARE  
North West

 RDASH  
leading the way with care

Rotherham   
Metropolitan  
Borough Council

## **Summary Sheet**

### **Council Report**

Rotherham Local Safeguarding Children Board – Annual Report 2016-17

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

**Strategic Director Approving Submission of the Report:** Ian Thomas

**Report Author(s)** Nina Martin & Board Team

**Ward(s) Affected** All wards

### **Summary**

This report introduces the 2016-17 Rotherham LSCB Annual Report. The report is a statutory requirement of Local Safeguarding Children Boards and provides a rigorous and transparent assessment of the performance and effectiveness of local services. It identifies areas of weakness, the causes of those weaknesses and the action being taken to address them as well as other proposals for action.

### **Recommendations**

That the Improving Lives Select Commission and Health & Wellbeing Board receive the LSCB Annual Report 2016-17

### **List of Appendices Included**

Rotherham Local Safeguarding Children Board Annual Report 2016-17

**Background Papers** None

### **Consideration by any other Council Committee, Scrutiny or Advisory Panel**

The report will be considered by the Improving Lives Select Commission and Health & Wellbeing Board

**Council Approval Required** No

Not exempt from the Press and Public

## **Rotherham Local Safeguarding Children Board – Annual Report 2014-2015**

### **1. Recommendations**

1.1 That the Improving Lives Select Commission and Health & Wellbeing Board receive the LSCB Annual Report 2016-17

### **2. Background**

2.1 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. Publication will be on the RLSCB website.

### **3. Key Issues**

3.1 See report

### **4. Options considered and recommended proposal**

4.1 n/a

### **5. Consultation**

5.1 All members of the RLSCB have been consulted on the content of the report.

### **6. Timetable and Accountability for Implementing this Decision**

6.1 n/a

### **7. Financial and Procurement Implications**

7.1 n/a

### **8. Legal Implications**

**8.1** 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.

**8.2** Under the 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.

**9. Human Resources Implications**

9.1 None

**10. Implications for Children and Young People and Vulnerable Adults**

10.1 Publication of this report is the means of holding RMBC and partner agencies to account over their safeguarding of children arrangements.

**11 Equalities and Human Rights Implications**

11.1 Equality & diversity issues are reflected in the report

**12. Implications for Partners and Other Directorates**

12.1 Publication of this report is the means of holding RMBC and partner agencies to account over their safeguarding of children arrangements.

**13. Risks and Mitigation**

13.1 See report.

**14. Accountable Officer(s)**

Approvals Obtained from:- Christine Cassell – Independent Chair of RLSCB 2/11/17

|   | <b>Named Officer</b> | <b>Date</b> |
|---|----------------------|-------------|
| Strategic Director of Finance & Customer Services | n/a                  |             |
| Assistant Director of Legal Services              | n/a                  |             |
| Head of Procurement (if appropriate)              | n/a                  |             |
| Head of Human Resources (if appropriate)          | n/a                  |             |

*Report Author:* Nina Martin Interim RLSCB Manager

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

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



# Rotherham

## Local Safeguarding Children Board

### Annual Report

### 2016 - 2017

|                  |         |
|------------------|---------|
| Status of Report | Final   |
| Approved by      |         |
| Date             | 1.11.17 |



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## 1. Foreword by the Independent Chair

Welcome to the Rotherham Local Safeguarding Children Board (RLSCB) Annual Report for 2016-17. The purpose of this report is to set out the work of the RLSCB in 2016-17 in co-ordinating and ensuring the effectiveness of partner activity in safeguarding children in the borough.

This report covers my first full year as independent chair and a period in which there has been change in personnel in a number of organisations. The leadership teams of both Rotherham Borough Council and South Yorkshire Police have both changed completely since 2015 and there have been significant changes at other levels of the organisations. The new leadership teams of both organisations have expressed and demonstrated their commitment to safeguarding children and to the Board.

The context for this report is one of increasing demand for family support and child protection services both locally and nationally whilst all public sector budgets are reducing. The role of local safeguarding children boards in this context is particularly important in requiring assurance that local services are appropriately targeted and resourced to ensure that children are protected.

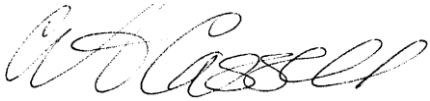
The increase in demand in Rotherham is apparent in the higher number of contacts made to children's social care, the high number of strategy meetings for children considered at risk of harm and the increase in the number of children in the care of the local authority. However, the number of contacts that lead to a formal referral to children's social care has remained steady and the number of referrals that then lead to an assessment has improved.

The general message from single and multi-agency audit and review and from inspection monitoring is that the safeguarding system in Rotherham, with the local authority as the lead agency, is becoming more compliant with statutory requirements and is beginning to improve in the quality of the assessment, decision making and planning for children at risk. Rotherham Safeguarding Children Board will continue to monitor the improvements in the quality of safeguarding practice and will focus in particular on the quality and compliance of multi-agency meetings which are held when a child is considered to be at risk of harm.

Rotherham Safeguarding Children Board will continue its activity to monitor and improve responses to child sexual exploitation, neglect, early help and the safeguarding of children who are looked after by the local authority. We will be seeking, through these priority areas and through more general audit activity, robust evidence that agencies are individually and collectively listening to children and young people and taking account of their views both in plans for individual children and in wider strategic planning of services.

I would like to acknowledge the work of all partners of the Rotherham Safeguarding Children Board and its sub groups in driving improvement across the priorities that we have identified by transparently challenging their own and other agency performance. It is through such openness and willingness to challenge and to be challenged that services will have the confidence of the local community.

Finally I would like to acknowledge those people who are in direct contact with children and families and who make critical assessments and decisions that affect children's lives every day. They need the support of managers and leaders across the borough to support them to make the right decisions and Rotherham Safeguarding Children Board will continue to work to ensure that support.

A handwritten signature in black ink, appearing to read 'Christine 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 261,900 (Office for National Statistics (ONS) mid-year estimate for 2016). There are 56,600 children and young people aged 0-17 (21.6%). The local age structure is slightly older than the national average, with a lower proportion aged 16-44 and a higher proportion aged 45-74.

The population of Rotherham has been steadily growing over the last 15 years, increasing by 14,900 (6%) between 2000 and 2016. The population is expected to rise by an average of 830 per year over the next ten years (an increase of 8,300), to reach 269,100 by 2025. This amounts to an extra 6,000 households. The projected increase reflects a combination of rising life expectancy and steady birth rates that result in a 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, private residential suburbs, industrial areas, rural villages and farms. About 70% of the Borough's land area is rural. Rotherham is centrally located and well connected to other areas of the region and country via the M1 and M18, both of which run through the Borough, and by the rail network, which links to Sheffield, Doncaster and Leeds.

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.

### Diversity

Rotherham's Black and Minority Ethnic (BME) population is relatively small but has been growing and becoming increasingly diverse. In 2011 8.1% of the population belonged to ethnic groups other than White British (6.4% were from non-white groups), well below the English average of 20.2%. It follows that 91.9% of Rotherham residents were White British.

Immigration and natural increase means that Rotherham's BME population has grown steadily in recent years increasing between 2001 and 2011, from 10,080 to 20,842. 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, and 50% are aged under 16. The Irish community is by far the oldest ethnic group with 42% aged 65+.

National Insurance Number (NINo) migrants accounted for 933 in 2016. People from states that joined the EU post 2004 make up 63% of all overseas migrants to Rotherham (585 in 2016). The countries with the most migrants to Rotherham are Romania (30%), Slovak Republic and Poland, which together accounted for 46% of NINo migrants in 2016. Two thirds of NINo arrivals in Rotherham between 2007 and 2016 moved to the three central wards. A high proportion of Slovak, Czech and Romanian migrants have been from Roma communities.

There are 31,000 carers in Rotherham, 58% of them female, 22% over 65 and 6% under 25. Rotherham has 8,500 lone parents, with a 21% increase projected between 2011 and 2021.

Rotherham LGBT population could number up to 4,840 people aged 16+

### **Context**

Rotherham LSCB, Local Authority and Police were subject to significant criticism in the report by Prof. Jay "Independent Inquiry into Child Sexual Exploitation in Rotherham 1997-2013", published in 2014. This principally related to practice pre-2009 but many on-going concerns were raised in relation to the partnership. An Ofsted inspection in September 2014 found both the Local Authority Children's Services and the LSCB to be inadequate, and HMIC also raised concerns about child protection activity by the Police. Since that time there has been significant activity and investment in improving service responses to children across the partnership, which is being reflected in improving commentary from the various inspectorates. Rotherham services continue on this improvement journey and the LSCB continues to challenge partners to demonstrate the effectiveness and robustness of their joint work in protecting children.



## What do children and young people think about living in Rotherham?

Listening to and communicating with children, young people and their families and communities is critical to safeguarding children. Work in this area was identified as a Board priority and the activity of the Board team and partners is evidenced throughout this report.

### Introduction

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

The Lifestyle Survey results, undertaken by CYPS Performance & Quality Team, provide an insight into the experiences of children and young people living in the borough, and offer a series of measures to monitor the progress of the development of child friendly Rotherham. 12 out of 16 secondary schools and 2,806 students participated in the 2016 Rotherham Lifestyle Survey.

### What's working well?

2126 young people have received CSE awareness raising sessions. 1,232 Y10 (91.5%) and 894 Y7 (61.2%), which is a significant increase since 2015.

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 are aware of internet safety

Reduction in the number of young carers but greater awareness of the Young Carers Service

Increase in positive responses against the participation in smoking, drinking alcohol and use of drugs which gives a positive message against the peer pressure to partake in these

Reduction in the number of young people actually smoking or trying alcohol

Improvement of young people feeling safe in all areas including Rotherham town centre locations

### Bullying

More young people in 2016 said they had been bullied. Y7 girls were the ones who were more likely to say they had been bullied. The majority of bullying occurs during school time. 20% of those who said they have been bullied said they were bullied almost every day. The reasons pupils said they were bullied, in the majority are:

- No specific reason
- People don't like me or hate me
- The way I look

Verbal is the most common form of bullying, although the 2016 results showed that cyber bullying and sexual comments/actions have increased. Fewer pupils said that they received help or support after reporting bullying than in previous surveys.

### Internet Safety and Risks

The majority of pupils have been taught about the internet and how to use it safely. Only 38 pupils (1.4%) said they had not been taught about internet safety. Pupils feel that the highest risks when using the internet are people lying about who they say they are, cyber bullying and messages from people they do not know

### Feeling Safe

More pupils said that they feel safe at home compared to the 2015 results. 33 (1.2%) of pupils said that they never felt safe at home compared to 6% saying they did not feel safe at home in 2015. The % of those pupils saying they never feel safe in other locations increased.

### What are we worried about?

Pupils reporting that they have been bullied increased for the first time in 3 years. 737 (26%) of pupils asked said they have been bullied, compared to (22%) in 2015. Pupils reporting that they have been bullied by cyber bullying increased. 62 pupils (8.2%) increased from (6%) in 2015.

Pupils reporting that they have been bullied by inappropriate sexual comments/ actions increased: 27 pupils (3.7%) increased from (1%) in 2015. Fewer pupils said they received some help after reporting bullying: 321 (58.7%) of those who reported bullying got some help, compared to (65%) in 2015.

A proportion of young people in Y7 saying that they use the internet to meet new friends

Fewer young people wanting to stop smoking

Increase in number of young people trying electronic cigarettes

One third of the young people who said they have drunk alcohol have tried it before the age of 12

A large proportion of the young people who say they have drunk alcohol say that 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 say they have had sex, did not use contraception

The number of 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 ways in which the 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) 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 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.

### 4 Governance and accountability arrangements

**Local partnership and accountability arrangements** - Improvement in this area was identified as a Board priority

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 LSCB 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
- Independent Chair of the Safeguarding Adults Board
- Chair of the Health and Well Being Board

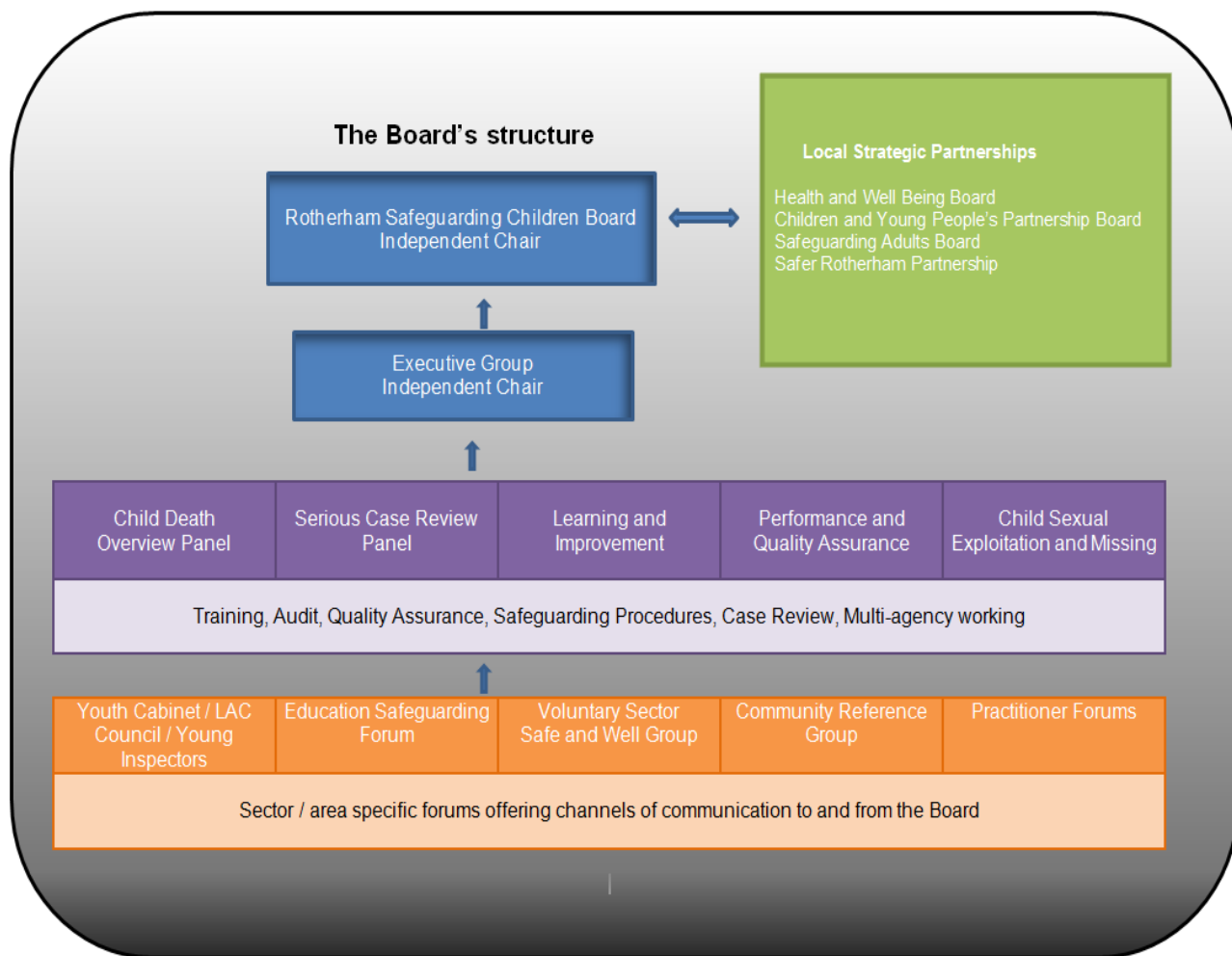
Members of an LSCB should be people with a strategic role in relation to safeguarding and promoting the welfare of children in their organisation and should be able to speak for their organisation with authority; commit their organisation on policy and practice matters; and hold their own organisation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

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

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.



Partner agencies in the LSCB also operate within other partnerships. Clarity about the relationships between these partnerships and their priorities are crucial to ensuring their effectiveness. A protocol was developed in March 2017 to achieve that.

**Rotherham Safeguarding Partnership Protocol**

The Rotherham Safeguarding Partnership Protocol was agreed in March 2017

The strategic partnerships that are stakeholders to this protocol are:

- Rotherham Health and Well Being Board (RHWBB)
- Rotherham Children and Young People's Partnership Board (RCYPPB)
- Safer Rotherham Partnership (SRP)
- Rotherham Local Safeguarding Children Board (RLSCB)
- Rotherham Safeguarding Adults Board (RSAB)

The purpose of this protocol is to ensure that strategic safeguarding priorities are translated effectively into action plans with each board being clear about its responsibilities in relation to those priorities.

The Board is supported by a Business Unit which consists of:

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

### Financial arrangements

The Board's budget is based on partner organisations contributions to an agreed formula. The funding formula and 2016-17 budget statement can be found at Appendix 2.

However this year there has been a reduced contribution from South Yorkshire Probation, South Yorkshire Community Rehabilitation Company and CAFCASS in response to national guidance to their organisations, amounting to £6,752.

