AGENDA

1. To determine if the following matters are to be considered under the categories suggested in accordance with Part 1 of Schedule 12A to the Local Government Act 1972

2. To determine any item(s) which the Chair 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. Minutes of the previous meeting held on 19th September, 2018. (Pages 1 - 13)

7. Communications

For Discussion

8. Local Safeguarding Children Board and Safeguarding Adults Board Annual Reports 2017/18 (Pages 14 - 106)

9. Refreshed Joint Strategic Needs Assessment Consultation. (Pages 107 - 113)

10. Update on the Health and Wellbeing Strategy Aims 1 and 3. (Pages 114 - 128)


12. Active for Health - Presentation by Amy Roden/Sheffield Hallam Researcher.
For Information Only

13. Rotherham Hospice Quality Account. (Pages 134 - 173)


15. Minutes of the Rotherham Integrated Care Partnership held on 3rd October, 2018 (Pages 194 - 197)

16. Date and time of next meeting - Wednesday, 23rd January, 2019, commencing at 9.00 a.m. - Venue to be confirmed.
HEALTH AND WELLBEING BOARD
19th September, 2018

Present:-

Councillor David Roche Cabinet Member, Adult Social Care and Health
(in the Chair)
Tony Clabby Healthwatch Rotherham
Dr. Richard Cullen Strategic Clinical Executive, Rotherham CCG
Chris Edwards Chief Operating Officer, Rotherham CCG
Carole Lavelle NHS England
Councillor Janette Mallinder Chair, Improving Places Select Commission
Mel Meggs Deputy Strategic Director, Children and Young
People’s Services
Chris Morley Chief Nurse, Rotherham Foundation Trust
(representing Louise Barnett)
Rob Odell District Command, South Yorkshire Police
Dr. Jason Page Governance Lead, Rotherham CCG
Jacquie Wiltchinsky Consultant in Public Health
(representing Terri Roche)

Also Present:-
Kate Green Public Health Specialist, RMBC
Gordon Laidlaw Communications Lead, Rotherham CCG
Councillor Short Vice-Chair, Health Select Commission
Janet Spurling Scrutiny Adviser, RMBC
Hannah Upstone Strategic Housing Assistant
6 Members of the Public

Report Presenters:-
Tom Bell Assistant Director of Housing
Ruth Fletcher-Brown Public Health Specialist, RMBC
Polly Hamilton Assistant Director, Culture, Sport and tourism
Dermot Pearson Assistant Director, Legal Services
Sarah Watts Strategic House Manager

Apologies for absence were received from Louise Barnett, Sharon Kemp, AnneMarie Lubanski, Kemp, Roche, Barnett, Wheatley and Watson.

11. DECLARATIONS OF INTEREST

There were no Declarations of Interest made at the meeting.
12. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

With regard to the Hospital Services Review, why have you not involved the staff in such a way that they understand the whole picture of what you are asking of them and where it may lead? In terms of consultation you have hardly grasped it with the fervour it warrants. Why have you not involved the staff inside the NHS so they understand the whole of what they are working on?

The Chair stated that, from the Council perspective, he had spoken out in public, including to the regional board, of his concerns about the lack of public consultation on the regional STP. He had argued long and hard for the Local Plan to be accountable and had insisted that it come under the Health and Wellbeing Board and, therefore, the minutes of the sub-groups belonging to the Place Board were submitted to the Board meeting. There had been at least 2 All Member seminars on the Plans to inform all Members of the Council and where they could ask questions. The Health and Wellbeing Board and the Place Board were both public meetings and the item had been included on both agendas in the “open” session. The Local Place Plan was based on what was happening locally and had formulised some of the actions but there were no cuts and no involvement in private companies. This had also been subject to public meetings and was aimed at improving the health of Rotherham people and not about bringing in another organisation.

Dr. Cullen stated that, in his view as a GP, the Place Board was part of closer working together and that was reflected through the organisations to the workers. People on the ground wanted that facility to work together more closely; they were listening to the patients and did not want duplication. The Place Board was the top part that would allow better working on the ground to improve patient care and co-ordinate the best value out of the Rotherham pound.

Chris Edwards reported that the Hospital Services Review was conducted by an independent company commissioned to produce a report. The comments regarding the length of the document and how it had been publicised would be fed back. Any major service change that affected Rotherham would legally require full public consultation and any decisions would be made in public.

The Rotherham Integrated Care Partnership Agreement would tie all representatives to make the best decisions for Rotherham people and to meet the Key Performance Indicators.

Rotherham was at the forefront of the possible changes. Can we not bring a team from the Labour Party down to look at it? We would press the local labour Party to deal with this

The Chair stated that there was no problem at all with people looking at what Rotherham had done and what intended to do.
Tony Clabby, Healthwatch Rotherham, reported that an engagement event on the Hospital Services Review had been held on 10th September at the Carlton Park Hotel at which over 40 people from hard to reach communities had attended.

13. MINUTES OF THE PREVIOUS MEETING

The minutes of the meeting of the previous meeting of the Health and Wellbeing Board held on 11th July, 2018, were considered.

Resolved:- That the minutes of the previous meeting held on 11th July, 2018, be approved as a correct record.

14. COMMUNICATIONS

A. The following question had been received from a member of the public on 29th July, 2018, submitted to all South Yorkshire Health and Wellbeing Boards. A South Yorkshire response had been provided. The question was:-

“The organisation in charge of the Health and Wellbeing Board i.e. the council must take these questions and statements and have them answered by the board under the Public Sector Equality Act. Circumventing any relevant policy that is not law, that would block these questions or statements, any non-compliance of this request will be subject to a legal challenge by myself (name removed) and any relevant persons or peoples to whom the issue applies.

Statement:
JSNA does not provide the full waiting list for primary care and secondary care services for assessment and diagnosis. Given that it is up to the statutory authority to deal with making sure that public sector equality is upheld will they do the following:

Question 1) Will the chair including all associated bodies that commission local services, now ask or provide waiting lists for each contract in place for assessment and diagnosis, in the NHS and provide the total cost of clearing each waiting list?

Question 2) Will the chair request that the waiting list for all Social Care services are published on a monthly basis for review emergency or otherwise, and the first assessment and provide a cost for each month to clear that waiting list?

Question 3) Will the board then provide the list to the Secretary of State for Health and Social Care, to make sure they are aware of the waiting list and hold them to account on funding the clearing of such waiting list under the health and social care act and the care act?”
A response was provided via email from the Chair which stated:-

“Thank you for your email. Unfortunately the Rotherham Health and Wellbeing Board cannot accept your request as it is not within the remit of the Board to do so.

The Health and Wellbeing Board is a strategic body whose role is to improve the health and wellbeing of the people in its area by encouraging integrated commissioning between health, social care and public health. It does not have a role in monitoring performance or waiting times, which are operational matters. You should, therefore, direct your request for information on waiting lists and the cost of clearing these lists to each individual provider of commissioned services.”

B. Peer Support Offer for Local Systems
An offer of Peer Support had been received from the Local Government Association for local systems, which included LGA NHS providers, NHS Clinical Commissioner and NHS Confederation, to provide a group of people to visit and work locally looking at what the Board was doing and how it was progressing.

However, a condition of the impending restoration of powers to the Council on 24th September, 2018, by the Secretary of State was that the Council undergo a health check in January/February, 2019.