#### Budget – 2016-17 Outturn

|              |        |          |        |          |
|--------------|--------|----------|--------|----------|
| Income:      | Budget | £335,900 | Actual | £329,148 |
| Expenditure: | Budget | £335,900 | Actual | £319,148 |

Overall expenditure for 2016/17 was £16,752 under budget and £10,000 under actual income. This is largely due to a salary underspend from a vacancy in the Quality Assurance Officer post while the recruitment process took place.

The underspend will be carried over to 2017-18 to compensate for the reduced contributions above and contribute towards any additional costs associated with independent consultants and authors for potential serious case reviews.



## Inspection and Evaluation Reports across the Partnership

Inspections of local agencies are routinely reported to Rotherham Local Safeguarding Children Board. This section summarises key findings from inspections of safeguarding board partners. Children's Social Care is subject to regular monitoring visits by Ofsted following the inadequate judgment in 2014.

### Inspection Feedback

#### Ofsted Monitoring Visit (October 2016)

During the course of this visit, inspectors reviewed the progress made in respect of the experience and progress of looked after children.

#### Summary of the key findings

The council has taken effective action to begin to address the significant shortfalls identified in the single inspection undertaken in October 2014. A strong focus on performance management is beginning to show improvement in compliance with some statutory requirements.

Children are being seen regularly by a social worker and there has been positive improvement in the timeliness of reviews. Improved partnerships with the virtual school have seen an increase in the number of personal education plans being completed, although it is recognised that there is much work to do to in order improve the quality and the aspirations for children.

Improved relationships with health partners have resulted in children looked after being prioritised for assessment and intervention from children and adolescent mental health services. The number of annual health assessments that are completed in a timely way has improved, as has the number of dental checks. Initial health assessment performance remains poor.

Improvement is evident in relation to compliance with statutory requirements. Social worker caseloads have reduced, providing more time to focus on individual children. However, frontline management oversight of social work practice is weak. Social workers are neither supported nor challenged sufficiently by managers to improve the quality of their work.

The number of children who become looked after has continued to rise as the council's focus on children in need of help and protection has improved. This is placing significant pressure on the council's ability to identify and match children to the right placement in a timely way. Placement stability has deteriorated and the number of placement disruptions is increasing. However, children who spoke to inspectors say that they feel safe in their placements and in school, and receive good support from their social workers and carers.

The number of children who go missing from care has reduced significantly in the last six months and an increased number of children receive a return home interview. However, this is not the case for children who live out of borough.

## Inspection Feedback

### Ofsted Monitoring Visit (March 2017)

During the course of this visit, inspectors reviewed the progress made in relation to access to early help services and whether children in need of help and protection are identified by professionals and receive timely help that is proportionate to risk and their levels of need.

### Summary of the key findings

The local authority is making continuous progress in improving services for children in need of help and protection. The implementation of multi-disciplinary locality teams is leading to improved coordination of early help support to families by the local authority.

The quality of early help assessments is slowly but steadily improving and they are leading to a direct offer of help which is highly valued by families. However, the number of early help assessments being completed by multi-agency partners remains too low.

The robust screening of contacts to children's social care, supported by effective multi-agency information sharing, is leading to more timely assessments of need and risk.

While assessment quality is beginning to improve with evidence of some good work emerging, assessments and section 47 investigations are not focused well enough on risk or children's holistic needs. This has an impact on the quality of children's plans and the interventions that they receive. Progress can be seen in the quality of management oversight and performance management.

Workforce planning is highly effective. Recruitment and retention rates are better than the national average. Due to a positive organisational culture staff are highly committed and motivated and they report feeling valued.

## Inspection Feedback

### HM Inspectorate of Constabularies (HMIC) PEEL: Police effectiveness (2016)

#### Summary of the key findings

##### Has the force improved since HMIC's 2015 vulnerability inspection?

South Yorkshire Police has maintained and improved performance in some areas since HMIC's 2015 effectiveness (vulnerability) inspection. The force has maintained its understanding and response to missing and absent children, and improved the way in which it risk-assesses and grades calls for service from those who are vulnerable, especially domestic abuse victims. However, HMIC is concerned about the quality of risk-assessments, and the way that the force conducts risk assessments of vulnerability at the scene and then completes referrals to partner agencies.

In 2015, HMIC was concerned about how the force responded to victims of domestic abuse. We made recommendations for the force to take immediate steps to understand the nature and scale of domestic abuse, improve call-handling consistency, carry out risk assessments at the earliest opportunity and ensure that it consistently records investigating and safeguarding activity, including supervision. In response, the force has undertaken a strategic assessment of domestic abuse and has an action plan to improve its response. HMIC found a more consistent response to incidents of domestic abuse through call-handling and despatch of officers to attend scenes. Through our file review, we found that the force generally provided good victim care and identified vulnerability in most cases, but safeguarding of victims was inconsistent and some opportunities were missed.

##### How effectively does the force investigate offences involving vulnerable victims and work with external partners to keep victims safe?

Those who are vulnerable often have complex and multiple needs that a police response alone cannot always meet. They may need support with housing, access to mental health services or support from social services. Nonetheless, the police still have an important responsibility to keep victims safe and investigate crimes. These crimes can be serious and complex (such as rape or violent offences). Their victims may appear to be reluctant to support the work of the police, often because they are being controlled by the perpetrator (such as victims of domestic abuse or child sexual exploitation).

Generally, South Yorkshire Police has trained and skilled officers to investigate the highest risk and more complex cases where victims are vulnerable. This includes specialist staff to investigate child protection offences, vulnerable adult offences, and serious sexual offences. The force has an allocation policy which means that the most serious and complex offences are allocated to the specialist investigators. A triage process is in place to support those decisions. Offences involving medium or standard risk to vulnerable victims are investigated by detectives within the hubs or by response officers within the local policing districts.

The standard of investigations and supervision within child abuse and child sexual exploitation teams is generally better than we found for other crime types. Although we recognise the challenges faced in relation to staffing within specialist teams, the proportion of staff who have not received specialist child abuse investigator training is still significant.

## Inspection Feedback

### Care Quality Commission (2016)

#### Rotherham Doncaster and South Humber NHS Foundation Trust

### Summary of the key findings

We rated the following service as outstanding:

Mental health crisis services and health based places of safety.

Community health services for children, young people and families;

We rated the following core services as good:

Specialist community mental health services for children and young people;

Overall rating for services at this Provider **Good**

Are services safe? **Good**

Are services effective? **Good**

Are services caring? **Good**

Are services responsive? **Good**

Are services well-led? **Good**

Following this inspection, which took place throughout September and October 2016, we changed the overall rating for the trust from requires improvement to good because:

- In September 2015, we rated 11 of the 15 core services as good. The intelligence we received, before the 2016 inspection, suggested they had maintained their quality and they were not visited during this inspection.

Following this inspection we have changed the ratings of three more core services from requires improvement to good. These core services are:

- Specialist Community Mental Health Services for children and young people
- Community Mental Health Services for people with learning disabilities or autism
- Substance misuse services

Care was provided in line with National Institute for Health and Care Excellence guidelines including offering patients access to a range of psychological therapies in specialist community mental health services for children and young people.

- There was effective multidisciplinary team working across all services.

**Inspection Feedback  
Care Quality Commission (2016)  
The Rotherham NHS Foundation Trust**

**Summary of the key findings relevant to children's safeguarding**

The Rotherham NHS Foundation Trust (TRFT) overall rating of requires improvement remains unchanged. At this inspection we found:

There were areas of notable improvement since the previous inspection. These included

- safeguarding training and awareness, improvements to the shortbreak service, access to sexual health records and improvements to training data.

Several areas of outstanding practice were noted including:

- Safeguarding and liaison had a daily meeting with the Emergency Department to identify any safeguarding issues and concerns.
- All patients with mental health needs admitted to the children's ward were reviewed by the Child & Adolescent Mental Health Service (CAMHS) liaison team/nurse within 24 hours of admission and were followed up after seven days.

Access to safeguarding supervision was a concern and was in the process of being addressed.

Actions identified for the trust:

- Ensure all staff are aware of their responsibility to report incidents and ensure learning is shared with all relevant staff.
- Complete the reviews of maternal and neonatal deaths and implement any further identified actions to support safe practice.
- Ensure staff have access to safeguarding supervision and support.
- Ensure the policies and procedures for the management of the children's and young people's service are up-to-date, regularly reviewed, document controlled and readily accessible to staff.
- Ensure children and young people's service risk register reflect current risks, contains appropriate mitigating actions, is monitored and reviewed at appropriate intervals and acted upon.
- Ensure that it improves the number of looked after children assessments carried out within the target timescale.
- Ensure children and young people's service risk register reflect current risks, contains appropriate mitigating actions, is monitored and reviewed at appropriate intervals and acted upon.

## Inspection feedback

### Quality & Impact inspection - The effectiveness of probation work in South Yorkshire

HM Inspectorate of Probation (June 2017)

## Summary of the key findings

### Community Rehabilitation Company(CRC) - effectiveness

The quality of work to protect the public was generally acceptable, but with some room for improvement.

Up to date policies and clear procedures were in place. There were examples of effective information exchange with the police about domestic abuse as cases started, and when they were reviewed. Good use was made of home visits. There was a clear commitment to the four Local Safeguarding Children Boards. Risk of harm training had been introduced for recently appointed professional staff lacking experience. Further attention was required to monitor and respond to signs of risk of harm deteriorating between reviews.

### National Probation Service (NPS) - effectiveness

The quality of work to protect the public was generally good. We found the NPS had a good grip on complex cases with work undertaken to engage those in denial and resistant to change. There was an effective victims' team who worked closely with the police and partner agencies to respond to the needs of victims of child sexual exploitation. We were pleased that following a review of Multi-Agency Public Protection Arrangements, a county probation coordinator had been introduced.

Reviews were completed in over two-thirds of cases but officers did not always adjust their planning to take account of changing circumstances. Some probation officers found working primarily with high risk of harm and complex cases challenging. Some were reluctant to move less demanding cases to probation service officers, as they doubted their skills and experience. Others resisted, knowing that it would further increase the concentration of high risk of harm cases in their caseload.

Overall, the CRC was effective in protecting those at risk of harm, but with some room for improvement. Up to date public protection policies and procedures were in place and being applied. There was a commitment to training and practice development in the management of risk and safeguarding; this was underpinned by quality assurance audits. Staff understood the importance of being attentive to managing risk of harm and knew where to turn to for advice. There were effective relationships at a strategic level with children's social care services.

Overall the NPS protected those at risk of harm well. The quality of assessment was good for the large majority of cases inspected. The quality of planning was satisfactory in around three-quarters of cases, although this dropped slightly in respect of planning to protect known adults. A protocol was in place between the South Yorkshire Multi-Agency Public Protection Arrangement (MAPP) Strategic Management Board and the four Local Safeguarding Children Boards in South Yorkshire to facilitate cooperation and communication. The two LDUCs were required to contribute to four separate safeguarding arrangements, which stretched limited resources. We thought there were opportunities for improved information-sharing arrangements, which would support initial assessment for on-the-day court assessments in particular.

Multi-Agency Risk Assessment Conference (MARAC) arrangements were jointly led by probation and the police and the LDUCs were working to the recent NPS MAPP protocol, which restricted their contribution to current cases. As with the CRC, there was some frustration that the police no longer notified probation of any repeat domestic abuse incidents after initial notification unless triggered by a request. Instead they were dependent upon Multi-Agency Safeguarding Hub (MASH) arrangements identifying probation involvement.



## 5 Effectiveness of arrangements to keep children in Rotherham safe

### Early Help Services

*Early help means providing support as soon as a problem emerges, at any point in a child's life, from the foundation years through to the teenage years. Early help services work with children and their families to prevent problems from getting worse.* Improvement in this area was identified as a Board priority

Since the Ofsted Inadequate judgement in 2014, RMBC has worked with partners to establish a cohesive Early Help offer to ensure that issues are identified early as problems begin to emerge and children, young people and families' needs are assessed and supported.

The new Early Help Offer was launched in January 2016 and the vision for Early Help in Rotherham is articulated in the Early Help Strategy 2016-2019. As a result there are integrated, Early Help locality teams, bringing together previously separate professional disciplines and co-locating staff with partners (including Social Care) in multi-agency Early Help hubs. There are new systems in place that allow the service to monitor and track progress and there is governance in place, through the Children and Young People's Strategic Partnership, the Early Help Steering Group and the Early Help Review Board to ensure there is appropriate accountability and effective support and challenge across the system.

Rotherham Local Safeguarding Children Board supported the launch of the new service, disseminating information about the service across partners, and will be monitoring its effectiveness.

### What has been working well?

During 2016/2017 there were 3914 contacts into the Early Help service. Of these, 85.3% were triaged within five working days.

Timeliness performance in relation to Initial Contacts increased during the year reaching 53.7% engagement within three working days compared with 18.4% in April 2016.

### Preventative Programmes

There have been several partnership Early Help and preventative programmes in Rotherham over the past year which have contributed to the safety and wellbeing of children. Examples include:

#### The Targeted Youth Programme

The Targeted Youth Programme was funded by the Office of the Police & Crime Commissioner via the Safer Rotherham Partnership in summer 2016, in order to support coordinated interventions to address multi layered issues in communities. The targeted intervention sought to offer outreach detached and street based sessions in high priority areas of Rotherham on Friday and Saturday evenings, in order to engage young people that are vulnerable for a variety of reasons. The provision sought to trial this approach to Friday and Saturday night provision and test engagement, attendance and impact.

### Operation Keepsafe

Operation Keepsafe is a multi-agency initiative that enables a proactive response to children and young people who are vulnerable due to being unsupervised in the community at night time. As a result of evidence from the Early Help Targeted Youth Programme, Operation Keepsafe has been running since 1<sup>st</sup> September 2016. Of the young people seen and spoken with, almost half were under 16; they were taken home and concerns about their vulnerability shared, with an offer of early help support.

### Troubled families

In 2016/17 Rotherham committed to identifying and engaging 882 families in the Troubled Families Programme (known locally as Families for Change). The target engagement figure for this financial year was achieved in March 2017 when 97 new families were attached to the programme.

Within the Families for Change programme, the 2016/17 target number of families for whom Rotherham claims a payment by results outcome was set in the range of 280-350. The total figure for this financial year was 80 or 29% of the total. In order to develop a solution focused action plan which will address performance in this area a deep dive is being planned by the Directorate Leadership Team (DLT) and is taking place on the 27th July 2017.

### Evaluation and Impact

It is too early to expect to see the impact of effective Early Help, but progress has been achieved; RLSCB continues to challenge and support the Local Authority and partners to demonstrate the impact of Early Help services on outcomes for children and a number of measures will be tracked going forward.

During the period (May 16 - March 17) 222 voluntary Early Help Exit Surveys were completed with 98% of people who completed the survey rating their overall experience of the help and support they received from the worker(s) within the Early Help Team as "good or excellent."

*Worker has been a great help to myself and my family she was always on call if needed...*

*The support was given straight away and nothing was too much trouble ...*

### Partnership Workforce Survey Relating to Early Help Pathway -April 2016

The RLSCB supported the launch of the new Rotherham's Early Help Service on 18<sup>th</sup> January 2016 when the integrated Early Help Teams went operational from their locality team bases. A questionnaire was disseminated seeking feedback regarding individual practitioner experiences of accessing the Early Help Service from across the partnership 3 months post launch. It asked whether they believe that the new Early Help Pathway is having an impact in terms of improving outcomes for Children and Families in Rotherham and whether we are successfully building on our Early Help principle of "One Family, One Worker, One Plan" to ensure that children and young people receive the support that they require.

A consistent theme that emerged throughout this survey was the importance of effective, timely communication between the Early Help service and the referrer. This appeared to be the single biggest influencing factor regarding the level of confidence that respondents felt regarding Early Help. The LSCB will ask for evidence of improvement in this communication.

**Inspection Feedback:****Ofsted Monitoring Visit (February 2017)**

*the local authority is making continuous progress in improving services for children in need of help and protection.*

*The implementation of multi-disciplinary locality teams is leading to improved quality and coordination of early help support to families. Early help assessments (EHAs) are being undertaken more efficiently, and these are leading to a direct offer of help for individual children and their families.*

*There is much evidence of children's circumstances improving as a result of the early help being provided. There are also some positive examples of very timely intervention and support for families who have an allocated worker within one of the locality teams. The local authority's use of exit interviews endorses this positive work, and it is clear that the service offered through early help is valued highly by families.*

*Staff within the locality teams are working well together. This follows a period of team development that included activities to help them to learn about each other's range of skills and ways in which they could network to provide enhanced support to children and their families. All workers who spoke with inspectors feel that they have been appropriately trained to undertake EHAs and team around the family (TAF) meetings. Most workers have also participated in a variety of other training to enhance their work with children and families. This training has covered restorative practice and child sexual exploitation, although not all workers have received training on how to use the child sexual exploitation screening tool.*

*The completion of EHA assessments within the locality teams is, in the majority of cases, timely. The quality remains variable, and all EHAs seen during this visit have a number of areas in which they could be improved.*

**What we are worried about****Early Help Assessments**

Of the 127 Early Help Assessments (EHA's) in scope for completion in March 2017, only 39.4% were completed within the target timeframe of 35 days although the trend was improving. Work continues at the Early Help performance meetings to ensure that the data is analysed and learning taken to enable further improvement in the future.

The completion of Early Help Assessments by partners remained consistently low in Rotherham at the end of March 2017. Overall performance for 2016/2017 was 6.5% which equates to 75 out of 1150 of completed Early Help Assessments.

**Inspection Feedback:****Ofsted Monitoring Visit (February 2017)**

*The local authority has improved in many areas of early help provision to children and their families, including outlining clear expectations to partners regarding their role in the assessment and provision of early help. However engagement by operational colleagues from other agencies remains extremely low. Although performance is very slowly improving in this area, there are too few other agencies undertaking EHAs and taking on the lead professional role to ensure the early help model can become embedded and sustainable.*

In order to improve this and embed shared responsibility for early intervention a range of initiatives is underway with partners including; the co-production of a new Early Help Assessment, the introduction of Integrated Working Leads across localities to work alongside partners and training with Health partners and Schools.

**Children’s Centres**

The year-end data shows that 52% of children aged 0-5 across Rotherham had engaged with activities in a children’s centre, which is below the target of 66%, although 62% of 0-5’s living in the 30% most deprived Lower Super Output Areas (LSOA’s) engaged.

**Contacts, Referral and Assessment**

*A “Contact” is a request for help when a child is thought to have support needs or to be at risk of harm. If there are concerns which cannot be managed through the provision of early help services, a referral is made for a multi-agency assessment to be undertaken, led by a social worker. 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 support put in place. The upper time limit for assessments to be completed is 45 working days.*

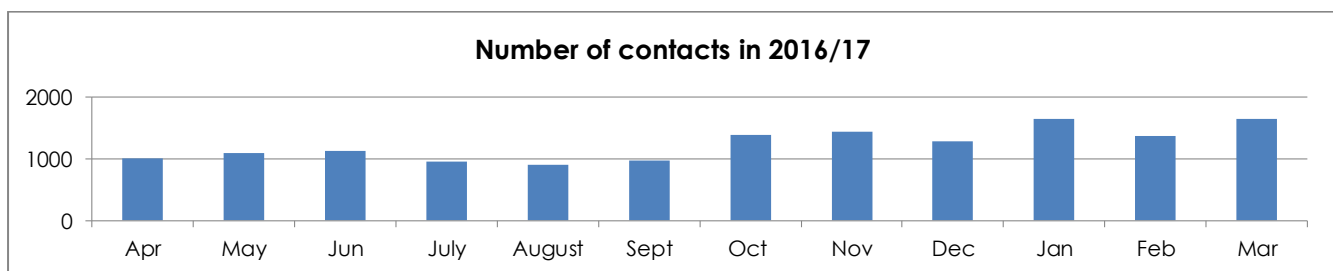
**Inspection Feedback**

**Ofsted Monitoring Visit (February 2017)**

The robust screening of contacts to children’s social care, supported by effective multi-agency information sharing, is leading to more timely assessments of need and risk. While assessment quality is beginning to improve with evidence of some good work emerging, assessments and section 47 investigations are not focused well enough on risk or children’s holistic needs. This has an impact on the quality of children’s plans and the interventions that they receive.

In 2016/17 there was a 23% increase in the volume of contacts to Children’s Social Care, 14,959 compared to 12,165 in 2015/16. This needs further analysis and interpretation, to ensure children receive services at the right level. It is anticipated that as early help services become more embedded, social care contacts will reduce.

Referral numbers to children’s social care services have been consistent with an average of 420 per month, representing a 26.6% progression rate from contact. In total there have been 5066 referrals in 2016/17, a 3% increase on the 4915 in 2015/16. If contacts reduce as anticipated going forward, the proportion progressing to referral will increase indicating better targeting of referrals.



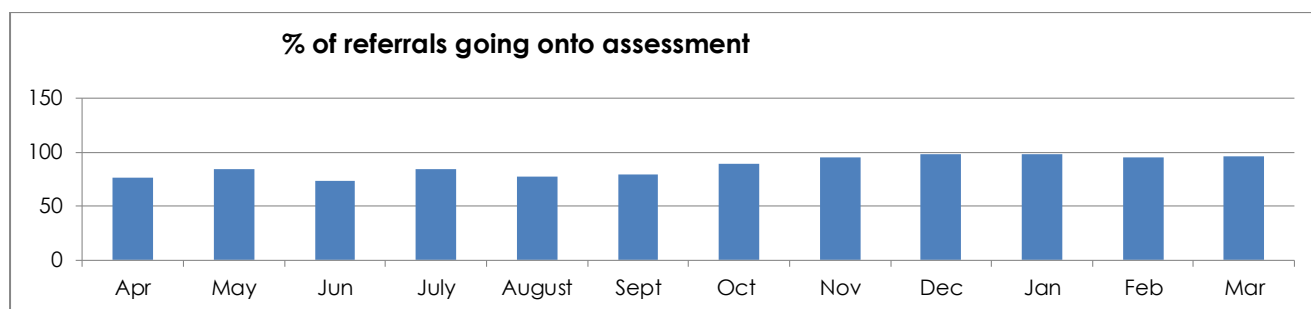
### Review of the Multi-Agency Referral Form (September 2016)

A review was commissioned and conducted by the RLSCB Practice Audit Officer to help understand what multi-agency practitioners in Rotherham think about the effectiveness of the Multi-Agency Referral Form (MARF); and to recommend any changes that need to be made to improve the effectiveness of information flow to the Rotherham Multi-Agency Safeguarding Hub (MASH). The MASH is Rotherham's single point of access where all contacts for early help and referrals for safeguarding concerns about children are dealt with. In summary, the response to the MARF was very positive:

- 75% of respondents could find the MARF online and use it
- 65% of respondents have read the procedures / guidance or have accessed them in the past
- 83% of respondents were happy with the overall layout of the MARF
- 53% of respondents thought the Agency Involvement section was fit for purpose
- On average, 73.6% of people thought the Strengthening Families assessment questions were useful and usually answered them; this rose to 92.42% for the questions about what they were concerned about.

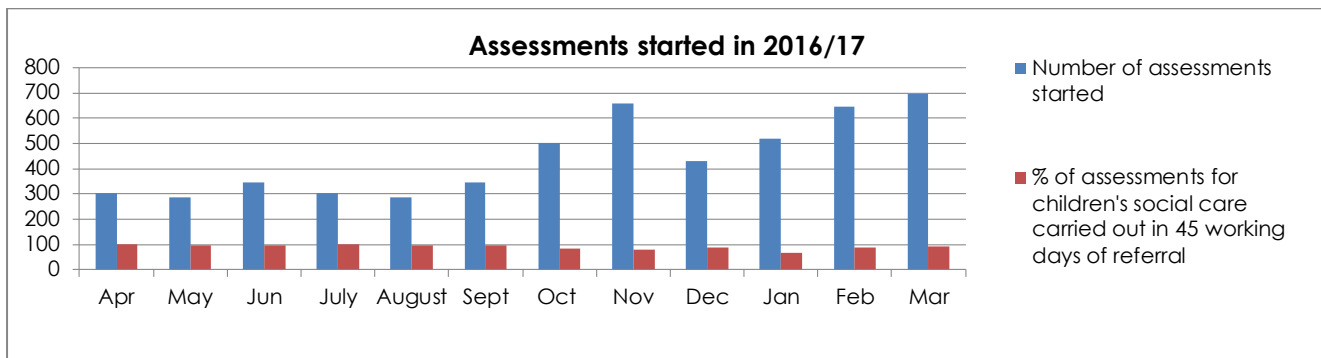
Recommendations were made and acted upon including improving the online technology to make completion of the form easier for professionals. An action for 2017/18 is to develop the referral form further to align it to the Signs of Safety framework.

The percentage of social care referrals progressing to an assessment has increased considerably to 90.0% compared to 77.6% in 2015/16. There were 5660 assessments completed in 2016/17 compared to 4064 in 2015/16 (39% increase). This indicator is now placed above the statistical and national averages and above the latest national top quartile threshold. This could be reflective of the impact of the improved screening work which is now undertaken at 'contact' stage rather than referral. The assessment resulting in 'no further action' (NFA) rate and audit outcomes will be monitored alongside this figure.



The rate of re-referrals within 12 months of last referral has seen incremental month on month reduction from the 2015/16 position of 30.7% to 27.6% for 2016/17. However this remains high when compared to the national average of 24% and the corporate plan priority target of 23% has not been met. This indicates that children's needs might not be being met in a sustained way and reinforces the findings of the CYPS audit programme on the quality of practice. RLSCB will continue to monitor the audit findings on quality of practice from Children and Young People's Services.

The overall trend of the proportion of assessments resulting in 'No Further Action' is downwards, which is indicative of the improvement in quality of decision making and application of thresholds. After a mid-year dip in performance, timeliness of assessments has improved significantly.



**A Strategy Discussion is a multi-agency meeting which considers the risks to the child and decides how the risk of harm is to be investigated and what action is needed to keep the child safe.**

**Section 47 investigations are the investigations that social workers, the police, paediatricians and other professionals carry out in order to find out whether children have suffered from or are at risk of, abuse or harm.**

### Inspection Feedback

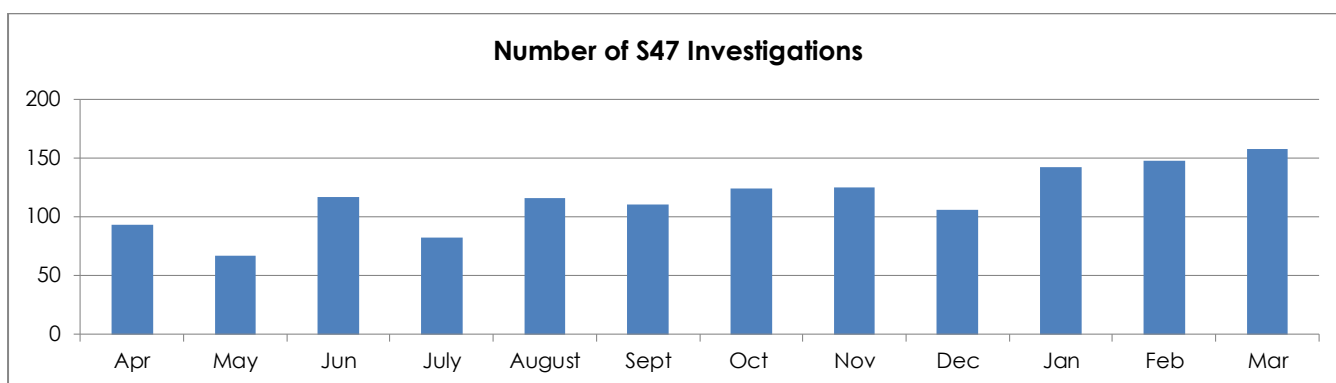
#### Ofsted Monitoring Visit (February 2017)

Children do not routinely receive an updated assessment of their holistic needs, thus their care plans do not focus well enough on the outcomes to be achieved. Risk and need are not robustly explored or understood. When child protection concerns arise, procedures are not always followed. Strategy meetings still do not routinely follow 'Working Together 2015' guidance. Screening tools to explore child sexual exploitation concerns are not being completed correctly in all cases when a child may be at risk, despite previous improvement visits identifying more robust practice in this area.

When child protection concerns are identified, a swift response to convene a strategy meeting ensures that children's immediate safeguarding needs are identified and secured. All strategy meetings are attended by South Yorkshire police (SYP) and other agencies, as appropriate, which is evidence of improvement. While the local authority has improved the recording of strategy discussions, team managers are not coordinating the timing and conduct of protective actions and the investigations required. In particular, when 'achieving best evidence' (ABE) interviews are required; South Yorkshire police are undertaking these interviews without social workers being present. Consequently, more than one agency is questioning the same child separately. Thus, the child has to tell their story more than once. Inspectors found delays in some ABE interviews taking place, thereby prolonging the investigation unnecessarily for the child and creating opportunities for the contamination or loss of evidence. There is a need for children's social care and the police to work closely together when planning investigative interviews of children, to ensure that welfare and justice imperatives are properly coordinated. South Yorkshire police responded positively to these findings during the visit and agreed to review practice with the local authority.

The numbers of Section 47 investigations undertaken in Rotherham are very high. A total of 1,428 S47's were started in the year compared to 954 in 2015/16 and the number is continuing to rise. This equates to a rate of 251.8 per 10,000 population which is significantly higher than the statistical neighbour average of 149.2. Data in relation to the outcome of Section 47 investigations shows that 55.8% of overall outcomes in 2016/17 were substantiated with a continuing risk of significant harm. Further audit and analysis is needed in this area of work to inform good shared understanding of risk.





### Evaluation of multi-agency practice relating to Strategy Discussions

During the early part of 2016 there was a growing evidence base that some basic minimum standards were not being achieved in relation to multi-agency Strategy Discussions.

This was evidenced through 3 specific processes:

- A multi-agency audit relating to strategy discussions (report considered at LSCB meeting in April 2016);
- A single agency audit completed by RMBC Children's Services in relation to section 47 investigations (including strategy discussions), considered by the Performance and Quality Sub Group in June 2016;
- A Learning Lessons Review undertaken through the case review function of the LSCB.

These processes identified similar themes with regard to multi-agency practice in the borough:

- Difficulties in relation to practical arrangements, attendance, representation and information sharing;
- Gaps in records pertaining to multi-agency decisions about levels and types of risk/need in strategy discussions;
- Plans for investigations were often not sufficient to elicit evidence / confirm or disprove initial views about the presence of significant harm;
- Lack of joint work (specifically by police and social care), and differences in timescales for investigation often led to a delay in information sharing and conclusions with regard to risk to children;
- The outcome of investigations was not always clear; the processes to conclude and complete the process were not as robust as the initial stages of the work.

It is significant that these issues are similar to those identified by OFSTED during the 2014 inspection of Children's Services indicating that insufficient progress had been made in relation to this area of practice.

### LSCB Response and Outcomes

Partner agencies have agreed to implement and sustain changes to the following standards in practice:

- Practical Arrangements and Attendance; The Role of the Chair; Information Sharing; Decisions about Risk;
- Plans for the Investigation and Joint Working; Achieving Best Evidence Interviews (ABE)

Progress is being monitored via some case sampling and meetings are held with Team Managers to reflect on practice within their teams and a further comprehensive multi-agency audit will be conducted later in 2017.

### What are we worried about?

The high number of contacts, re-referrals and S47s suggests that there is a need to improve the multi-agency understanding and application of thresholds. Given the rising number of assessments, few of which recommend no further action, there is likely to be an increase in the numbers of children receiving a social care service which may impact negatively on the service response. Despite the increasing number of assessments, timeliness has improved. Although this is

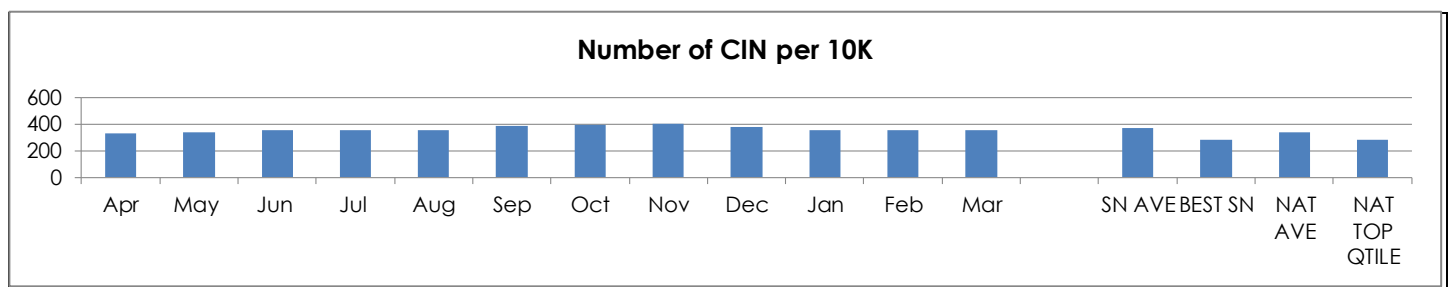
important, an emphasis on quality in Children and Young People's Services remains a priority and this will continue to be monitored and tested to ensure that the drive to improve timeliness is not at the cost of achieving best practice

## Children in Need

**A child is deemed to be a Child in Need where their needs are more complex, but they are not suffering from significant harm, and require support and intervention from a social worker and other professionals. A child with a disability is by definition a Child in Need.**

There is no good or bad performance in relation to the number of Children in Need (CIN), although it is important to monitor against statistical neighbour and national averages as numbers considerably higher or lower than average can be an indicator of other performance issues. At the end of March 2017 there were 1 656 CIN; when combined with those subject to child protection plans (CPP) this equates to a rate of 360.1 per 10k population, sustaining Rotherham's position below the statistical neighbour average (372.4) but above the national average (337.3).