It was felt that the Board may wish to consider the Peer Support Offer towards the end of 2019.

15. HWB STRATEGY AIM 4 UPDATE

A Draft Cultural Strategy for Rotherham 2018-2025
Polly Hamilton, Assistant Director, Culture, Sport and Tourism, presented the above document, with the assistance of a powerpoint presentation, which was developed by the Rotherham Cultural Partnership Board, an organisation formed during 2018 bringing together people and agencies that cared about Rotherham’s future.

The Strategy set out Rotherham’s aims for culture, leisure and green spaces and described how it would develop the local assets and resources, making the best use of what existed and building agreement about priorities for development, supporting the case for external funding and investment.

The Strategy would build understanding about how engagement with the arts, sport and natural environment could improve people’s personal growth, health and wellbeing and sense of purpose. It would set out how enabling more people to participate, to get active, get create and get outdoors, would not only make sure that everyone felt part of and proud of their community but also help to strengthen the economy.
The document was out for consultation until 31st October, 2018.

The Board was asked:-

- Do you support our key goal – to enable everyone to get active, get creative and get outdoors, more often?
- Was the argument clear?
- What can you or your organisation do to support the ambitions and actions of the Strategy?
- Volunteers from NHS/CCG to develop action plan?

Resolved:- (1) That the report and presentation be noted.

(2) That representatives email Polly Hamilton with any comments on how their organisation could support the ambitions and actions of the Strategy.

**ACTION:** All Board members

(3) That Dr. Jason Page and Rob Odell assist with the development of the action plan.

**ACTION:**- Rob Odell/Jason Page

(4) That Voluntary Action Rotherham be contacted as to whether they could assist with the development of the action plan.

**ACTION:** Polly Hamilton

**Housing Strategy Refresh 2019-2022**

Sarah Watts, Strategic Housing Manager, gave the following powerpoint presentation:-

- Overview of housing in Rotherham
  - 112,000 households – largely 3 bed semi-detached houses
  - 6,500 applicants on the housing register
  - The Council owns and manages 20,500 tenanted properties, 500 leaseholders
  - 64% were owner-occupiers, 22% social rented and 14% private rented
  - 900+ overall target for homes built (SHMA) per annum
  - 600 average delivery in recent years
  - 202 sold via Right to Buy last year

- Current Strategy: The 5 Themes - Housing growth, Social housing, Private rented housing, Affordable housing and Specialist housing

- Achievements e.g. Grant funding for new homes, Shared ownership and affordable housing, Clusters Partnership – Wates, Town Centre residential programme, Excellence in Tenant Engagement Award and Selective Licensing
Things have changed - Housing and Planning Act 2016, Policy u-turns, HRA Business Plan refresh, Increasing resources, Homelessness Reduction Act and Social Housing Green Paper

The New Strategy – Vision
- Meeting housing need through growth
- People living in high quality homes, affordable and energy efficient homes
- Rotherham Council being the best housing provider in the country
- Rotherham’s people can live independently in safe, healthy and vibrant communities
- A revitalised town centre with a new urban community

Value of new housing - More than bricks and mortar, Economic, Social value, Energy efficiency, Health, Neighbourhoods and Community engagement

Structure – 5 Priorities
- Providing new homes to meet Rotherham’s housing needs
- Investing in Rotherham housing stock
- Improving health and wellbeing through housing
- Strengthening Rotherham’s economy
- Working in partnership to deliver the Strategy

Timetable for Refresh
- July-October, 2018 – consultation period
- November 2018 – first draft
- January 2019 – final draft

Pipeline Projects – More new homes, housing profiles and land review, transformation of Adult Care, modern methods construction and the new Repairs and Maintenance Contract

Public Health would be interested in the work around health inequalities and the targeting of what might need to be considered specifically

In the past enforcement had been missing; now 95% of Rotherham citizens lived in safer and warmer homes

It had only been quite recent that the connection between Housing and health had been taken into account

As various parts of the Borough were developed it would change what the localities had been set up to accommodate. The Locality Plan would need to adapt
The Local Estates Forum was crosscutting and starting to develop and look at the whole of Rotherham estates and the housing implications as well as the health implications.

Resolved:- (5) That the presentation be noted.

(6) That Public Health be included in the work with regard to health inequalities.

**ACTION:- Sarah Watts/Jacqui Wiltchinsky**

**Loneliness**

Ruth Fletcher-Brown, Public Health Specialist, gave a brief update on loneliness.

It was felt that the Better Mental Health For All Group contained all the partners required to address loneliness and to get the strong message across that loneliness did not just affect older people. Following discussion it not felt necessary to have a public campaign to address loneliness as the Five Ways to Wellbeing Campaign was a good tool to use.

There was a strong message that anyone could experience loneliness at any point in their life. Work was taking place in the South Multi Agency Group which had identified loneliness as a key theme and from April 2019 MECC would address Loneliness. It was felt that there should be some initial pilot work and discussions were taking place with the South MAG with regard to possibly piloting some workers making MECC around Loneliness. Discussions were also taking place with Voluntary Action Rotherham with regard to their website GISMO which tried to capture all the community groups.

The Chair stated that performance indicators would be submitted to the next meeting. A Loneliness Plan was being developed and would be submitted in due course.

Councillor Short reported that there was a Loneliness project in his Ward, working with Churches Together, and a coffee morning held every week.

(7) Resolved:- That the report be noted.

(8) That the Five Ways to Wellbeing Group drive the Loneliness agenda

(9) That the Board support the need to take the Five Ways to Wellbeing message forward as partners and consideration be given as to it being the front facing message around Loneliness.
16. **HWB STRATEGY AIM 2 UPDATE**


Both actions plans evidenced the work that all partners were carrying out to promote the mental health of people living and working in Rotherham and the prevention of suicide.

**Better Mental Health for All**

The action plan drew upon the evidence of what worked promoting the mental health for the whole population, for individuals who were more at risk of developing mental health problems and for those living with a mental health problem.

The co-ordination of the action plan was through a local implementation group with partners of the Health and Wellbeing Board represented. The focus of the work was linking into community assets (strengths) and connecting people within their local community. The Strategy and action plan recognised the skills, knowledge and expertise of individuals and the assets that communities and organisations had to improve mental health and wellbeing.

10.8% of adults over the age of 18 years in Rotherham (2014/15) had depression, the average for England for the said period being 7.3%. For self-reported emotional wellbeing (2015/16) Rotherham residents reported high levels of low satisfaction with life, low happiness and high anxiety; these rates were higher than the average for England and for the Yorkshire and Humber region.

**Key Actions:-**

- Film and resources produced to support the Five Ways to Wellbeing campaign completed by April 2018
- Launch of the Five Ways to Wellbeing Campaign in May 2018
- Partner organisations signed up to roll out the different topic areas (Be Active, Connect, Give, Keep Learning and Take Notice) from the launch until October/November 2018
- Work now ongoing to ensure the Five Ways to Wellbeing principles were embedded in all partners’ commissioning processes and provider services
- A future focus of the Better Mental Health for All Group would be to look at actions to address loneliness in line with Aim 4 of the Health and Wellbeing Strategy. The proposal was to utilise the Five Ways to Wellbeing campaign as the public campaign to combat loneliness
- The action plan was being updated with a progress report to the November meeting
Rotherham Suicide Prevention and Self-Harm Action Plan
The Plan had been written to recognise the role of all partners in addressing the complexity of preventing deaths from suicide.

The All Party Parliamentary Group (APPG) on Suicide and Self-Harm published an “Inquiry into Local Suicide Prevention Plans in England” January 2015. The APPG considered there were 3 main elements that were essential to the successful local implementation of the national strategy. All local authorities must have in place:

1. Suicide audit work in order to understand local suicide risk
2. A suicide prevention plan in order to identify the initiatives required to address local suicide risk
3. A multi-agency suicide prevention group to involve all relevant statutory agencies and voluntary organisations in implementing the local plan

Key Actions:

- Launch of the young people’s campaign STILL on World Mental Health Day on 10th October 2017 at Oakwood School
- All Rotherham schools received an updated Critical Incident Prompt sheet from Educational Psychology in May 2017
- 6 schools piloted a Whole School Approach to mental health and emotional wellbeing during 2016-17. This work had now been shared with other schools across the Borough
- Suicide prevention training provided in May 2017 by Public Health Specialist to Crossroads and Rotherham Alzheimer’s Society staff. In 2018 Youth Mental Health First aid training courses also provided to the Rotherham Parent Carers Forum and a second women’s group from BME communities
- During 2017 Wentworth Valley Area Assembly identified funding for suicide prevention work in the Maltby, Hellaby and Wickersley Wards
- 4 SafeTalk suicide prevention courses delivered in March 2017
- Bereavement pathway for children who had experienced a sudden and traumatic death revised in October 2017 and re-issued to all partners. The next revision was due in October 2018
- Rotherham Samaritans launched their bereavement support project in January 2017
- The action plan was currently being refreshed and would address issues highlighted through Rotherham’s real time surveillance work
- South Yorkshire and Bassetlaw had received NHS England funding for suicide prevention work for one year. The funding could not be used to support local plans in their entirety but could be used to support the national themes of:-

- Reducing suicide and self-harm in Mental Health Services
- Reducing self-harm in Community and Acute Services
- Suicide prevention in men and/or work with Primary Care
The Rotherham Suicide Prevention and Self-Harm Group had submitted initial proposals for spending the funding in the Borough to NHSE. The proposals had been supported by the Rotherham Mental Health and Learning Disability Transformation Board and were in line with priorities within the Local Plan. Discussions were still taking place as to how the funding would be divided. It was hoped to know of the outcome by the end of September.

Discussion ensued on the report with the following issues raised/clarified:-

- The 6 schools who had piloted a Whole School Approach were all meeting on a regular basis and were taking the work forward. They had presented their approach to various school meetings resulting in additional schools expressing interest

- The Whole School approach had a really strong element of environment level and local level and would feature in the new SEMH Strategy

- The participating schools had given a presentation to Children Services’ Departmental meeting and looked at how it could be taken wider than schools. It had made a difference to the culture of those schools

- Rotherham CCG had bid for Trailblazer funding which would place Mental Health Workers within schools. It was hoped to hear if the bid had been successful sometime next month

- Excellent suicide prevention work had been carried out in the Wentworth Valley Area Assembly. It was now a matter of persuading individual Wards if they would fund similar work

- The refresh of the action plan gave an opportunity to establish which partners were still missing/not engaging with the work

- The Police were obviously involved in the crisis but intervention after the event to hopefully prevent a further attempt was really important

- All Healthwatch Rotherham staff had received Safe Talk training and suicide prevention training

Resolved:-  (1) That the Lead Officers from their organisations continue to assist with the implementation of the Better Mental Health for All Action Plan and the Rotherham Suicide Prevention and Self-Harm Action Plan.

(2) That the proposal for the Better Mental Health for All Group being the place to implement the section on loneliness within Aim 4 of the Health and Wellbeing Strategy be supported.
(3) That the revised Rotherham Suicide Prevention and Self-Harm Action Plan be submitted in December 2018.

(4) That annual progress updates be submitted to the Board on both action plans.

(5) That updates on the NHSE funding for suicide prevention and how this was being implemented locally be submitted to the Board.

**ACTION:** Ruth Fletcher-Brown

17. **FINAL INTEGRATED CARE PLACE PLAN**

Chris Edwards, Chief Operating Officer, RCCG, presented the final draft of the Rotherham Integrated Health and Social Care Place Plan for information and endorsement.

Rotherham’s first Integrated Health and Social Care Place Plan (Place Plan) was published in November 2016. It had now been refreshed to facilitate alignment with the revised Health and Wellbeing Strategy agreed in April 2018.

The version attached addressed all the comments received from partners and all sections were complete with the exception of some minor additions which would be completed shortly. It should also be noted that there was an additional priority within the Children and Young Peoples Transformation Workstream in relation to Maternity and Better Births:-

The areas to be completed were:-

- Completion of milestones and KPIs for the new Maternity and Better Births priority
- Addition of a patient story for Children and Young Peoples Transformation Workstream

Resolved:- That the final draft of the Integrated Health and Social Care Place Plan be endorsed.

18. **ROtherHAM INTEGRATED CARE PARTNERSHIP AGREEMENT**

The Board received the final draft of the Rotherham Integrated Care Partnership Agreement.

The Agreement was intended to strengthen the governance arrangements underpinning the Rotherham Integrated Care Partnership Place Plan and to capture the culture of how the Place Plan Board worked together.

The Agreement was based on a Memorandum of Understanding approach and aimed to provide an overarching arrangement to oversee the development of integrated multi-agency solutions for health, care and support across Rotherham. The Agreement was not intended to be
legally binding except for specific elements such as confidentiality or intellectual property. However, if areas such as payment mechanisms and risk sharing/outcomes performance were developed over time, the partner organisations would need to consider moving to a legally binding agreement in the future.

Clause 21 of the Agreement confirmed that the Council did not have the obligations of the other parties to the Agreement in relation to the South Yorkshire and Bassetlaw Integrated Care System.

Resolved:- That the Agreement be approved and the Chief Executive be delegated, in consultation with the Chair, authority to finalise and sign the Agreement.

ACTION: Councillor Roche/Sharon Kemp

19. HEALTHWATCH ROTHERHAM ANNUAL REVIEW 2017-18

The Board received, for information, the 2017-18 annual report of Healthwatch Rotherham.

Attention was drawn to the review of CAMHS undertaken by Healthwatch Rotherham. A report would be produced by the end of the month which would contain some far reaching recommendations.

20. ADULT SOCIAL CARE VISION FOR ROTHERHAM

The Board received, for information, the Adult Social Care Vision 2017-2020, which was based on 3 key themes:-

Theme 1 Act to help yourself
Theme 2 Act when you need it
Theme 3 Act to live your life

It was a very important document that set up the framework by which current decisions were made.

21. HEALTH AND CARE SELECT COMMITTEE - REVIEW OF INTEGRATED CARE SYSTEMS

The Board noted the House of Commons Health and Social Care Committee “Integrated care: organisations, partnership and systems” seventh report of session 2017-19.

22. THE LOCAL GOVERNMENT ASSOCIATION GREEN PAPER: THE LIVES WE WANT TO LEAD

The Board noted the Local Government Association Green Paper for Adult Social Care and Wellbeing “The Lives We Want to Lead”.
23. **INTEGRATED CARE PARTNERSHIP PLACE BOARD**

The notes of the minutes of the Rotherham Integrated Care Partnership Place Board held on 6th June, 4th July and 1st August, 2018, were noted.