At the end of 2015/16 98.6% of eligible Children in Need (CIN) had an up-to-date plan, at the end of 2016/17 this has now declined to 93.9%.



**An education, health and care (EHCP) plan is for children and young people aged up to 25 who need more support than is available through special educational needs support. EHC Plans identify educational, health and social needs and set out the additional support to meet those needs.**

All Education Health and Care Plan (EHCP) completions and conversions are measured nationally on an annual basis as a cumulative target for how many have been completed within timescale from the beginning of the SEND reform in September 2014. The monitoring of these two targets has improved dramatically recently with the fortnightly involvement of the Performance and Quality team, which has both challenged and supported the development of greater accuracy and scrutiny of data. The cumulative % for timeliness of completion for new EHCPs remains static overall at 52% but within the quarter performance has risen significantly since December 2016 where compliance and conversions of Learning Difficulty Assessments (LDAs) to EHCPs, completed by 31st December 2016, was the focus of the team. The cumulative percentage of conversions from statements to EHCPs completed in a timely manner has risen from 52% to 58%. Within the quarter, performance has been varied with a high of as much as 82% of conversions completed within 20 weeks during February 2017. Rotherham continues to have the lowest level of SEND

tribunals nationally, with one being taken beyond the mediation stage since the reforms began. The LSCB will monitor the effectiveness of EHCPs and how well children with special educational needs and disabilities are safeguarded.

#### **Children with a Disability Service audit reported to the LSCB**

The audit was undertaken during the month of November 2016 and involved a sample of 20 cases across the whole service.

From the 20 cases audited and 11 moderated, a majority of 67% were judged as Requiring Improvement or Good whilst the remaining 33% were judged to be Inadequate. There were no cases that were judged to be Outstanding or Inadequate Critical.

In general there were elements of drift and delay within case practice going back many years – but more recently it is noted that this has shown some improvement. There are elements of positive work being completed with children and in the way in which the social workers engaged with families. There was evidence of some assessments being well written, but some would have benefited from agency input and exploring the family's history more. The audit program has identified that further work is required in relation to care planning for children and the need for SMART care plans, particularly in Child in Need cases. The supervision of social workers has improved significantly in terms of regularity in recent months some but still requires some improvement .

#### **What are we worried about?**

Disabled children have additional vulnerabilities so tighter safeguarding arrangements need to be in place for this group of children. Actions have been put in place and the LSCB will monitor progress in 2017-18.

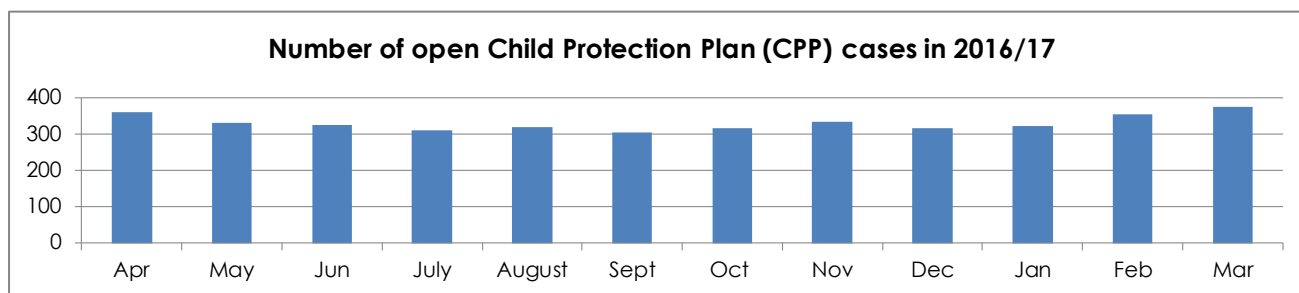
#### **Child Protection Plans**

***Children who are at risk of significant harm through abuse or neglect have a Children Protection Plan to help make sure that they are supported and kept safe. 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.***

At the end of March 2017 there were 375 children who were subject to a Child Protection Plan (CPP), which is a slight increase from March 2016 when there were 369, but a decrease from March 2015, when 433 were subject of CPP.

In the middle of last year, from June 2016 to January 2017, there had been a significant reduction to a low of 310, which was reversed in the last two months of the year with an increase of 53 children becoming subject to CPP.

The rate per 10,000 population of 65.4 is still very high when compared to statistical neighbours and the national average of 46.1 and 42.9 respectively. Further audit and analysis is needed to understand the reasons for this, to be sure that children are receiving the right level of service response.



65% of plans during the year have emotional abuse as a factor, 49% have neglect as a factor, 30% included physical abuse and 10% included sexual abuse. The total exceeds 100% because multiple categories are used.

In 2016/17, 91.4% of the total Initial Child Protection Conferences (ICPCs) were carried out within 15 days which is an improvement on last year's position of 88.3% and better than the latest statistical neighbour and national averages (85.7% and 74.7% respectively). Monthly data demonstrates that current performance is now regularly higher than 90%. The LSCB has been assured that where conferences are not meeting timescales the reasons are reported to senior managers and recorded on each case.

Performance in relation to Child Protection cases reviewed within timescales continues to be good. Of the children subject to a CPP plan at the end of the year, 98.6% of their reviews over the entire year were completed in time which is an increase on the previous year which was 94.2%. In month performance for August 2016 to March 2017 was consistently 100% each month.

At the end of March 2017 there remained only one child with a Child Protection Plan exceeding two years. This equates to 0.3% compared to 0.8% at the end of March 2016

The proportion of children who are subject to their second or subsequent plan within 24 months has been increasing month on month from 4.7% in 2015/16 to 8.4% in 2016/17 and remains higher than the target of 4%. Work continues in social care services to assess the quality of plans and to ensure that plans are only ceased when children and young people are no longer at risk or are supported appropriately at a lower level of intervention.

***Every child who has a Child Protection Plan should be visited by their social worker every two weeks (local standard).***

The percentage of children subject to a CPP who have visits in line with local standards has seen month on month decreases in performance. At the end of March 2017 this was 88.4% compared to 99% at the end of March 2016. Visits data is monitored and exceptions reviewed at the weekly children's social care performance meetings. The LSCB is assured that this is regularly monitored through the children's social care performance board which is attended by the LSCB independent chair.

### **Partnership Working and Attendance at Child Protection Conferences**

While attendees at conference are recorded within the child protection minutes, there is currently no systemic way of capturing data around attendance at meetings, other than qualitative notes. The CYPS Safeguarding Unit completed a validation exercise between September and November 2016 which confirmed that attendance by most agencies is at an appropriate level. However, a

key and ongoing discussion remains around the attendance of police at Initial Child Protection Conferences and Review Child Protection Conferences even where there are ongoing investigations. Children’s social care worked with South Yorkshire Police Vulnerable Person’s Unit (VPU) to look at this; the VPU has since reinstated an officer to compile reports and attend conferences.

Representatives from Health and Education agencies consistently attend, or send a representative or report if there are health or education issues in relation to that child. Further work is needed to ensure that all agency contributions to conference are recorded effectively and analysed, so that targeted feedback and training can be used to support good practice and challenge areas of concern.

**LSCB monitoring of the Voice of Children - Participation of Children and Young People and their families in Child Protection Conferences**

Barnardo’s Rotherham Child Protection Conference Advocacy Service provides advocacy for children and young people involved in child protection conferences to ensure they are able to influence decisions made about them and feel supported that they have an independent voice.

In the 2016/17 year they worked with 678 children aged between aged 8 and 17. The service has consistently achieved 60% of children and young people aged 8 to 17 having their voice heard and represented at their Child Protection Conference throughout the year. 67% of children aged 8 to 17 were represented and able to express their views at their Initial Conference, an increase of 7% from the previous year. The feedback (below) highlights the difference that independent advocacy is making in supporting a young person to feel engaged in the child protection process.

I told my advocate things I couldn’t tell my social worker

My advocate took me to see the chair lady person, she seemed nice and listened

It was good to have someone to write my words on paper so I did not get stuck

**Child Protection Plan escalations**

***In October 2016 a new “Challenge protocol” was implemented which placed the focus on the impact of work in achieving improved outcomes for children subject to a Child Protection Plan. The new process involves Conference Chairs completing quality and compliance documents, resolution work and escalations.***

The new process provides more information about the quality of work being completed for children with child protection plans. The majority of cases during 2016-17 were rated by the Conference Chairs as ‘requires improvement’ with a decreasing number rated as ‘inadequate’ and more cases rated as ‘good’.

The RLSCB Practice Review Group monitors all cases where a Conference Chair has raised concern about multi-agency practice in Child Protection. The Practice Review Group makes recommendations where necessary, including training for staff and changes to procedures. The RLSCB Performance and Quality Assurance Sub Group monitor the challenges on a quarterly basis through the Performance Management Framework.

**What are we worried about?**

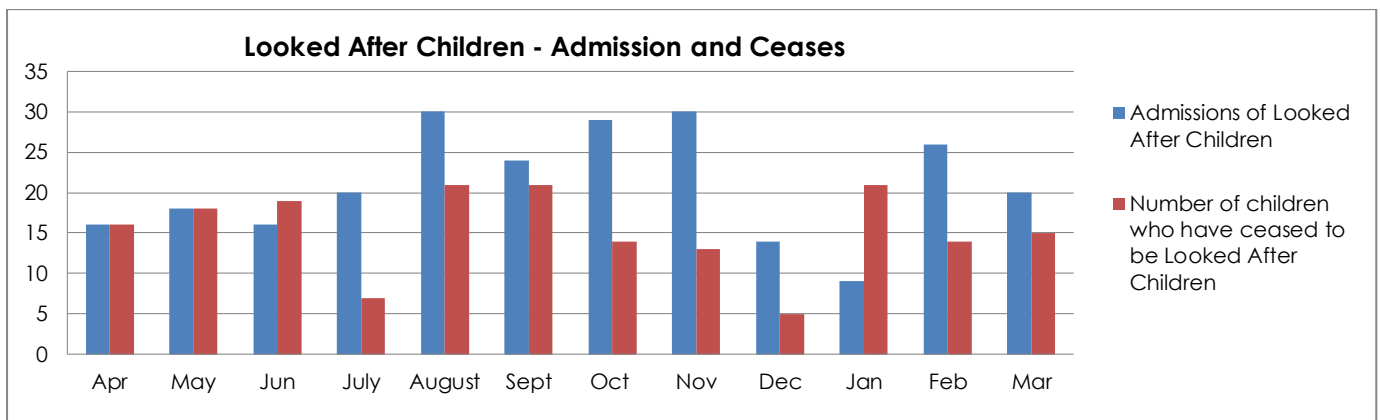
Whilst it does reflect the national picture, the increasing number of CP plans from an already high base is a cause for concern and requires further scrutiny, with more explicit application of threshold to ensure the intervention is at the correct level.

Although there is an improving picture, it remains of concern that there are CP cases judged “Inadequate”; this will be highlighted as a priority.

**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”.** Safeguarding children in care was identified as a Board priority

At the end of March 2017 there were 487 children in care which is an increase of 55 on March 2016 and equates to 86.4 per 10,000 population. This places Rotherham above statistical neighbours (75.8) and national average (60.0) and there is an upward trajectory as admissions to care continue to increase as predicted by the local authority.



It is not unusual for numbers of children in care in an authority in intervention to rise as action is taken to address 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 courts to suggest that children’s cases are being brought before them unnecessarily.

In relation to children in care, performance in LAC visits within the national minimum standards has decreased to 94.7% from last year’s outturn of 98.1%, but over the year there has been a steady rate of improvement. Visits according to more exacting local standards have improved in 2016/17 by 6.2% to 86.4% compared to 80.2% in 2015/16.



**A Review is a meeting in which the plans for a child's care are monitored by an independent person (Independent Reviewing Officer). Reviews take place at set timescales to ensure that there is no delay for the child.**

94.7% of completed LAC reviews over the entire year were completed in time, which is an improvement on the previous year's figure of 83.3%. The LSCB has been assured that the reasons for any late reviews are fed back to social care managers and action taken to address any practice issues.

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

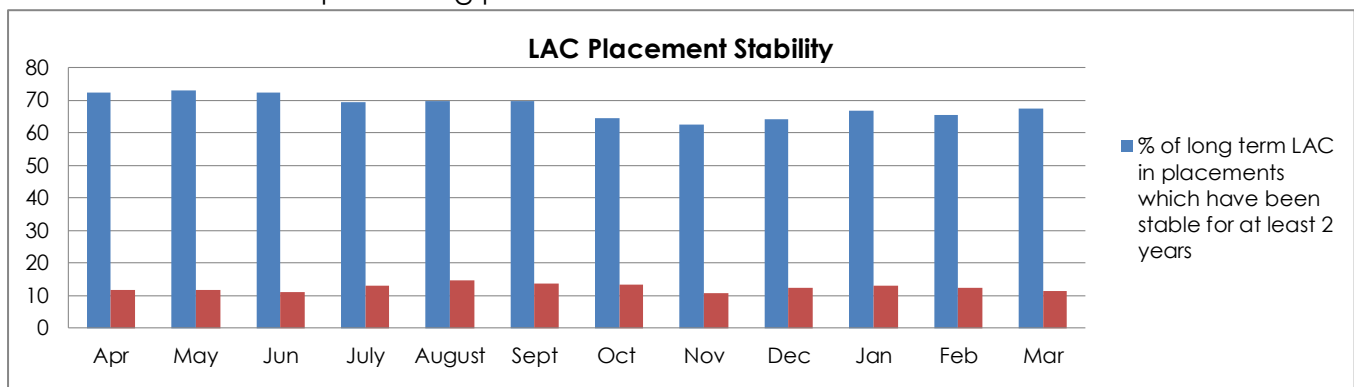
The Rotherham Placement Sufficiency Strategy 2017-20 was approved by the Corporate Parenting Panel in February 2017. The Strategy sets out the plan to increase in-house and family based care placements and the following actions have already been taken:

- Foster Carer recruitment continues to be strong, with 23 new carers approved over 2016/17 against a target of 15 and this target has been reset at 25 for each of the 3 years of the Strategy.
- A marketing post has been approved and further initiatives are being developed such as 'Refer a Friend', Virtual Assessment Team and Council Tax Discounts for Foster Carers to further support recruitment.
- The Fostering Service are working to significantly increase the support available to carers.

At the end of 2016/17, 98 of the 145 long-term LAC (67.6%) had been in the same placement for at least two years. This is only slightly below that of our statistical neighbours (68.2%) and the national average (68%), but is below the 2015/16 position of 72.7%.

Following highs of 14.7% in August, the proportion of all LAC who had three or more placements in 12 months improved and at the end of 2016/17 it stood at 11.3%. Whilst this is an improvement, the 11.9% for 2016/17 continues to be higher than all other benchmarks. The target of reducing this to less than 10% remains and is still achievable in the next financial year.

These two placement measures suggest that there is a need to improve preventative work to reduce initial placement disruption. If a child experiences a disruption they are more likely to disrupt again. It will also be important to consider the impact of the "return home programme" - to return children from out of authority placements to live in Rotherham which will increase the number of children experiencing placement moves.



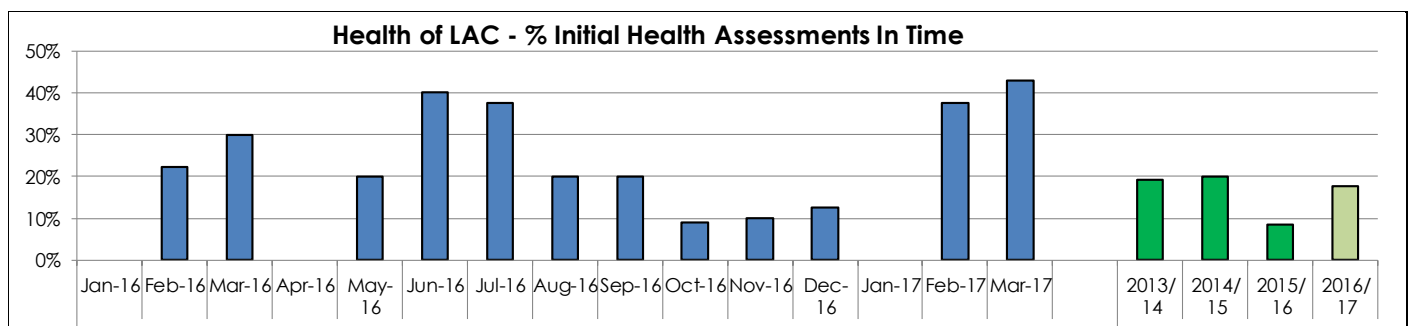
There is high level and multiagency oversight given to all out of areas placements, either residential or foster care, by the Out of Area Placement Panel chaired by the Head of Service for Children in Care. This has worked to ensure that arrangements are regularly reviewed from a strategic as well as case planning position. Every effort is made to place children in Borough or within a 20 mile radius.

RMBC is a member of the White Rose Residential Framework, a collaborative framework across the region which aims to secure high quality independent residential care for young people and to meet local demand for LAC. RMBC also has commissioned framework arrangements for standard independent fostering provision although it is sometimes necessary to source placements which are not on the framework and which may be out of area. It is a priority in the Council Plan to place children and young people within a family setting, at the end of March 2017 84.6% of children and young people were placed in a family setting which equates to 412.

***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. It has been the focus of concerted joint effort and had started to show improvement. However, performance in 2016/17 has fallen from 92.8% (2015/16) to 87.1% (2016/17) for Health Assessments and from 95% (2015/16) to 62.7% (2016/17) for Dental Assessments. Reviews show that those not having health or dental checks are the older young people who are recorded as 'refusers'. This was no longer accepted at face value and there has been active exploration with health colleagues about how the reviews can be promoted as something useful and 'young person friendly'. This will focus on the things that interest most young people such as weight, hair and skin care as well as other aspects of health, and alternative venues will be offered.

Of the **LAC Initial Health Assessments** completed in 2016/17 17.7% were within 20 working days of entering care. This is low performance but it is an improvement on the previous year's (8.4%). In-month performance shows a recent improvement of 37.5% in February 2017 and to 42.9% in March 2017 but this is still not good enough. Health colleagues have identified that early contact in a non-clinical setting may prove to be the best way to sustain young people engagement in the process. As a result they are running a pilot whereby they visit newly admitted young people in their placement to support them to attend their health assessment. Joint intervention between Health and the LAC Head of Service is in place to support locality teams to better performance in respect of Initial Health Assessments.



### **LSCB Initial Health Assessments Audit**

A multi-agency audit was conducted in April 2016 to examine the timeliness of Initial Health Assessments when a child becomes looked after. Performance was very poor with only 10.2% of Initial Health Assessments being completed with 20 working days of the child becoming Looked After. A further audit was quickly undertaken to identify the key barriers in practice.

The key practice and process areas for improvement were identified as:

- Timely notification from social care services to health of a child becoming Looked After.
- Cancelled appointments by social workers and/or carers
- Delay in producing the IHA report / health plan by Paediatricians for the first LAC Review
- Lack of effective systems to monitor, challenge and escalate from and within both organisations

Senior managers in Children's Social Care Services and The Rotherham Foundation NHS Trust agreed to make the necessary improvements and monitor progress weekly. A further audit was conducted in November 2016 and despite the increased level of scrutiny, challenge and escalation from and within partner organisations there was no evidence that the situation improved. The outturn for 2016/17 was 17.7% within timescale with some evidence of better Performance for February and March 2017 but this remains a priority area for improvement, scrutiny and challenge.

### **Children in care are entitled to a Personal Education Plans (PEP) to support their education.**

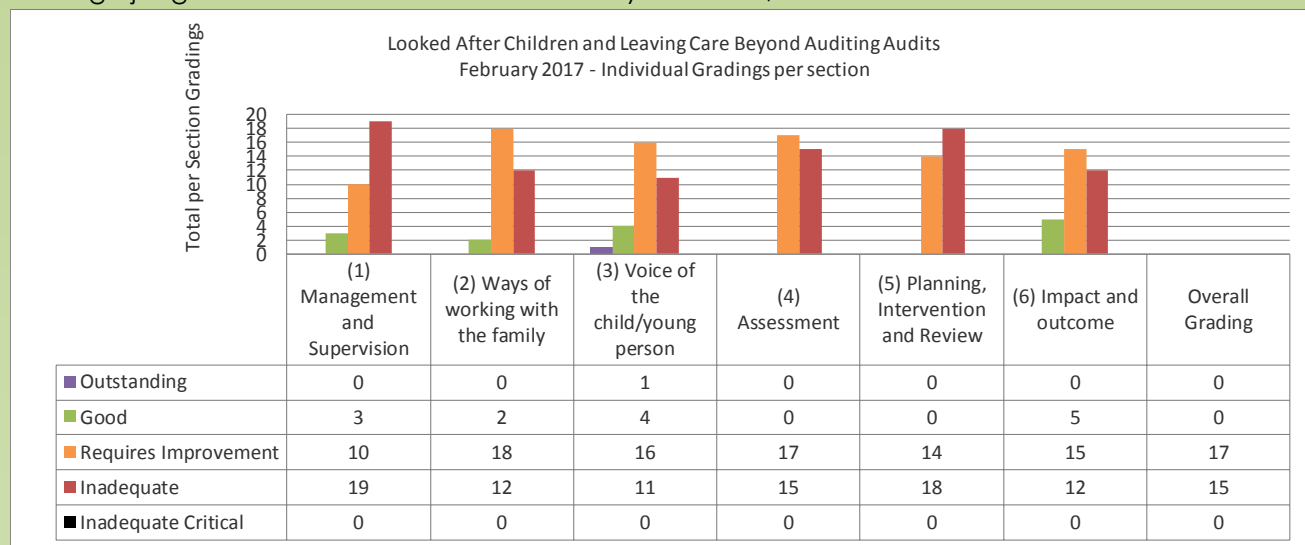
In 2016/17 the virtual school introduced a new standard for timeliness. Rather than annual PEPs with 6 monthly reviews it is now expected that every child will have an updated PEP every school term. Therefore caution should be taken when comparing performance against previous years. The proportion of children with an up-to-date PEP was 87.9% at the end of March 2017. This is lower than expected; a solution has been put in place to rectify this and performance should begin to increase in 2017/18. The focus is now shifting to quality in order to address the numbers of children and young people in care who are not in full time education and those whose school place is known to be fragile. The virtual school governing body will take responsibility for driving this improvement area. Exception reporting has been provided for the children who are without an up to date PEP.

### **Children who leave care after a period of time are entitled to ongoing support**

The number of care leavers has increased in the last 12 months from 197 at March 2016 to 223 young people at the end of March 2017. Pathway plans for care leavers have seen a further 2% improvement to 99.3% when compared to last year's outturn of 97.5%. A total of 96.9% of these young people are in suitable accommodation, a slight increase on the previous year of 96.5%, and is still above the statistical neighbour and national averages. This equates to seven young people not in suitable accommodation, of these six are in custody, and one (aged over 18) has made himself intentionally homeless. A total of 63.2% of young people are in education employment or training, above the national average (48%) but a drop on the previous year of 68.0% and disappointing in terms of the aspirations for Rotherham young people. This equates to 60 care leavers not being in education, employment or training (NEET).

**Audit reported to the LSCB - What does audit tell us about services for Looked After Children and Care leavers?**

Children and Young People's Services undertook a single agency audit on 32 children's cases held in the LAC and Care Leaver Service between February and March 2017. The audit process made findings in the six outcome areas with an overall judgment regarding practice in the case. The average judgments for the service are set out by outcome, below.



The findings evidence that audited performance is demonstrably different in the LAC Teams compared to the Leaving Care Teams. Overall the audited judgements reflect deterioration in Good and Requires Improvement judgements within the LAC Teams; conversely, audited judgements reflect an improvement within the Leaving Care Service in comparison with the judgements from June 2016.

**Permanence arrangements for children in care**

Most children in care will return to their families. The percentage of LAC who have ceased to be looked after across the year due to other forms of permanence (special guardianship orders, adoption, residence order) in 2016/17 was 27.2% compared to the 2015/16 outturn of 40.1%.

The percentage of children in care who were adopted currently stands at 14.4% for 2016/17 compared with a target of 22.7% and 22.9% in 2015/16. This equates to 31 adoptions in the current year compared to 43 in 2015/16. 38.7% of these were made within 12 months of the decision that the child 'Should Be Placed for Adoption' which is low when compared to previous years at 53.5%. In respect of 'Average number of days between child becoming LAC and having an adoption placement' Rotherham is performing well with a reduction from an average of 661 days in 2013/14 to 404 in 2016/17. Similarly for 'Average number of days between placement order and being matched with adoptive family (A2)' it has reduced from an average of 315 days in 2013/14 to 232.9 in 2016/17; however this is an increase on 2015/16 (136 days).

## What are we worried about?

The main concern for children in care is around how well their health and educational needs are being met; although there has been progress this will remain a priority for the Board. The Local Authority audit also suggests the quality of social work support to the children and their families is not good enough, and improvement work is in place.

See also "Missing children"

## Social care capacity & caseloads

Although, as demonstrated above, there has been an increase in demand across the service, the average number of cases across the key safeguarding teams has been consistent throughout the year and has been below the target of 22, ranging from 13.3 to 18.3 across the teams. Average number of cases held by LAC social workers was 11.6. Ensuring that social workers have manageable caseloads was a key priority for Rotherham and the current performance is testimony to what has been achieved in this regard.

The average caseload of key safeguarding teams continues to be monitored for every social worker in detail. All those over 22 are examined and the reasons explained. For example, some senior social workers have students allocated to them and the student caseload shows under the supervisor's name.

## Children in specific circumstances

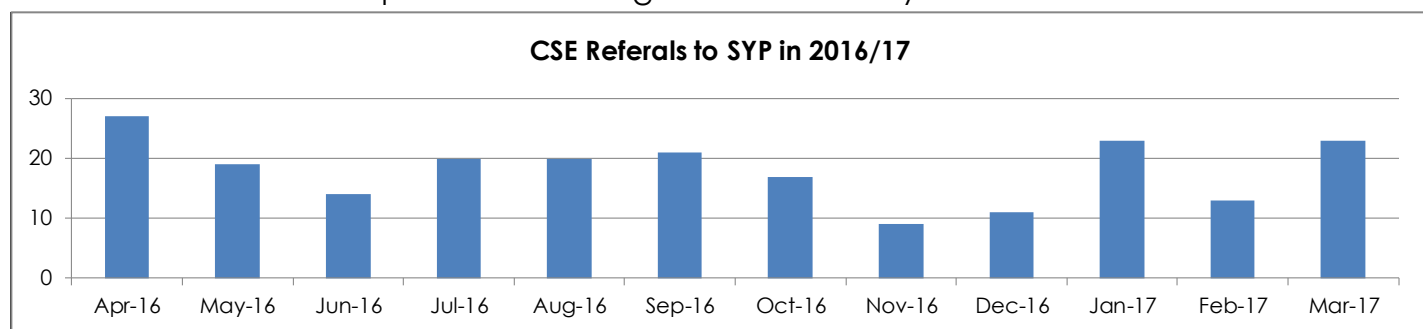
### Child Sexual Exploitation (CSE) Improvement in this area was identified as a Board priority

CSE has been very high profile in Rotherham, especially since the Jay report in 2014 which revealed a number of areas of shortfall. Since then there has been a significant amount of work across the partnership to improve responses to children and ensure they are being protected from CSE. The partnership has developed a comprehensive strategy to address the problem of CSE in the Borough, involving:

- Prevention of CSE in the community,
- Protection of children at risk,
- Pursuing & prosecuting perpetrators,
- Providing support for victims,
- Promoting participation by young people

The number of new referrals to social care where CSE is the presenting issue has seen an increase from 200 in 2015/16 to 231 in 2016/17. This increase may not be indicative of an increasing risk profile but instead reflective of improved identification and awareness in agencies and greater public confidence in local services in tackling CSE. During 2016/7 there were 17 convictions for Child Sexual Exploitation. There were 327 referrals to the Post Abuse Support Services.

South Yorkshire Police report the following referrals for the year:



This table shows the result of offences finalised - April 2016 to March 2017 as extracted April 2017 (SYP)

| District         | Charged/<br>Summons<br>(Various) | Cautions<br>(Various) | Further<br>Action by<br>Another<br>agency | Named Suspect,<br>Evidential<br>Difficulties (Police<br>Decision) | Named Suspect,<br>Evidential<br>Difficulties (CPS<br>Decision) | Named Suspect,<br>Evidential – Victim<br>does not support<br>Police Action | No suspect<br>identified –<br>Investigation<br>Complete | Other    | Total     |
|------------------|----------------------------------|-----------------------|---|---|--|--|---|----------|-----------|
| Doncaster        | 5                                | 1                     | 2   | 10  | 3  | 2  | 5   | 1        | 29        |
| Barnsley         | 4                                | 1                     |   | 9   |  | 5  | 7   | 7        | 33        |
| <b>Rotherham</b> | <b>18</b>                        | <b>3</b>              | <b>5</b>                                  | <b>24</b>   | <b>9</b>   | <b>12</b>  | <b>18</b>   | <b>8</b> | <b>97</b> |
| Sheffield        | 11                               |                       | 15  | 12  | 1  | 8  | 3   | 6        | 56        |

These are outcomes recorded within the period detailed and not necessarily cases recorded or committed within the same period. Decisions in relation to outcomes are made taking into



consideration the evidence available, the views and needs of the victim and the wider public interest. This data excludes the reports of non-recent offences being managed on a multi-agency basis through Operation Stovewood.

Operation Stovewood is an independent investigation conducted by the National Crime Agency (NCA), into non-familial child sexual exploitation and abuse (CSEA) in Rotherham between 1997 and 2013. It is the single largest law enforcement investigation into non-familial CSEA in the UK. It is a unique and unprecedented investigation, and challenging in its scale and complexity.

The three main strategic objectives of Op Stovewood are to:

- Deliver a victim-focused investigation, working appropriately with other agencies to provide the best possible support and advice for individuals;
- Seek to identify and bring all offenders to justice, prioritising those who may still be active in Rotherham or elsewhere today and those who have caused most harm in the past; and
- Work with local partners and communities to rebuild public confidence in agencies

The National Crime Agency (NCA) is working with partners, including South Yorkshire Police (SYP), Rotherham Metropolitan Borough Council (RMBC), Rotherham NHS Foundation Trust, Rotherham Clinical Commissioning Group, Rotherham, Doncaster and South Humber NHS Trust (RDaSH) and other statutory and voluntary groups, to ensure those who have committed non-familial CSEA in Rotherham (between 1997-2013) are held to account and brought to justice.

Operation Stovewood is currently overseeing 36 major crime investigations, with over 17,000 lines of enquiry. There are now 88 designated suspects, with 30 persons arrested and 21 charged to date. It is anticipated that many more arrests will follow as the investigations progress. The Senior Investigating Officer is Paul Williamson, and he is determined, with his team, to identify and bring all offenders to justice.

Significant work has been done to improve the quality of multi-agency practice in the specialist CSE team (Evolve) as shown in audit outcomes. A multi-agency Governance Group is now in place for the team and is establishing the means to collectively oversee the quality, nature and impact of their work. In early 2017 the operating guidance for the Evolve Team was further developed and amended. Social Workers in the team do not 'key work' cases but co-work cases alongside the child's main key worker providing specific support and guidance in reducing the risk of CSE and engaging and supporting the child through any prosecution processes where appropriate. This offers a more holistic approach for the child whilst ensuring the specific CSE risks are addressed. Police officers in the team manage the investigations.

RMBC commissioned services have regular access to liaison, advice and clinical consultation around emotional development and mental health for those affected by CSE. Rotherham, Doncaster and South Humber NHS Trust (RDaSH), who provide Rotherham mental health services, have CSE pathway clinicians who are available to all levels of organisations in developing family based trauma informed services, both in order to address the varied needs of those affected by CSE across the lifespan and to support the workforce in managing the emotional impact of such work.

All elements of work relating to CSE is routinely scrutinised by the RLSCB through the CSE Strategic Sub Group.

The CSE and Missing sub group has continued to meet bi monthly and has good attendance from a broad range of partners. The sub group has the following work streams in support of the Safeguarding Board CSE strategy – ‘The Way Forward 2015 – 2018:

- Multi Agency Communications in relation to CSE to enable the public of ‘Spot The Signs’ of CSE and have confidence in the partnerships response.
- Intelligence submissions to enable a better understanding of the scale and nature of CSE locally
- Performance monitoring; Organisational learning and reflective practice
- Scrutiny and challenge to the partnership response to missing children
- Supporting all communities affected by CSE and specifically the ROMA, Pakistani heritage and LGBT communities

Key achievements include:

- Initiating awareness campaigns on public transport and over the school summer holiday period.
- Sponsorship of a project to increase the volume of information submitted by professionals to South Yorkshire Police. Rotherham is the first partnership in the country to go live with a mobile phone APP which provides trusted professionals with the ability to submit information speedily and effectively to the Police.
- Production of a benchmarking document incorporating the recommendations from all the local CSE related reviews conducted during 2016 and this been adopted jointly by the Children's and Adults Safeguarding Boards. This document ensures that local recommendations are captured in one place and reflects the needs of young people transiting from children to adult services.
- The response to missing children has been subject to significant scrutiny and the operational and governance structures amended to improve practice.
- A mapping and assurance exercise was conducted in terms of understanding the response to specific LGBT community needs. The response to the Roma community has been subject to a bespoke review and the recommendations form part of the benchmarking document. A number of initiatives explored to engage with the Pakistani heritage community; specifically supporting projects where community members seek to support the families of individuals accused of CSE and raise the awareness of CSE within all BME communities.
- The sub group has agreed a series of key performance indicators to assist in providing scrutiny and challenge to the partnership.