24. **DATE AND TIME OF NEXT MEETING**

Resolved:- That a further meeting be held on Wednesday, 21st November, 2018, commencing at 9.00 a.m. venue to be determined.
Rotherham
Local Safeguarding Children Board
Annual Report
2017 - 2018

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1. Foreword by the Independent Chair

I am pleased to present the Rotherham Safeguarding Children Board report for the year 2017-18.

The past shortcomings in safeguarding in Rotherham have been much publicised. In the wake of the Jay Report on Child Sexual Exploitation, an Ofsted inspection in September 2014 found both the Local Authority Children’s Services and the LSCB to be inadequate, and the wider council was deemed by the government to be failing in its responsibilities. HMIC also raised concerns about child protection activity by the Police.

Since that time there has been significant activity and investment in rebuilding the council and improving service responses to children across the partnership, which is being reflected in improving commentary from the various inspectorates. This includes an overall judgement of ‘Good’ for Rotherham Local Authority Children’s Service from Ofsted in February 2018.

The improvements in Rotherham have been achieved over a remarkably short period of time given the extent of the change that was needed, which is a tribute to the leadership across services and to all the staff involved. The partnership agencies of the LSCB recognise, however, that there are still areas for improvement to ensure that children and young people are kept as safe as possible. Rotherham services continue to work together and to challenge one another in areas highlighted for improvement by inspections and by the quality assurance activity of the LSCB. The LSCB will continue to challenge partners to demonstrate increasing effectiveness and robustness of their joint work in protecting children.

As services in Rotherham have improved, there has also been a significant increase in the numbers of children identified as requiring help and protection, including the number of children needing to be looked after by the local authority. This is a national trend but one complicated by some local factors, including the very effective partnership response to some complex abuse and the investigation of non-recent abuse cases. These increasing demands coincide with reducing budgets for all services. This is undoubtedly placing those partnership services required to support these children under pressure. There will be real challenges ahead in maintaining and improving the quality of services and positive outcomes for children. The LSCB will continue to make representations to ensure that strategic decisions give priority to safeguarding children.

In July 2018 new guidance was published on how partners should work together to protect children (Working Together 2018). This guidance requires that new Local Multi-agency Safeguarding Arrangements should be in place by September 2019. The responsibility for these new arrangements will sit with three key partners, The Local Authority (Chief Executive), the police (Chief Constable) and health (the Clinical Commissioning Group). These three partners have been working with the wider group of agencies involved in safeguarding to prepare for these future arrangements. Their commitment is that the new arrangements will build on the exiting good partnership around safeguarding to make further improvements.

I would like to finish by acknowledging the work across all agencies at all levels to make the improvements that have been achieved in Rotherham and the commitment shown by
partners of the LSCB to improving further the quality of the direct contact and work with children and families.

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 263,400 (Office for National Statistics (ONS) mid-year estimate for 2017). The number of children and young people aged 0 to 17 years is 56,900 (21.6%). Growth in the older population is evident, with a 23% increase in the population aged 65 and over. Rotherham has as many people aged 63 or over as children aged 0-17.

The population of Rotherham has been steadily growing over the last 17 years, increasing by 16,400 (6.6%) between 2000 and 2017. The population is expected to rise by an average of 769 per year over the next ten years (an increase of 7,700), to reach 270,600 by 2027. The projected increase reflects a combination of net migration into the Borough and natural increase (more births than deaths).

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, Thurcroft and Wales.

Rotherham is a diverse borough with a mixture of people, cultures and communities. There are densely populated multi-ethnic inner urban areas, large council built housing estates, leafy private residential suburbs, industrial areas, rural villages and farms. About 70% of the Borough’s land area is rural so the most notable feature of Rotherham is its extensive areas of open countryside, mainly agricultural with some parkland and woodland. Rotherham is strategically 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 2015, 31.5% of Rotherham’s population lived in the most deprived fifth of England whilst only 8% lived in the least deprived fifth of England).

**Diversity**

Rotherham’s Black and Minority Ethnic (BME) population is relatively small but has been growing and becoming increasingly diverse. In 2011 it was 8.1%

Rotherham's Black and Minority Ethnic (BME) population is relatively small but has been growing and becoming increasingly diverse. The BME population more than doubled between 2001 and 2011, increasing from 10,080 to 20,842. 8.1% of the population belonged to ethnic groups other than White British in 2011 (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 Black and Minority Ethnic population has grown steadily in recent years. The white minority population (almost all European) was 2,368 in 2001, rising by 82% to 4,320 in 2011, mainly as a result of immigration from Eastern Europe. Most minority ethnic groups have young populations, including Pakistani/Kashmiri (33% under 16), Black African (31% under 16) and Eastern European (24% under 16). The mixed or multiple heritage population is growing rapidly as a result of mixed marriages or relationships, 50% are aged under 16. The Irish community is by far the oldest ethnic group with 42% aged 65+.

National Insurance Numbers (NINo) migrants accounted for 933 in 2016 before falling again to 724 in 2017. This trend was evident amongst EU migrants from the 10 countries which joined the EU post 2004, where numbers fell by 65% from 877 in 2007 to 309 in 2012 before increasing to 585 in 2016 and falling back to 422 in 2017. People from states which joined the EU post 2004 made up 58% of all overseas migrants to Rotherham in 2017. The countries with the most migrants to Rotherham are Romania, Slovak Republic and Poland, which together accounted for 42% of NINo migrants in 2017. Two thirds of NINo arrivals in Rotherham between 2007 and 2017 moved to the three central wards. A high proportion of Slovak, Czech and Romanian migrants have been from Roma communities, although no by all means all.

There were 31,000 carers in Rotherham in 2011, 58% of them female, 22% over 65 and 6% under 25. Rotherham LGBT population could number up to 5,600 people aged 16+.
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 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 2017 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.

11 out of 16 secondary schools and 3811 pupils participated in the 2017 Rotherham Lifestyle Survey.

Bullying
The pupils who said they have been bullied told us what form of bullying they have been subject to:
- Verbal bullying 64.3% (72.4% in 2016)
- Physical bullying 16.4% (10.5% in 2016)
- Being ignored 10% (5.2% in 2016)
- Cyber bullying 6.6% (8.2% in 2016)
- Sexual bullying (inappropriate touching/actions or comments) 2.6% (3.7% in 2016)

Pupils saying they have been bullied physically has had the largest % increase. Pupils saying they have been bullied verbally has had the largest % decrease. It is positive to see that both cyber bullying and sexual bullying has decreased in 2017.

15% learned about internet safety at home the same as 2016. 2% learned about internet safety on-line the same as 2016. 0.8% learned about internet safety through friends. 0.75% in 2016.

Feeling Safe
There has been a decline in the % overall of pupils who said they always feel safe in Rotherham town centre. 18% (683) of pupils said they always feel safe, compared to 24.6% in 2016. More pupils said they sometimes feel safe 50% (1900) compared to 45.4% in 2016.

6.6% reduction in the number of pupils who said they always feel safe 18.5% (697) compared to 19.3% in 2016. 13.5% (501) of pupils said they have never visited Rotherham town centre.

91.8% (3474) said they always feel safe at home, compared to 92.6% in 2016 and 6.9% said they sometimes feel safe at home, compared to 6.2% in 2016.