The partnership has commissioned and provided a number of preventative initiatives, including:

## **Barnardo's ReachOut**

ReachOut has received referrals for 1:1 support for over 200 vulnerable children; typically children referred to the service are struggling with a number of issues indicating increased vulnerability to a range of poor outcomes including sexual exploitation but the rationale for the request for service from ReachOut is commonly due to concerns around inappropriate/unsafe relationships, online safety and image sharing. Inevitably as the work progresses additional vulnerabilities are often identified. Of those referred 68% continue to be aged 11-15yrs but the service is receiving an increasing number of enquiries from primary schools concerned about children's online safety and their access to pornography. Our referrals are received from a range of partners but Early Help and Children's Social Care referred 32% and 34% respectively from 1st January to 30th June 2017 with 13% of referrals being received from Schools

The service has worked with 19 boys and 20 children from BME communities; 28 children are recorded as having an identifiable disability including 15 with a learning disability and 5 assessed as having an autistic spectrum disorder. The year ahead will focus on increasing the number of self-referrals, referrals from boys, from those identifying as LGBTQ and children from BME communities particularly Pakistani heritage families.

### **Understanding the Sexual Exploitation of children & young people**

The University of Bedfordshire provided Barnardo's ReachOut service and other Rotherham workers with the opportunity to participate in a five day course which identified current academic debates within the field of CSE and explored the implications for policy and practice in the UK. The majority of staff participated in the course and everyone was given the opportunity to gain accreditations towards an MA by completing a written assessment. The aims of the course were:

- To increase students' understanding of, and ability to effectively engage with the issue of child sexual exploitation.
- To identify current academic debates within the field and explore the implications for policy and practice within the UK.
- To critically engage with the complexities of safeguarding young people who may not see themselves as victims of abuse
- To explore and understand the challenges associated with the merging of the online and offline worlds and other key contextual factors.

Participants reported that they appreciated the opportunity to reflect on how to incorporate current theory into existing and developing practice of the service. The LSCB will evaluate the impact of this training through the Learning and Improvement sub group.

### **Evaluation of Theatre in Education Tour - Working For Marcus on Child Sexual Exploitation Awareness in Rotherham Secondary Schools Academic Year 2016-2017**

Working for Marcus is a child sexual exploitation prevention programme. It helps learners to understand how to spot the signs of grooming and abuse of power and control in relationships. The programme explores online safety, consent and where to go for support. This was the second year that funding for the Working for Marcus programme was offered to secondary schools. The tour was funded by Rotherham Metropolitan Borough Council (MBC) and Rotherham Clinical Commissioning Group (CCG) as part of a preventive strategy.

Loudmouth ran a total of 12 sessions, in 11 different mainstream secondary schools, of Working for Marcus, in a choice of two formats depending on the schools' requirements. They worked with 2,395 young people aged 13 to 16 years old.

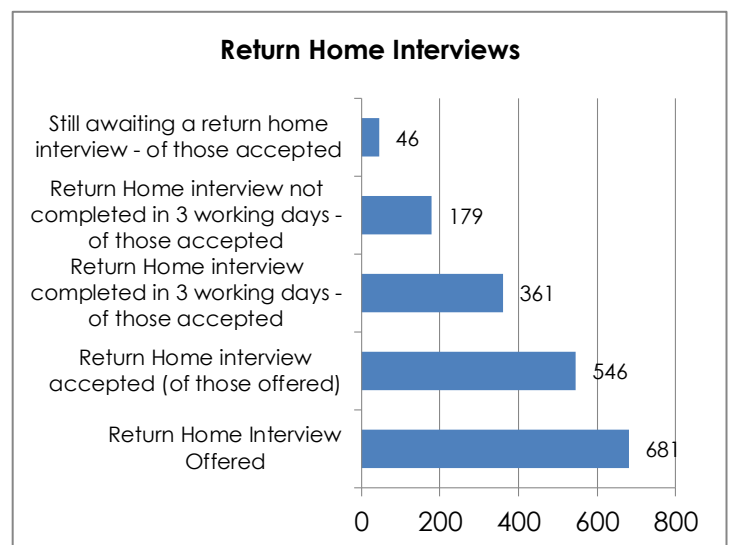
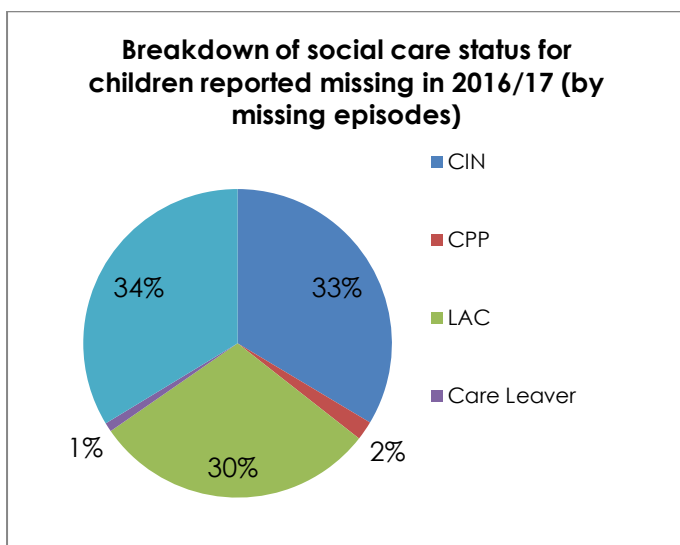
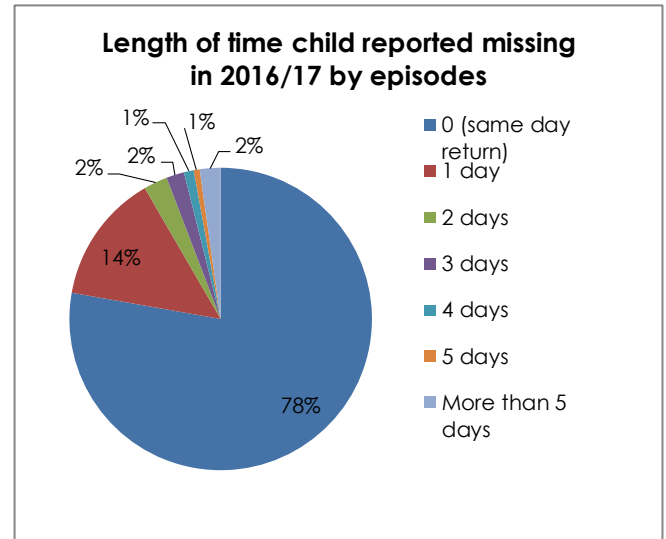
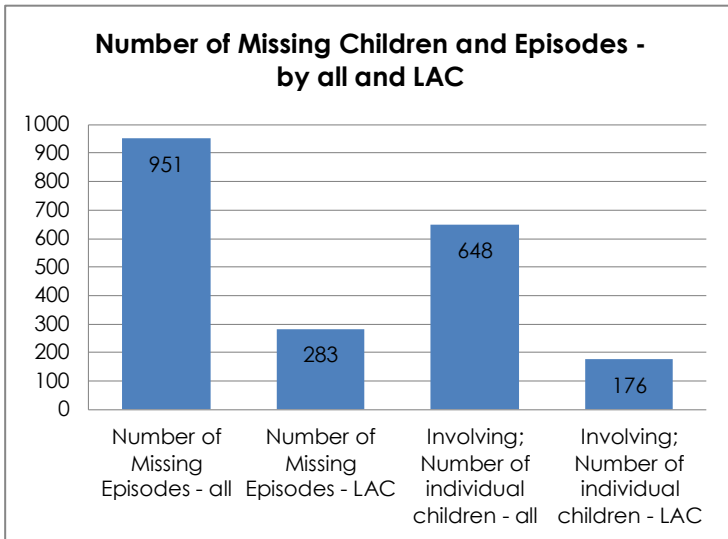
After participating in the Working for Marcus programme, 89% of students stated that they knew 'Quite a lot' or 'Loads' about sexual exploitation and grooming. This is a rise from 32% before the sessions. As a result of the session, 94% of students were able to identify a series of scenarios where clear consent was NOT given. This was an increase from 80% before the sessions. 96% of students recorded that after participating they felt 'Very confident' or 'Confident' about spotting the signs of sexual exploitation and grooming, a rise from 60% before the sessions. 91% of students stated they would think or act differently. The main ways they stated were to be more careful online especially in terms of who they talk to and to be able to identify the signs of grooming.

All staff stated that after participating in the Working for Marcus programme their groups' knowledge of the issue had increased and 59% of staff stated that being involved in Working For Marcus had increased their own confidence in teaching the issues covered.

## Children and Young People who go 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)*

A significant number of children living with their families and in care are reported as going missing every year (see below).



#### Inspection feedback

##### PEEL: Police effectiveness 2016

South Yorkshire Police has maintained and improved performance in some areas since HMIC's 2015 effectiveness (vulnerability) inspection. The force has maintained its understanding and response to missing and absent children, and improved the way in which it risk-assesses and grades calls for service from those who are vulnerable, especially domestic abuse victims.

### **The Missing Children Strategic Oversight Group (“Strategic Missing Group”)**

The Strategic Missing Group is the multi-agency group which meets to oversee implementation of the partnership processes and practice which support children and young people when they go missing from home, school or care. The aim of the group is to reduce the frequency and likelihood of young people who go missing from school or where they live in Rotherham; this includes ensuring cross referencing of children with risk indicators such as children on reduced school timetables in order to understand the profile across the town and subsequently improve services. A task and finish group has also been established to consider the vulnerabilities of children who are electively home educated (schooled at home) and further work is underway to ensure that Looked After Children placed out of Rotherham receive a better service.

The group commissioned an audit to better understand the issues surrounding children and young people who go missing, the findings of which is reported below.

The impact of this audit on practice will be monitored through future reports to the LSCB.

The audit highlighted a range of practice issues around how agencies can work together more effectively, sharing information and escalating concerns. It also identified young people at increased risk, such as those new to the area, those with mental health difficulties or recent crises, and found examples of where parents exhibited disguised compliance with agencies.

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

### **Inspection Feedback**

#### **Ofsted Monitoring Visit – October 2016**

The number of children who go missing from care has reduced significantly in the last six months and an increased number of children receive a return home interview. However, this is not the case for children who live out of borough.

LSCB partners have worked together to improve the multi-agency response to children who go missing. This has included:

- The appointment of a Missing Person coordinator and Return Home Interview support workers
- The Missing Team are located in the MASH 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 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.
- ‘Trigger Plans’ for all young people who have gone missing or are vulnerable to going missing.
- The Council has signed up to the National Runaways Charter.

**Neglect** Improvement in this area was identified as a Board priority

Neglect is the main issue for 88% of children in need with social care involvement, and 50% of child protection plans started this year are due or partially due to neglect. Learning reviews and audits over recent years have identified neglect as a significant concern and have highlighted gaps in the multi-agency response to neglected children. The Board has highlighted this as an area for development and work has been undertaken to develop a strategy to address neglect in this area (since completed). This work will be taken forward in 2017/18.

Neglect is often associated with parental difficulties, and particularly the “Toxic Trio” of domestic violence, mental ill health and substance misuse. The latter two are identified for further focus, including the adoption of a “Think Family” approach to ensure the needs of children are taken into account where parents and other adult household members experience these difficulties.

## Domestic Abuse

*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.*

The Police receive high volumes of referrals for domestic violence, many of which are in households which include children and many of which are categorised as medium or high risk; these children are all potentially in need or at risk of harm. Domestic abuse is a feature within the family for 70% of Rotherham children who are subject to a Child Protection Plan.

| Indicator – 2016/2017   | Number or % of cases |
|---|----------------------|
| Number of all domestic abuse incidents reported to South Yorkshire Police | 6297                 |
| Number of MARAC cases with children involved                              | 204                  |
| Number of repeat referrals to MARAC with children involved                | 66                   |

### Inspection feedback

#### PEEL: Police effectiveness 2016

In the 12 months to 30 June 2016, South Yorkshire Police's use of outcomes for domestic abuse flagged offences was in line with those in England and Wales as a whole. However, any interpretation of outcomes should take into account that outcomes will vary dependent on the crime types that occur in each force area, and how it deals with offenders for different crimes.

South Yorkshire Police is inconsistent in the way that it responds to victims of domestic abuse. HMIC has some concerns over the service that the force provides to victims, particularly vulnerable adults. The force has specialist investigators in place to deal with the highest-risk and more complex cases. However, we found that they had high levels of workload and some have yet to complete specialist training. The threshold the force has for allocation of specialist detectives to work on high-risk investigations is very high.

Officers are generally taking positive action when attending crime scenes and the arrest rate for domestic abuse is in line with the England and Wales rate. The force has a higher charge rate for domestic abuse than for England and Wales as a whole. The force has developed a domestic abuse action plan and is in the process of allocating and implementing those recommendations.



### **Longitudinal multi-agency Domestic Abuse audit (April 2016)**

In September 2015, a strengthened daily triage system was put in place in the Multi-Agency Safeguarding Hub (MASH) to deal with incidents of domestic abuse reported from the night before or weekend. An audit was undertaken by the RLSCB Practice Audit Officer in April 2016 to evaluate whether the new process was improving outcomes for children and young people who experience domestic abuse. A cohort of 50 cases was examined and then re-audited in August 2016 to consider the effectiveness of the original decision-making. The audit will be conducted again in 2017 to consider the longitudinal impact.

#### **What was Working Well?**

There was evidence to say that the police are responding to incidents of domestic abuse and sending the notification through to MASH in a timely way with an appropriate risk assessment; and that the MASH social workers were effectively screening the information and calling for additional multi-agency information where required. There is also evidence of management oversight of decision-making and appropriate risk management. The process appears to be particularly successful in drawing together the multi-agency information quickly and accurately and developing a safety plan for the victim and children.

Implementation of the Operation Encompass practice will enhance the effectiveness of the MADA for the children who will be in school following an incident of domestic abuse.

#### **What are we worried about?**

The vast majority of the concern remains for children who were ineffectively dealt with historically. There is still some concern about the decision-making and application of thresholds after the referral leaves the MASH for the duty team to progress to assessment.

#### **What are we going to do about it?**

Draft recommendations include the need to embed the Operation Encompass principles, review of the LSCB Domestic Abuse procedure and training offer; more work on the understanding the voice of children who experience domestic abuse; more liaison between agencies under the auspices of the Safer Rotherham Partnership and Domestic Abuse Steering Group; and further audits to be planned for 2017.

## 6 Learning and Improvement Framework

*The role of the LSCB is to ensure the effectiveness of organisations individually and collectively to safeguard and promote the welfare of children. To achieve this there should be a culture of continuous improvement across the partnership.* Improvement in this area was identified as a Board priority

For Rotherham LSCB, the Learning and Improvement Framework is delivered through five mechanisms:

- The Performance & Quality Sub Group focusses on quality assurance through performance management and auditing, mainly at an aggregated level of information; this includes S11 & S175 audits / self-assessments.
- The Practice Review Group focuses on learning from individual cases;
- The Serious Case Review (SCR) Sub Group considers and monitors cases which meet the statutory criteria for a Serious Case Review;
- The Child Death Overview Panel (CDOP) considers learning from all child deaths in Rotherham;
- The Learning and Improvement Subgroup draws the learning points from all reviews and oversees the changes to safeguarding policies and procedures, commissioning of safeguarding training and monitoring improvement actions.

### Performance & Quality Assurance

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

The Performance and Quality Assurance Sub Group meets on a six weekly cycle, with 8 meetings held per year. The meetings focus alternatively on performance management and auditing. The Sub group utilises quantitative and qualitative methodologies to provide an accurate position in relation to aspects of safeguarding children. The quarterly Performance Management Framework (PMF) Reports are scrutinised; these reports are compiled of information supplied by statutory and voluntary sector agencies to demonstrate the effectiveness of their services in relation to safeguarding children in Rotherham.

There is a programme of auditing by the Board team (see below) and partners also submit relevant internal audits for consideration at this sub-group.

#### **Multi-agency audits completed by RLSCB in 2016/17**

Looked after children – Timeliness of initial health assessments  
 Early Help – workforce survey to show understanding of the service and thresholds  
 Thresholds and MASH – implementation and impact of multi-agency referral form  
 Missing children – compliance and effectiveness of assessment & intervention  
 CSE – thematic review of service response and assessment

A report is then written by the Sub Group Chair detailing the key issues and messages for the LSCB, partner agencies and other sub groups (including action taken)

**Quarterly LSCB Performance Management Framework Report**

The report provides information to answer:

- 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?

By using:

- Quantitative data which compares where possible other authorities (statistical neighbours; region; Best Performing Local Authorities and LSCBS, and monitors over time, tracking trends
- Qualitative data - strategic and case file audits, inspection reports, evaluation from training / procedures
- Feedback from children and young people
- Feedback from frontline professionals to improve understanding of workforce perspectives
- Feedback from single agency perspectives triangulated with feedback from other agencies and external processes

Some examples of issues raised in the Subgroup include:

The Sub Group identified and monitored the following practice issues:

Improved performance:

- Assessments completed to timescale.
- Initial Child Protection Conferences taking place within 15 working days.

Areas for further improvement:

- LAC visits and Initial Health Assessments
- Reviews
- Three or more placement moves
- Care leavers engaging in education, employment or training.

**Safeguarding in Emergency Department(ED) of TRFT**

An issue of significant risk was identified within the Emergency Department of TRFT - safeguarding incidents were not being recognised by staff. Members of the Sub Group volunteered to sit in the ED to review case files and offer support to staff. Support and training are now in place, and progress is being monitored through performance meetings. It was agreed that the issue would be escalated to the Board if the intensive four week turnaround process did not have a satisfactory outcome. This was not necessary and the issue continues to be monitored through the P&QA Sub Group

The timeliness of social work **single assessment** was identified an issue of concern. Figures may have been affected by legacy issues from practice and the IT system. There were concerns about the high level of assessments ending in no further action, so the Service Manager for CYPS Duty & Assessment Team performed a regular dip sample and refers any concerns to the management group; the numbers referred in this way have been small.

**Early Help Assessments**

completed by partners – Early Help Steering Group has agreed to develop a universally accepted assessment form that might increase the number of assessments that are undertaken by partner agencies, which only comprise 6.4% of the total.

The **Initial Health Assessments** for children who become looked after was an issue identified through this Subgroup. An audit was requested and a task and finish group commissioned. More information about the process and impact can be found in the Looked after Children – Health section of this report.

## Section 11 & 175 Audits 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 to ensure that they have arrangements in place to safeguard and promote the welfare of children.

| 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)        |

S11 Audit discussion at the Performance & Quality assurance Sub Group has focussed on the need to capture the voice of the child. There is a plan for young people to have involvement at board level. The voluntary community sector has convened a group to focus on the child's voice, and guidance has been produced as to how organisations can embed this in their practice.

Bi-annually all statutory partners undertake a self-assessment to determine how well they are safeguarding children and young people and promoting their welfare. The 2015/16 audit was completed by 11 statutory agencies. The aim of a Section 11 self-assessment is to provide the Board with reassurance that organisations have good structures and processes in place to safeguard children. It provides a benchmark of current performance to enable organisations to monitor progress and quantify improvement in safeguarding practice over time.

**Section 11 Audit Reports:** All agencies submitted action plans which were reviewed through the Subgroup. The findings were included in a report that was presented to the Board in June 2016, with appropriate recommendations. The sub group supported the suggestion that Section 11 should be built into an online audit tool for future use.

Between the 9<sup>th</sup> and 16<sup>th</sup> February 2016 three challenge days were held and it was positive that all organisations who had submitted a completed audit attended a challenge meeting. The challenge meetings were pivotal in gaining a greater understanding of where organisations felt they were in terms of their safeguarding arrangements

There were many areas of good practice and evidence of a strong commitment to safeguarding. The following were identified as areas for improvement across the eight individual standards:

- 1) Organisations do not always provide enough evidence through either 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; 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 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.

All organisations have action plans to fulfil any gaps identified in their Section 11 self-assessment, and the majority were analytical and open. These have been reviewed by the Performance and Quality Assurance Sub Group held in March and May 2016. Subsequent monitoring has shown improvement; For example, the Rotherham Council Corporate self-assessment evidenced positive improvement that has taken place to embed safeguarding across the spectrum of selection and recruitment, most significantly around the monitoring of DBS checks. Also, promotional work has taken place around raising awareness of broader safeguarding issues and the differences to CSE, and focused work towards a ‘child friendly Rotherham’, most significantly young people having the chance to have their voice heard and to influence decision making. Some examples include engagement and participation by young people with Schools meals policy (Housing), Town Centre ‘Master Plan’, Library Strategy, Mind Matters website (Health).

Schools are expected to complete the S175 self-assessment which is available on-line; 127 schools / education settings registered to do this. The progress towards completion of the self-assessment tool included 39% of schools/education settings that have completed 90-100% of the entire self-assessment with a further 32% having completed over half by 31/3/17; this has subsequently improved to 67% completed.

It was evident from 2015-17 Section 11 self-assessment process that the involvement of peer reviewers was seen to be a significant positive development that added value to the process. This development will be built on and an annual rolling programme of section 11 supportive peer reviews will be co-ordinated by the LSCB Board Members and Business Unit. The peer review process will also be extended to schools.

This will also see members visiting partner organisations to:

- Explore key areas within partners’ self-assessment and review the evidence partners used to reach their own judgement
- Speak to front line practitioners and senior managers to ensure that safeguarding responsibilities are embedded and understood through the organisation.

A simplified Section 11 for voluntary organisations is under development and the self-assessment tool will be available online, enabling a dynamic assessment of organisational safeguarding children arrangements. This will serve to keep safeguarding children as an organisational priority and will promote the gathering of evidence to support the S11 standards and identify areas for improvements with more efficacy than a biennial audit.

### **Practice Review**

The Practice Review Group considers specific cases that are referred to the group where there has been cause for concern in terms of the safeguarding of a child from significant harm where there is, or has been multi-agency involvement, but where the criteria for an SCR have clearly not been met. The Group also reviews cases where formal dissent relating to the outcome of a Child

Protection Conference is submitted in writing by a professional or agency represented at the conference; or where the Child Protection Conference Chair has concerns about multi-agency thresholds or practice.

The Group evaluates other aspects of multi-agency work across the continuum of need that give rise for concern or are recognised as good or outstanding practice. The methodology for each learning review is determined by the circumstances of the case and agreed by the group, but can range from a desktop review, a small learning event with agencies involved in a case, to a large scale multi-agency challenge event. In 2016/2017 The Practice Review Group met on 6 occasions through the year. Multi-agency membership is comprised of Health (CCG & Providers), Early Help, Voluntary sector, Education, RLSCB business unit, Social Care, and police as required.

Six cases met the criteria for multi-agency learning lessons. A variety of methods were used, including desk top reviews and practitioner events. All cases had reports submitted to the Performance and Quality sub-group with recommendations and appropriate actions subsequently taken, eg:

- Refresher training at the Hospital A&E
- Review of procedures re children moving across boundaries
- Analysis of those children being electively home educated
- Inclusion of good practice examples in training and in the newsletter

## Serious Case Reviews and Lessons Learned Reviews

### Serious Case Reviews

There is a requirement for LSCBs to undertake reviews of serious cases (SCRs) in specified circumstances. "Lessons Learned" reviews are a local response where the criteria for a SCR are not met, but there has been a serious incident and there is a need to learn from what happened around the multi-agency response.

A SCR was completed in 2015 and published this year on completion of the criminal trial. A multi-agency action plan was put in place in 2014/15; the actions have all been completed and confirmed. The conclusion of this review is that there was a failure to protect Child R from suffering harm while he was in hospital. The reasons for this include:

- enquiries under Section 47 (Children Act 1989)1 were not initiated in a timely way when concerns were first identified
- opportunities to assess his parents' care of him and to minimise any risk he continued to be exposed to were not taken
- lack of clarity about the process to be followed and the respective roles and responsibilities of social workers and Police Officers when conducting joint enquiries under s47
- the uncertainty about whether Child R's symptoms (and the reason he was in hospital) were, at least partially, the result of having been non-accidentally injured
- a failure to recognise that undertaking s47 enquiries is as important when there is uncertainty about whether a child has suffered significant harm as it is when the cause of the harm is obvious

A further SCR has been undertaken jointly with Sheffield this year but the criminal investigation is on-going; the findings will be published once this is complete.



A “Lessons Learned” review has also taken place and been completed; learning related to the interpretation of injuries in pre-mobile babies by Health staff.

In all cases where there has been a case review, recommendations have been made in relation to any improvements in practice. These are developed into an action plan, and progress by individual agencies and the partnership has been monitored by Performance & Quality Assurance sub group. The findings are also considered by the Learning & improvement sub-group and single and multi-agency training has been up-dated to reflect any relevant findings.

### **Child Death Overview Panel**

*The Child Death Overview Panel (CDOP) is a multi-agency panel, which reviews the death of any child from 0-18, who is normally resident in the borough, to see if there are any areas of learning and/or changes to practice to prevent a similar death in the future.*

Since 1st April 2008, all deaths of children up to the age of 18 years (excluding still births and medical terminations) are reviewed by a panel of people from a range of organisations and professional disciplines. CDOP is committed to reviewing every child death in the Borough in order to identify whether there is any learning that could influence better outcomes for children at both a local and national level. 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. CDOP make recommendations to the Rotherham Local Safeguarding Children’s Board (RLSCB) and influence actions that can be taken to reduce the number of child deaths in the future. The process of responding to a child death is set out in [Chapter 5 Child Death Reviews](#) of Working Together to Safeguard Children( March 2015).

The number of child deaths 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 over a number of years. Current methods of data collection mean that accurate regional and national comparisons are not readily available.

The functions of the CDOP include:

- 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. They, in turn, can then convey this information in a sensitive manner to the family;
- Determining 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 RLSCB 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 RLSCB;

- Where a suspicion arises that neglect or abuse may have been a factor in the child's death, referring a case back to the RLSCB 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.

Rotherham CDOP met on 6 occasions and undertook the following review and developmental work in 2016-17:

- concluded the review of 24 cases of children who had died compared to 7 in 2015-16;
- delivered 3 sessions to TRFT, where attendees included; Children's Complex Nurses, Midwifery, 0-19 Nurses (Health Visiting, CSE Nurses, School Nursing and Family Nurses). The aim of which is to raise awareness of CDOP and the importance of good quality reports submitted to the CDOP;
- Actively contributed to South Yorkshire CDOP meetings. This includes undertaking a modifiability exercise to ensure that CDOP members understood the complexities at arriving at such a judgement and applied the criteria consistently across South Yorkshire;
- A representative from the Council Housing and Neighbourhoods department gave a presentation on the assessment and enforcement action which could be taken against landlords or tenants where there were environmental issues that could impact on children and their families;
- Provided information for frontline staff to remind them to advise all primary carers on the importance of child safe environments at all residences in which children are cared for including water safety around garden ponds;
- Following the revision of the Rotherham Safe Sleep guidance, a re-audit of the safe sleep assessment use was commissioned;
- CDOP continued to review its membership in order to strengthen the work of the panel in 2016-17 a vice chair was nominated to further support the work of the panel.

### **CDOP Priorities for 2017-18**

- Review the Rapid Response Policy;
- Produce a bereavement pathway for families and professionals;
- Continue to deliver CDOP refresher training to agencies.

**Key Learning Points from 2016-17**

- The Rotherham Safe Sleep guidance has been updated. The updated guidance has been adopted by the Learning and Improvement Sub Group on behalf of LSCB. The guidance has been added to the LSCB procedures portal to which professionals have access. Each agency is reviewing the guidance and embedding it as part of their processes. A Train the Trainer session was held at the end of January and a pack developed to support the dissemination process.
- Local retailers are encouraged to provide information on safe sleep for parents who are purchasing baby equipment. The local Mothercare store has agreed to have the Lullaby Trust safe sleep leaflet available in their baby changing and breast feeding room. CDOP have particularly focused on raising awareness of the dangers of nappy sacks and cot bumpers. The Chair of the LSCB has written to Mothercare head office to see if we can influence the retailer across a wider area.

**Learning and Improvement**

*The Learning and Improvement Sub Group has responsibility for ensuring that the RLSCB maintains a shared local framework which promotes a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the welfare of children, identifying opportunities to draw on what works well and promote good practice.*

**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, through courses, conferences and briefings, and e-learning. It is offered to all staff and volunteers who come into contact with children, young people and/or their families within Rotherham, via multi-agency and single agency training. The aim is to support individuals and organisations to undertake their safeguarding roles and responsibilities in a committed, confident and competent manner.

The Board also circulated newsletters in April, July & November 2016, with information from case reviews, procedure changes, training events, etc.

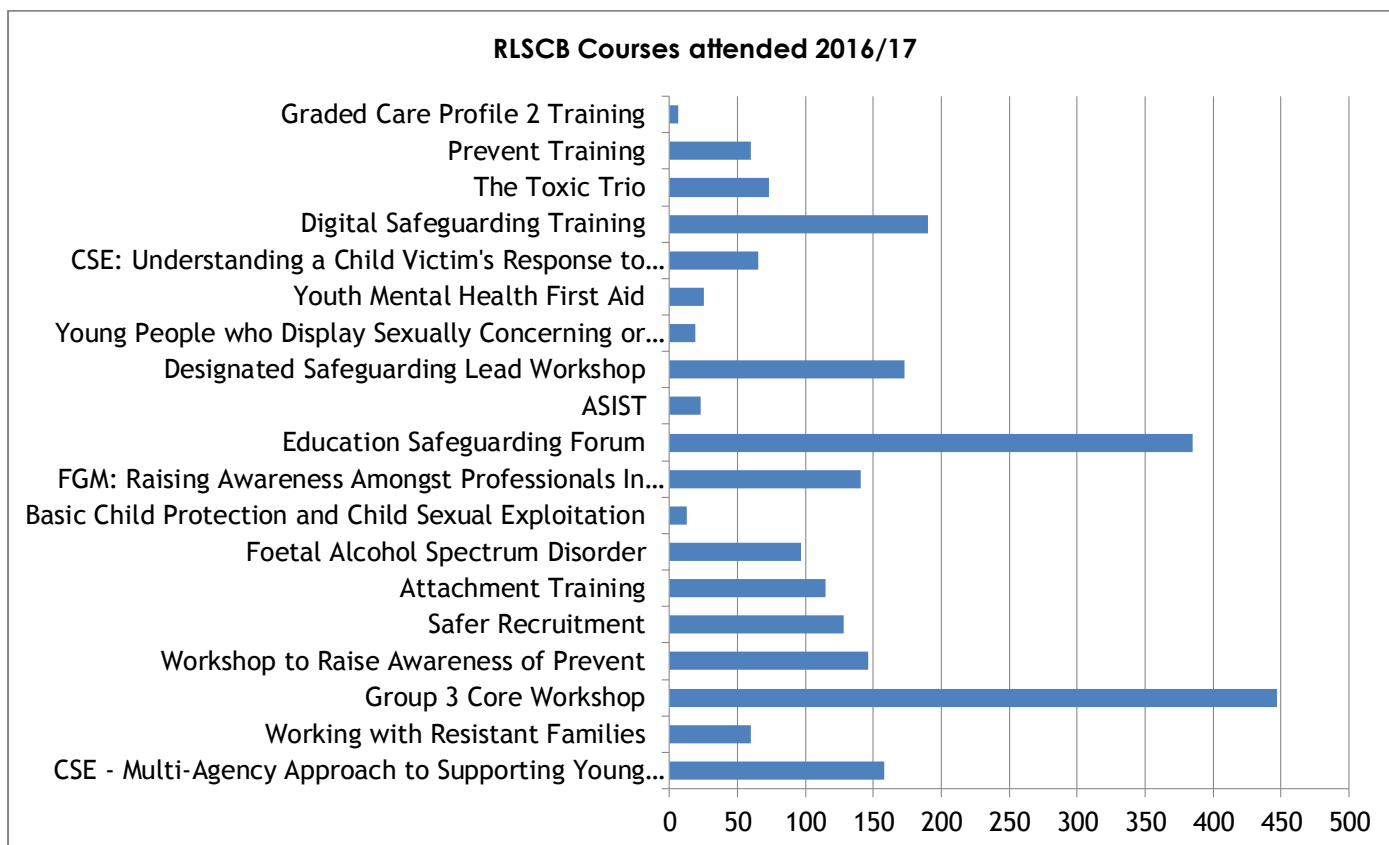
The Rotherham Multi-Agency Workforce Safeguarding Competency Framework was approved at the Learning and Improvement Subgroup in March 2017. It outlines a key set of competencies that are aligned to specific public and voluntary sector roles. The Framework has been developed across multi-agency partners and the competencies are ordered in relation to the levels and complexity of practitioner engagement. As described in the [Intercollegiate Document: March 2014](#): "They are a combination of skills, knowledge, attitudes and values that are required for safe and effective practice".

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.