59.4% (2249) said they always feel safe at school, compared to 66.4% in 2016 and 36% said they sometimes feel safe at school, compared to 29.5% in 2016.

What’s working well?
3515 (93%) of pupils said they visit their dentist.
More young people said they are eating the recommended 5 fruit and vegetables each day, more young people said they have breakfast in a morning and more young people said they participate in regular physical activity.
Less pupils are worried about their weight and there has been a 5% increase in the % of pupils who feel their weight is about the right size.
Increase in the number of pupils who said they regularly visit Rotherham town centre.
Far more Y7 pupils have received education about child sexual exploitation;
Reduction of 5% in the number of Y10 pupils who said they have had sexual intercourse.

What are we worried about?
Increase of 3% in the number of pupils saying they consume 2 or more high sugar drinks each day and also an increase of 2% of the number of pupils saying they consume high energy drinks. (in particular boys).
A 3% reduction in the number of pupils who aspire to go to university. Overall 42% (1592) said they aspire to go to university in 2017 results from 45% in 2016.
A 6.6% reduction in the number of pupils who said they always feel safe in Rotherham town centre. Overall 18% (683) pupils said they always feel safe, compared to 24.6% in 2016.

An increase of 3% of pupils saying they have been bullied out of school time. More pupils of those who have been bullied said they have been bullied out of school time, 12.8% (124) said this in 2017, compared to 9.3% in 2016.
Decrease of 6.7% of young people who have identified themselves as a young carer who have heard of the Rotherham Young Carers service. 37.3% (267) said they had heard of this service in 2017, compared to 44% in 2016.
Decrease of 4.7% of homes identified as smoke-free homes. In 2017 59.3% (2243) said their home was smoke-free, compared to 64% in 2016.
Decrease of 3.5% of Y7 pupils who said they have never tried an alcohol drink. This has decreased to 76.3% (1643) from 79.8% in 2016.
An increase in the % of pupils in Y10 who said they did not use contraception when having sexual intercourse, this has increased to 27.5% from 20%, and the increase is more prevalent with boys.
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 strategic 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 Rotherham Safeguarding Adults Board
- Chair of the Health and Well Being Board
- Chair of the Safer Rotherham Partnership 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.

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

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

The Board’s budget is based on partner organisations contributions to an agreed formula. The funding formula and 2017-18 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 – 2017-18 Outturn

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<th></th>
<th>Budget</th>
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<tr>
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<tr>
<td>Expenditure:</td>
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Overall expenditure for 2017/18 was £11,650 over budget. This is due to a number of budget pressures and remedial action has been taken within the 2018/19 budget to recover this overspend.
Regulatory Inspections 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.

Inspection Findings:

**NB: The Trust also provides services to other areas.**

**ROtherham Doncaster and South Humber Nhs Foundation Trust**
**Care Quality Commission (11 January 2018)**

Summary of the key findings

- We rated caring, effective, responsive and well led as good and the overall rating for Community inpatient services went up to good at this inspection.
- With the exception of mental health rehabilitation services, patients’ physical and mental health risk assessments were comprehensive. Appropriate management plans were in place and patients had up to date and comprehensive care plans, which reflected national guidance and best practice and met their individual needs.
- The trust board and senior leadership team had the appropriate range of skills, knowledge and experience to perform its role and the non-executive directors had the appropriate skills and knowledge in order to provide relevant challenge to the trust board. The senior leadership team and senior managers understood the key priorities within the services.
- We rated one adult social care location, 88 Travis Gardens, as outstanding in the caring domain.
- The trust had an excellent staff, patient and public engagement strategy which followed a recognised methodology. Staff throughout the trust had access to specialist training and development and had been empowered to implement quality improvements.
- Leaders were visible in the service and approachable for patients and staff. Staff felt supported by their managers and felt they could raise concerns or approach their managers for support.
- A physical health and wellbeing strategy was in place under the executive lead of the medical director. We saw in all core services we inspected that patients had good access to physical health care; physical health checks were undertaken and staff promoted healthier lifestyles.

However:

- We rated safe as requires improvement in four of the 14 core services. The overall rating for acute wards for adults of working age and psychiatric intensive care wards had gone down to requires improvement.
- Although the trust had improved its overall mandatory training compliance, staff in some wards and teams were not up to date with their mandatory training requirements. Training for prevention and management of violence and aggression, a key component of enabling safe care was below 75% in acute wards for adults of working age and psychiatric intensive care units.
• There were medicines management issues in three core services at this inspection. At our last inspection we found that patients allergy status was not completed on some prescription charts in the community based mental health services for adults of working age. At this inspection we found that this had not been rectified across all teams.
• Patients in some services had limited access to psychological therapies and occupational therapy.

Inspection Findings:

Metropolitan Borough of Rotherham
CHILDREN’S SERVICE INSPECTION (6-November – 30 November 2017)

Metropolitan Borough of Rotherham Re-inspection of services for children in need of help and protection, children looked after and care leavers.

Summary of the key findings
Services to children in need of help and protection are now good. The recruitment of effective senior managers has resulted in sustained improvement. The quality and impact of services for children are transformed. Risks to children are recognised early and responded to, ensuring their safety. The corporate response and associated change in the quality of children’s services has been impressive. Leaders and senior managers have appropriately prioritised the improvement of key service areas.

The local authority is effective in its recruitment and retention of high-quality staff. Enhancing the workforce environment and, in particular, valuing frontline managers and staff have been essential components in securing change for the better. The local authority is a learning organisation and fully utilises relationships with its improvement partner and other local authorities through peer reviews, in order to test practice and identify further areas for development. Senior managers and leaders have a comprehensive understanding of the quality of service provided. Corporate ownership, well-cultivated partner relationships and increased financial investment enable the service to be highly responsive to local needs. This includes the creation of a dedicated multi-agency team to focus on complex abuse work and investment in identifying and supporting children who are at risk of sexual exploitation.

The complex needs of children who did not become looked after soon enough due to historic failures are understood, and children are supported effectively through dedicated therapeutic services. Families benefit from a broad range of early help services. Partners have grown in confidence in completing early help assessments. However, the early help offer is not sufficiently responsive to the needs of a small number of children, including children who have disabilities.

There is an effective multi-agency response to children in need of help and protection. Thresholds are understood and appropriately applied, resulting in swift protective action. Specific groups of vulnerable children and young people, including those who are privately fostered and young people who present as homeless, receive a well-coordinated multi-agency response that meets their needs.

Children become looked after when they need to be. The number of children becoming looked after has risen because of the improved identification of risk and the focused work on complex abuse. This increase has impacted on placement capacity and matching children who have more complex needs with permanent foster carers.
A previously unstable workforce, both in the fostering service and the locality social work service, meant that some children did not achieve permanence quickly enough. The development of a more stable workforce and the systematic review of children with a plan for long-term fostering who have not yet been formally matched are supporting improvements in the achievement of permanence for children. The quality of court work is improving. Decisions to return children home to their parents are informed by good-quality assessments. Children benefit from early consideration of placement with their extended families. Although management oversight is evident and supervision is regular, management challenge of the quality of practice and planning for children looked after is not consistently good.