During 2016/17 the LSCB offered 28 different themed training courses delivered to 3525 attendees. Examples of the training subjects included:

| <b>Multi-Agency Training courses delivered in 2016/17</b>   |
|---|
| Group 3 Core Workshop (Working Together to Safeguard Children and Young People)   |
| Safeguarding Young People at Risk of Child Sexual Exploitation – A Multi-Agency Approach to Supporting Young People at Risk |
| The Toxic Trio, Safeguarding Children and Child Mental Health   |
| Working with Resistant Families   |
| Safer Recruitment   |
| Attachment Training   |
| Workshop to Raise Awareness of Prevent and similar courses  |
| Safeguarding Children and Young People in Education   |
| Safeguarding and CSE for Schools  |
| Education Safeguarding Forum  |
| Foetal Alcohol Spectrum Disorder Events   |
| Training for Designated Safeguarding Leads in Schools and Colleges  |
| Applied Suicide Intervention Skills Training  |
| Understanding a Child Victim's Response to Sexual Exploitation  |
| Youth Mental Health First Aid   |
| Recognising and Responding to Children and Young People who Display Sexually Concerning or Harmful Behaviour                |
| Digital Safeguarding Training   |
| Graded Care Profile Version 2   |
| Basic Child Protection for Early Years  |
| Basic Child Protection and Child Sexual Exploitation  |
| Female Genital Mutilation: Raising Awareness Amongst Professionals in Rotherham and similar courses                         |
| FGM and CSE for Schools   |
| Early Help – Genogram Training  |
| Early Help Assessment and Support Plan Workshop (Early Help Pathway Workshop)   |
| Early Help – Restorative Practice Workshop  |
| Early Help Assessment Skills Training   |
| Early Help – Child Neglect  |
| Understanding Early Help Assessment   |

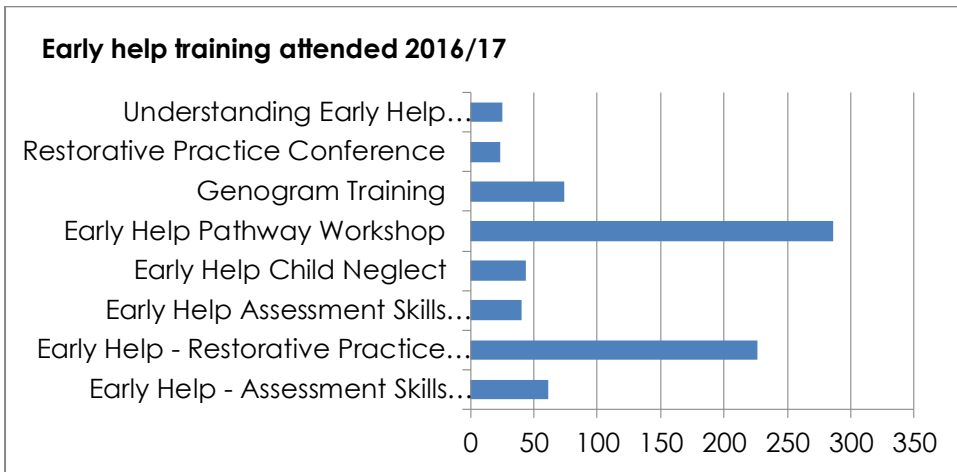
All RLSCB courses are free of charge to all partner agencies and non-profit organisations. 2324 people attended the courses and the attendance across the courses is illustrated below:



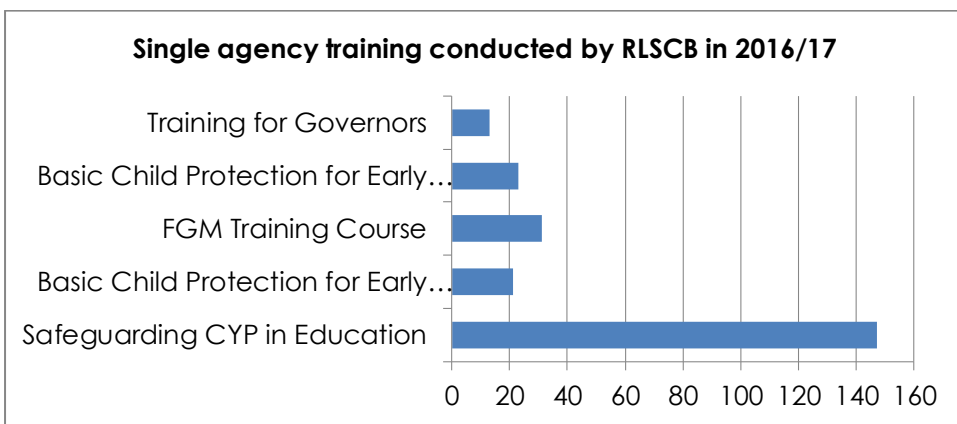
#### Agencies who attended included

- RMBC Children and Young People's Services
- RMBC Neighbourhoods and Adult Services
- The Rotherham NHS Foundation Trust (TRFT)
- Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH)
- Rotherham Clinical Commissioning Group
- Rotherham schools and colleges, including governors
- Early Years Providers, including children's centres, nurseries and childminders
- Probation Services
- South Yorkshire Police
- West Yorkshire Police
- South Yorkshire Fire and Rescue
- Voluntary and independent organisations
- Foster carers, adoptive parents etc.

Early Help training was attended by 779 people across the following courses:



Single agency training provided by the RLSCB was attended by 422 people as follows:



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:

**Attachment Training:**

“Brilliant session; thoroughly enjoyed. I have learnt more in one session than I have throughout my paediatric career and health visitor training.”

**Foetal Alcohol Spectrum Disorder:**

“Always consider what life is like for a child - day to day experiences and whether there is a diagnosis - rather than being labelled as problematic.”

**Digital Safeguarding:**

“I feel confident to share links I have been made aware of and can signpost childcare settings to future support, guidance and training.”

“Good session reminding us of the dangers of the internet and preventative measures.”



**Working with Resistant families:**

"Clearer with families about expectations to improve. Persevere with concerns for children, especially neglect."

"She made this training interesting with her different techniques, thought provoking, non-intrusive and made everyone feel comfortable enough to share thoughts or not"

**Female Genital Mutilation: Multi-Agency Learning Event**

Changes to the 2003 FGM legislation (Section 5B) introduced a mandatory reporting duty in October 2015 which required regulated health and social care professionals and teachers in England and Wales to report 'known' cases of FGM in girls under 18 that they identify in the course of their professional work to the police.

A task and finish group was commissioned to ensure that all practitioners who came into contact with girls at risk of FGM were aware of the issues and their safeguarding responsibilities. The multi-agency procedures in relation to FGM were reviewed and refreshed, and a campaign to raise awareness amongst practitioners was planned and implemented.

A week of activities was planned; more than 150 people attended the sessions and the feedback was that the sessions were well received. The week after the sessions were conducted, two different professionals rang to feedback that they had made referrals to the MASH about girls at risk of FGM because of their increased understanding of the signs and issues. Feedback from participants includes:

"Listen with empathy and know who to signpost to but also the mandatory reporting"

"Greater awareness of FGM and will be much more mindful in working with families, identifying signs and taking that one chance"

**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 should 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

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

In the autumn of 2016 update, the following procedures were added to the manual:

- Safeguarding Children who are at Risk because of Communication Technology and Social Media
- Children Affected by Gang Activity and Youth Violence
- Safeguarding Children at risk due to Faltering Growth
- Discharge Planning from hospital when there are safeguarding concerns about a child
- Notification to the LSCB of Serious Safeguarding Incidents
- Supporting Children who are Bereaved

The following procedures were amended:

- Referring Safeguarding Concerns about Children
- Neglect
- Early Help Guidance: Integrated Working With Children, Young People and Families With Vulnerable or Complex Needs
- Bullying
- Supporting Children and Young People Vulnerable to Violent Extremism
- Safeguarding Unborn and Newborn Babies
- Safeguarding Children at Risk because of Domestic Abuse
- Abuse Linked to Spiritual and Religious Beliefs
- Contact between Parents and their Children in Hospital where there are Safeguarding Concerns
- Safer Recruitment and Employment
- Allegations Against Staff, Carers and Volunteers

Work was also completed on the following, with the update going live in June 2017.

These new procedures were added to the manual:

- Bruising in non-mobile babies and children
- Notification by Other Local Authorities of Looked After Children Placed in Rotherham
- Safeguarding Children from Modern Slavery
- Safe Sleeping for Infants

These procedures were significantly reviewed and amended:

- Protocol for Safeguarding Children in Whom Illness is Fabricated or Induced
- Allegations Against Staff, Carers and Volunteers

These procedures were reviewed to update changes to legislation, guidance or local practice:

- Rotherham Multi-Agency Continuum of Need Guidance
- Multi-Agency Threshold Descriptors
- Referring Safeguarding Concerns about Children
- Action Following Referral of Safeguarding Children Concerns
- Early Help Guidance: Integrated Working With Children, Young People and Families With Vulnerable or Complex Needs
- Safeguarding Children and Young People from Sexual Exploitation
- Abuse by Children and Young People
- Safeguarding Children who are at Risk because of Communication Technology and Social Media
- Safeguarding Children Subject to Private Fostering Arrangements

## 7 Safer Workforce

### 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 (LADO) to deal with these allegations. 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:

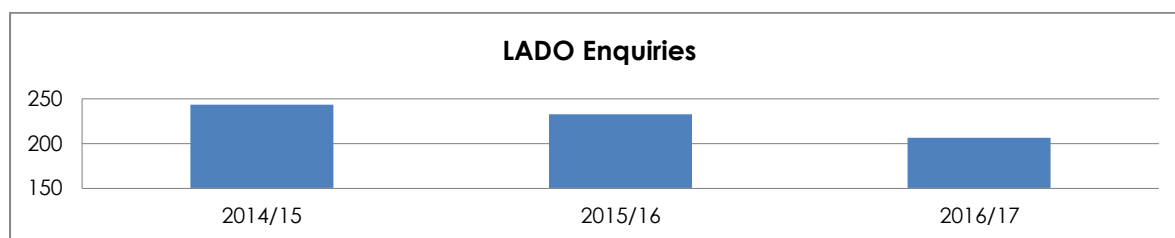
- Cause or potentially cause harm to a child;
- Commit a criminal offence against or related to a child; or
- Indicate that he or she would pose a risk of harm if they were to work regularly or closely with children.

In 2016-17 the LADO role, function and governance in Rotherham has developed and improved:

- The LADO role has benefitted from added capacity of a further Service Manager for Child Protection which has provided qualitative oversight of the role
- The review and implementation of the LADO procedure
- Improved understanding and the application of LADO thresholds
- The reporting of LADO data to the CYPs performance board and on a quarterly basis to the LSCB Performance and Quality subgroup.
- The alignment of the MASH / LADO interface
- The work completed with licencing/ transport which supported strategic and policy changes
- The work completed with Adult Safeguarding which supported strategic and policy changes

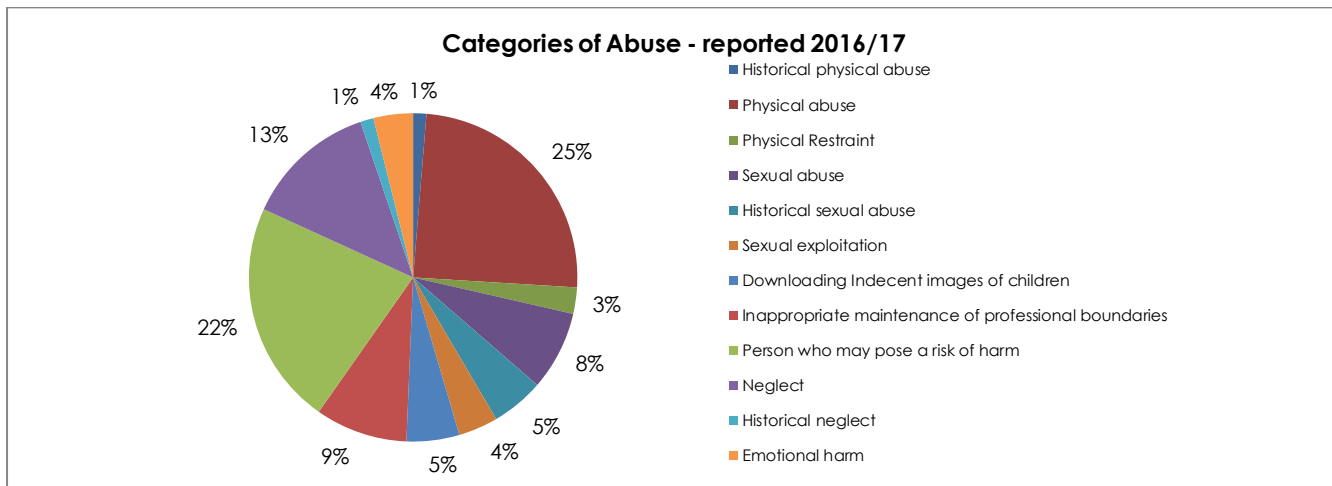
The new LADO procedure has been signed off and went live to all partners in April 2017. This procedure strengthens the interface between LADO and MASH. All referrals and contacts are screened and progress through MASH and the definition of LADO thresholds is strengthened.

During the year 1st April 2016 – 31st March 2017, 206 enquiries to the LADO were recorded. This represents a slight decrease in volume from the previous year (2015-2016) when 233 enquiries were recorded. In addition to these, there were a number of other queries which did not fit the LADO criteria or required intervention from another Local Authority LADO. An additional 73 of this type of query were taken in the year but they lacked the detail or content to be formally recorded.



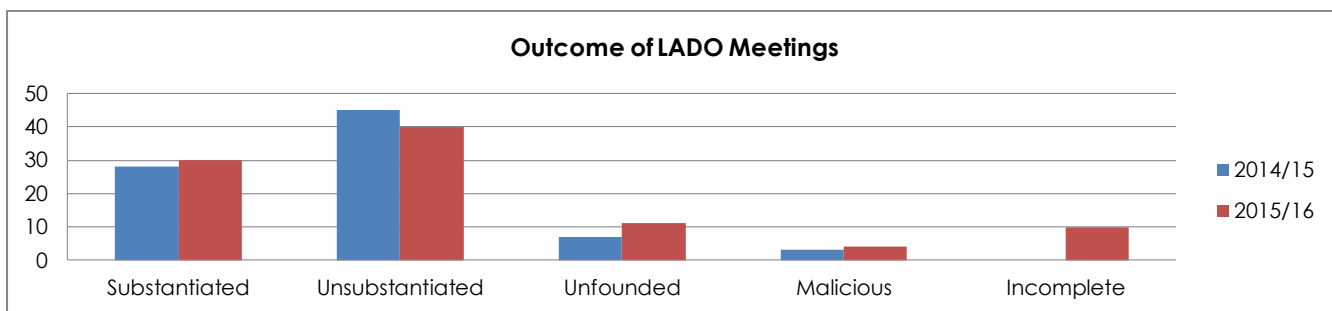
Of the 206 recorded enquiries, 129 were dealt with by way of provision of advice and guidance only and 77 progressed to a full LADO investigation. This is a slight decrease on the figures for 2015-2016 when 83 allegations were progressed into the full LADO investigations.

Of the 77 enquiries that progressed to a full LADO investigation, the nature was as follows:



Of the 77 investigations that took place during the year, 24 were conducted jointly by Police and Social Care under S47- a decrease on the figures for 2015-2016, when there were 34. 22 of the children concerned were in the care of the Local Authority, 6 more than last year.

Of the 77 enquiries that progressed to Allegation Management Meeting, the outcome of the investigations were as follows:



Within this current reporting year, there are 20 incomplete outcomes. The majority of cases referred were completed in year. There are however 20 cases in which the investigation is still on-going. This is generally due to the length of time taken for police investigations to be progressed and/ or for decisions to be made by the CPS regarding whether criminal prosecution will take place.

There is good engagement across the partnership with the allegations processes in terms of referrals and employer action. There is however a lack of clarity and consistency around attendance at allegations meetings which should be addressed by the revised procedures.

## 8 Appendices

### Appendix 1 – Board Member attendance 2016-17

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

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

\*membership now delegated via CCG

## Appendix 2 – Financial Statement 2016-17

| <b>Budget Statement 2016/17 Outturn</b>                              | <b>Funding Formula</b> | <b>Budget 2016/17</b> | <b>Outturn 2016/17</b> |
|--|------------------------|-----------------------|------------------------|
|  | %                      | £                     | £                      |
| <b>Income</b>  |                        |                       |                        |
| 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 Yorks Probation & South Yorks Community Rehabilitation Company | 2.70%                  | 7,849                 | 1377                   |
| 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                  |
| <b>Total Income</b>  |                        | <b>335,900</b>        | <b>329,148</b>         |
|  |                        |                       |                        |
| <b>Expenditure</b>   |                        |                       |                        |
| LSCB Salaries *  |                        | 238,150               | 226,419                |
| Public Liability Insurance   |                        | 800                   | 1,541                  |
| IT & Communications  |                        | 900                   | 1,233                  |
| Printing   |                        | 2,900                 | 2,682                  |
| Stationery and Equipment   |                        | 50                    | 40                     |
| Learning & Development   |                        | 49,800                | 31,515                 |
| Independent Chair  |                        | 39,800                | 35,125                 |
| Software licences & maintenance contracts                            |                        | 3,500                 | 13,500                 |
| Memberships  |                        | 0                     | 2,500                  |
| Miscellaneous  |                        | 0                     | 4,593                  |
| <b>Total Expenditure</b>   |                        | <b>335,900</b>        | <b>319,148</b>         |
|  |                        |                       |                        |
| <b>Surplus / Deficit</b>   |                        | <b>0</b>              | <b>10,000</b>          |



## Appendix 3: Glossary

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

**Appendix 4: Contact details**

**Rotherham LSCB**

**Independent Chair: Christine Cassell,**

**Vice Chair: Rob Odell**

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

**Emails to: [CYPs-SafeguardingBoard@rotherham.gcsx.gov.uk](mailto:CYPs-SafeguardingBoard@rotherham.gcsx.gov.uk)**