Most assessments identify risks and are of good quality, particularly those recently completed using the Rotherham family approach. For a small number of assessments, the cumulative impact of harm is not always considered well enough, and issues of diversity and identity are not fully explored. For children looked after, assessments are not always up to date and some do not reflect sufficiently the complexity of needs or how these will affect the children’s future requirements. For some children, a lack of sharpness in care plans can lead to drift and delays in permanence being achieved and broader needs being met. The local authority is working to address these areas of provision that require improvement.

Strong management oversight identifies children who have a plan for adoption. Matched children move in with their new families in a planned way without delay. Adopters experience an effective recruitment, assessment and training offer with bespoke support provided by the local authority’s in-house therapeutic service. Wider family and friends of adopters access high-quality training to enable them to understand children’s experiences. Life story work and later life letters often contain professional language, and are not completed in a timely manner for children who are placed in foster care or have a plan for adoption. Support for birth families is not sufficiently promoted or utilised. Children have their health needs well met through timely health assessments and a dedicated therapeutic service.

The local authority has successfully challenged schools that are using informal exclusions, which has resulted in an increase in formal exclusions. More work is needed to reduce these and persistent absenteeism.

Rotherham achieves excellent outcomes for a great majority of its care leavers. Since the last inspection, councillors and senior leaders have invested significantly in the care leaving service, expanding its capacity and providing excellent new facilities, including a dedicated drop-in centre and good-quality housing. Highly effective partnership working has developed a broad range of services that give care leavers access to good-quality housing, and opportunities to receive education and training, and to gain employment.

**Inspection Findings:**

**Quality & Impact inspection** The effectiveness of probation work in South Yorkshire
An inspection by 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 quality of work delivered by the NPS to reduce reoffending was good, but there was room for improvement with reviewing work. Assessments and plans were sound, and appropriate cases were referred to the sex offender treatment programmes. Assessments for personality disorder traits were undertaken, with good use of available consultancy provision. Responsible officers’ default position was to deliver one-to-one work, however, rather than making greater use of probation service officers and available CRC services to deliver structured work.

The quality of work to support service users abide by their sentence was good. Effective arrangements were in place to share information with partner organisations. NPS responsible officers were working hard to engage and address difficult and challenging behaviour and the individual diversity needs of service users were taken into account. This promoted compliance. Most service users abided by the requirements of their sentences. When they did not, appropriate enforcement action was taken in the majority of cases.

**Inspection Findings:**

**HM Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS).**

**PEEL: Police effectiveness, efficiency and legitimacy programme (2017)**

**Summary of the key findings**

**Effectiveness**

South Yorkshire Police is good at keeping people safe and reducing crime. Since HMICFRS’ 2016 effectiveness report, the force has made progress in several areas. HMICFRS is pleased to see the positive effect recent improvements have had across the force, particularly in neighbourhood policing and investigations. Further action is needed to ensure the force is providing all vulnerable people with an effective service. South Yorkshire Police is good at keeping people safe and reducing crime.
Since HMICFRS’ 2016 effectiveness report, the force has made progress in several areas. South Yorkshire Police is effective in its approach to reducing crime, tackling anti-social behaviour and keeping people safe. The force must improve its ability to protect people who are vulnerable through their age, disability, or because they have been subjected to repeated offences, or are at high risk of abuse, for example. South Yorkshire Police is generally good at investigating crimes. The force effectively investigates some crimes over the telephone, through its new crime support hub and its dedicated investigation teams.

Efficiency
South Yorkshire Police is judged to require improvement in the efficiency with which it keeps people safe and reduces crime. This is consistent with last year’s assessment. The force’s understanding of demand is judged to require improvement; it is assessed to require improvement for its use of resources to manage demand; and its planning for future demand is judged to require improvement.

Legitimacy
South Yorkshire Police is judged to be good at how legitimately it keeps people safe and reduces crime. For the areas of legitimacy we looked at this year, our overall judgment is more positive than last year when we judged the force to require improvement. The force is judged to be good at treating all of the people it serves with fairness and respect and good at ensuring its workforce behaves ethically and lawfully. However, some aspects of the way in which it treats its workforce with fairness and respect are judged to require improvement.

Inspection Findings:
Children and Family Court Advisory and Support Service (Cafcass) Inspection of Cafcass as a national organisation 2018 (2 February 2018 – 2 March 2018)

Summary of the key findings
The overall judgement is outstanding Cafcass leads effective services that meet the requirements for outstanding.
The quality and effectiveness of Cafcass private law practice with families – Good
The quality and effectiveness of Cafcass public law practice with families - Good
The leadership and governance of the national organisation – Outstanding
The leadership and management of local services - Outstanding

Exceptional, aspirational corporate and operational leaders work relentlessly to ensure that children and their families benefit from good or outstanding services. Shared priorities are communicated clearly. Listening to children, understanding their world and acting on their views are strongly embedded in practice in both public and private law. This is enhanced by the splendid work carried out by the influential Family Justice Young People’s Board (FJYPB).

Since the last inspection, the chief executive, together with the national service director and supported by an effective and active board, have worked diligently to develop and support a culture of continuous learning and improvement. Stability of leadership and strong aspirations to ‘get it right’ for vulnerable children are key factors in their success. The vast majority of Cafcass staff at all levels consistently provide excellent quality services for children, their families and the family courts.
Cafcass’s highly evolved and mature strategic relationships with its key family justice partners (Her Majesty’s Courts and Tribunal Services (HMCTS), the Judiciary and the Association of Directors of Children’s Services (ADCS) have led to creative and innovative services nationally and locally. The chief executive and the national service director are held in high regard. They work tirelessly, driving much needed development and reform to meet the increasing levels of demand.

Cafcass practitioners’ effective and authoritative practice adds value and leads to better outcomes for the majority of children. In the vast majority of cases, family court advisers (FCAs) and children’s guardians provide the courts with cogent, well-balanced and analytical risk assessments. These help the courts to make child-centred and safe decisions.

Strong, evidence-based and succinct reports minimise the need for experts. They also reduce delay and the need for further appointments. In a very small number of cases seen, delay in establishing children’s views and progressing cases quickly enough was linked to poor case planning. Most direct work is well planned, done at the child’s pace, and ensures that the child understands what is happening. Reports are enhanced by using the child’s own words, resulting in the powerful voice of children informing recommendations to the court. Inspectors observed some highly sensitive, knowledgeable work in relation to a wide range of diversity issues.

Performance management is a key priority. A rigorous, strength-based performance framework supports the delivery of good and outstanding services nationally and locally. Key strengths and areas for development, identified accurately in Cafcass’s self-assessment, are used to inform both management understanding of the quality of practice and individual staff development. Senior managers have clear plans in place to help staff improve the consistency of 3 performance learning reviews (PLRs) and case planning, and to ensure that relevant diversity issues are fully considered.

Strong governance arrangements are firmly in place, augmented by a culture of professional accountability and respectful challenge at every level across the organisation. Cafcass has successfully implemented a model of proportionate working to address demand on services. Despite having high workloads, staff who spoke to inspectors felt extremely positive about working for an organisation in which they are treated well, as professional adults, and their views and needs are important and highly valued.

The national business centre (NBC) is exceptionally well-managed, effective and efficient. This means that Cafcass’s services for children benefit from the support of a coherent and expertly coordinated range of centralised systems. Business services and social work staff are skilled and committed.
5 Effectiveness of arrangements to keep Rotherham children 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 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 to ensure there is appropriate accountability and effective support and challenge across the system.

**Inspection Feedback**

**Ofsted Inspection Report (February 2018)**

Partners’ increasing understanding and trust of thresholds are further supported by co-located staff delivering a comprehensive early help offer and by improved confidence in completing early help assessments. Families benefit from a broad range of early help services. Partners have grown in confidence in completing early help assessments. However, the early help offer is not sufficiently responsive to the needs of a small number of children, including children who have disabilities.

Early Help Initial Contacts: The annual out-turn for the number of Early Help Contacts that were triaged within five working days was 85.3% which although below the target of 100%, does maintain performance against last year which was also 85.3%. Annual performance shows that 59.7% (604/1011) of families were contacted and engaged within the three working day local timescale with a further 32.5% (329/1011) being engaged with outside of timescales. This indicates that the majority of families are being contacted promptly and most 92.2% are being engaged.

Early Help Assessments (EHA’s). Overall, during the year, 47.2% (518/1097) of EHA’s were completed in timescales, with a further 29.8% (327/1097) being completed outside of local timescales. There was a total annual completion rate for assessments at 77% (845/1097).
The Triage Team within the MASH is increasing the numbers of requests to partner organisations to complete an Early Help Assessment. This will have a positive impact on the time for locality Early Help teams to spend supporting families.

**Early Help Assessments:**
Partner agencies are increasingly involved in undertaking Early Help Assessments. By the end of March 2018 15.9% (225/1415) of Early Help Assessments in 2017/2018 had been completed by partners which is a significant improvement on last year when only 6.5% of these were completed by partners.

Partners are also supported by the four integrated working leads which are now based across Early Help localities. Partner engagement with the Early Help Assessment is now being effectively tracked to highlight progress being made across agencies.

During 2017/2018, Primary and Secondary schools completed 67.5% (152/225) of Partner EHA’s with the remaining Partners (including Health service providers) completing the remaining 32.5% 73/225). Work will continue with health colleagues and other organisations during 2018/2019 to focus on increasing the numbers completed in these areas.

**Education Health and Care Plans (EHCP)**

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. EHCP Plans identify educational, health and social needs and set out the additional support to meet those needs.

Education Health and Care Plans are given to children who have been assessed as having high level Special Educational Needs (SEN). They were introduced in 2014 replacing the old SEN Statements. All Education Health and Care Plan (EHCP) completions and conversions from SEN Statements are measured nationally. Locally the monitoring of these two targets takes place fortnightly through an ‘Inclusion Performance Clinic’.

All local authorities were required to convert any old SEN Statements to EHCPs by April 2018. Therefore the percentage of completed new EHCP’s within 20 weeks has fluctuated over this year due to the necessary prioritising of these conversions and seasonal fluctuations in demand (ie school holiday periods). Cumulative performance over the year for new EHCPs was 56.5%. New incremental quarterly targets have been set and are being monitored for 2018/19 with the aim of returning the service to performance levels of 90% in the following reporting year 2019-20.

In relation to ‘conversions’ from SEN to EHCPs, there were a total of 998 to convert. 98% of all conversions were completed by the target date (April 2018) the remaining 2% (24 cases) were delayed due to the complexity of the individual cases.
**Children’s Centres.** Overall Children’s Centres fell slightly short of their registration rates during 2017/18 at 91% against the 95% target. However, performance in the 30% most deprived Super Output Area (SOA) neighbourhoods was better with 96% of children registered against the 95% target overall. Good performance was found in the South and North localities of the borough achieving 101% and 97% respectively. Engagement rates saw a similar trend with the 30% most deprived SOA’s achieving overall performance of 68% against a 66% target. Overall performance across the borough was 58% against the 66% target, however this was an increase when compared with 2016/2017 when performance reached 52%.

**Contacts and Referrals**

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.

In total 15,684 contacts were been received over the year compared to 16,609 in 2016/17, which equates to a 5.6% decrease. However, in the same period the proportion progressing to referral has increased by 2% to 28.6% with a trajectory towards 30%. Similarly progression from referrals to assessment has increased over the year and now consistently achieves 99% each month.

The increased conversion of contacts to referrals reflects the positive impact the partnership is making with improved quality in the operational process and information sharing within the Multi-Agency Safeguarding Hub (MASH) with the majority of screening activity taking place earlier and ensuring progression to social care referral only when appropriate.

![Volume of contacts per month](chart.png)
Referral rates by month:

Over the last 12 months the re-referral rate has made incremental reductions each month reaching 23.1% at the end of 2017/18 resulting in a 4.4% positive decrease on the 2016/17 outturn. This evidences and supports audit findings that social work case practice is significantly improving. The month on month trend also suggests that the improvement is being sustained. However, to be confident that this is fully embedded the rate needs to fall below the national average (21.9%) for a sustained period and then move to a top quartile position (16%).

Improvement in information sharing between partners:

The increased conversion of contacts to referrals reflects the positive impact the partnership is making with improved quality in the operational process and information sharing within the Multi-Agency Safeguarding Hub (MASH) with the majority of screening activity taking place earlier and ensuring progression to social care referral only when appropriate.
Assessments

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.

Provisional performance for 2017/18 in relation to assessment timeliness stands at 78% which is a 7.3% decline on the previous year, however it is worth noting that the volume of assessments completed has increased by 32% in the same period (6781 compared to 5148).

Assessments completed:

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. The
service managers in the Locality social work teams continue to lead regular reviews in conjunction with early help colleagues on Child in Need work to minimise drift and ensure only those children that require this type of intervention are open to the service.

At the end of March 2018 there were 1686 CIN, when combined with those subject to child protection plans (CPP) this equates to a rate of 413.8 per 10k population; positioning Rotherham above both the statistical neighbour average (372.7), and the national average (337.7).

Child Protection

Section 47 investigations are those child protection enquiries 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.

Trend data in relation to Section 47 investigations demonstrate a continued high volume. A comparison of year-on-year outturn data shows a 54.4% increase in the total volume of new S47s from 1457 to 2235. Investigation outcomes show 63.9% (1429 children) over the year were proven to be at risk of continuing harm and therefore progressing to a safeguarding intervention through the child protection process. Only 7.3% (164 children) were not in line with the "significant harm" threshold. This low level indicates continued improvement; with 2015/16 having 11.2% and 2016/17 10.9%.
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.

Demand across the partnership is high with further increases for children subject to Child Protection Plans reaching 656 children. If compared to the 2016/17 outturn figures of 370 children. This equates to an increase of 77% and appears to be as a result of a combination of factors: an improvement in social work assessments identifying and responding to risk, the complex abuse enquiry and the upward trend nationally.

The trend for the number of children with a Child Protection Plan (CPP) continues to remain upwards and our rate per 10k population is now 115.9 which is significantly higher than statistical neighbour (56.6) and the national average (43.3). This is placing increasing pressures on the partnership child protection system despite audit and inspection findings indicating that thresholds are being applied appropriately.

**Inspection Feedback**

**Ofsted Inspection Report (February 2018)**

Child protection enquiries and strategy meetings involve appropriate multi-agency representation that informs robust decision-making in order to protect children. Work with South Yorkshire Police on the conduct of Achieving Best Evidence interviews is beginning to improve the quality of joint social work and police interviews.
Performance in the timeliness of Review Child Protection Conferences for the year as a whole was 94.6% which is a decline when compared to the previous year’s 98.6% but still places Rotherham above the national average of 92.2%.

**Child Protection Visits**

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

Compliance against the local Child Protection visit standard sees a disappointing year end position of 89.1%, given the consistent achievement levels earlier in the year of 93%+ however this is less than 1% below last year’s outturn position when there were 241 fewer children on a Child Protection Plan. Children’s Services reports that performance clinics continue to monitor this alongside other compliance measures and team managers are able to articulate the reasons, attempts to visit made and the plans which are in place to ensure that children are safe.
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.

The LSCB Practice Review Group monitors all cases where a Child Protection Conference Chair has either raised concern about multi-agency practice in Child Protection or has vetoed a decision at the Conference. This provides an independent check and challenge to practice and decisions about significant harm.

The feedback from children (below) highlights the difference that independent advocacy is making in supporting a young person to feel engaged in the child protection process.

Child Protection Advocacy Service (Barnardo’s)

In 2017/18 the service engaged with 1035 children aged between ages 8 and 17, which is an increase of 357 children on the previous year. The percentage of children and young people aged 8-17 having their voice heard and represented at their Child Protection Conference has decreased from 60% in 2016/17 to 44% in 2017/18 because the number of CP plans and subsequently the demand for advocacy has increased.

48% of children aged 8 to 17 were represented and able to express their views at their Initial Conference, a decrease of 19% from the previous year, which is due to the significant increase in demand for Advocacy in Child Protection, however the number of children who were able to express their views at initial conference has increased from 162 in 2016/17 to 213 in 2017/18.

The feedback from children (below) highlights the difference that independent advocacy is making in supporting a young person to feel engaged in the child protection process.

The Advocacy Safe booklet and activity sheets are good’

The Advocacy Service was very helpful, I knew who was going to be there at the meeting

The Advocate explained to me what happens at a conference

The advocate service was friendly and helpful

The Advocacy Safe booklet is very good’
Demand across the whole service and partnership is high with further increases in number of Looked After Children to 624 at the end of March 2018. If compared to the 2016/17 outturn figures of 488 LAC this equates to an increase of 29%. This appears to be as a result of a similar combination of factors as seen in the CPP rise, (improved identification and response to risk, the complex abuse enquiry and the upward trend nationally). The rate per 10,000 of the population now stands at 110.3 as compared to the statistical neighbour average of 81.3 and the national average of 62 (as reported at March 2017).

A ‘Right Children, Right Care’ transformation action plan is now being implemented focusing on both reducing the number of admissions through edge of care preventative approaches and ‘safely’ increasing the number of children ceasing care. The scoping process has been completed for the Right Child Right Care programme and there are 170 children for whom discharge from care is assessed to be a viable option. Work progressing these plans will now commence, although significant positive impact is not anticipated until late 2018.

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<tr>
<th>SN Ave</th>
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**Rate of Looked After Children per 10K pop**

**Inspection Finding:**

**Ofsted Inspection Report (February 2018)**

Decisions to look after children are now made in the children’s best interests and are timely and planned in most cases. This has resulted in increasing numbers of children entering care appropriately. Children are beginning to benefit from early consideration of placement with their extended families. Permanence is not yet achieved for all children soon enough. Assessments are not sufficiently robust or up to date to inform decisions about placement choice or identify broader needs. Brothers and sisters are often placed together in foster care, but children’s relationships, in terms of placement and contact needs, are not fully considered. Plans are not as sharply focused as they could be.
Positively the rate of discharge reached its highest level for 6 months at the end of the year with 20 children ceasing care in March 2018 indicating the Right Child Right Care programme is beginning to have some impact.

**Looked After Children - Statutory Reviews**

_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._

Due to a combination of Independent Reviewing Officer sickness levels, high demand and social workers not completing their pre-review reports within timescales there was a dip in the timeliness of LAC statutory reviews at the beginning of 2018. However, it is reassuring to note that, in March performance improved to above target at 95.5% and helped improve the full year’s performance to 90.4%. The LSCB will continue to monitor the performance in this area as timely statutory reviews are key in preventing children’s cases from drifting.

**Looked After Children – Placements**

_It is important that who are Looked After by the local authority have a stable place to live (placement)_

The proportion of long term LAC who have lived in the same placement for over two years continues to have achieved incremental month-on-month improvements towards the end of the year towards an outturn of 61.3% (92 out of 150 children) this followed an in year low in November of 59.2%. Progress on this measure has been impacted by the increasing number of long term LAC and our desire to bring children closer to home and into family placements, (positive placement moves). Due to the timeframes within the definition this is an area of performance which cannot be improved quickly. A forward projection analysis of the current cohort predicts that this measure potentially could reach 66-67% within the next reporting year.

In the last three months of 2017/18 there was an increase in the number of children experiencing multiple placement moves. The provisional outturn position of 13.1% (81 out of 618 children) is an increase on the 2016/17 figure of 11.9%. The local increase in LAC is part of a national trend and as a result the placement market is increasingly saturated making appropriate matching decisions an increasing challenge. The Intensive Intervention Programme being implemented by the Rotherham Therapeutic Team is clearly having some positive impact on the number of placement disruptions for the most vulnerable and challenging of our young people who are known to be at risk of placement breakdowns. However, it is also likely that the impact of the Right Child Right Care project will mean more placements will be converted to Special Guardianship Orders/Child Arrangement Orders, which will be a positive outcome for the child but may have a significant negative impact on the stable placement performance over 2018/19.
Despite the further increase in LAC numbers, the proportion of children in a family based placement remains relatively stable at 82.4% of the total cohort. Given the increasing numbers of LAC performance regarding the proportion of LAC in commissioned placements has declined to 50.5% (315 of 624 LAC). This decline is not significant and reflects the same level as October when there were only 267 LAC in the cohort. This indicates that the in-house Fostering and Placements team have become far more efficient in placing children within in-house placements.

In relation to children in care, performance in LAC visits within the national minimum standards has decreased slightly to 94.7% from last year’s outturn of 94.9%. Performance has been impacted by the increase in numbers of LAC and the increased travelling distances required due to placement market saturation. This remains an on-going focus of attention in performance clinics.

**Looked After Children – Health and Dental assessments**

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.

The performance figures reported by the LAC Health Team are higher than those recorded in local systems, suggesting there is still some time lag in inputting data onto social care system by social workers. The number of Initial Health Assessments (IHAs) complete each month remains relatively consistent however timeliness performance according to internal recording is below 40% at 36.4% (4 out of 11 completed IHAs). This is particularly low when compared to achievements earlier in the year of between 75-90%. Over the year 55.3% of the 226 IHAs completed were within timescale, it is acknowledged that this is low but it is a significant improvement on levels achieved in the last three years (18.2% in 2016/17). The reported figure by Health colleagues for March is 56% with a further five “did not attends” and one last minute cancellation which needed to be followed up. Both Health and Dental LAC reviews have seen a decline to 76.8% and 64.1% respectively. In respect of the Health Review Assessments the figure reported by the LAC Health Team colleagues is 86%.

**Re thinking missed appointments for children:**

Children rely on parents/carers to take them to appointments and missed appointments are always a cause for concern. Often this is recorded as the child Did Not Attend. The LSCB is supporting an initiative for all organisations and professional to change this to Was Not Brought to reflect that it is the responsibility of those with parental responsibility and prompt a more positive intervention.

**Looked After Children – Education**

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

97% of eligible LAC have a Personal Education Plan (15 LAC with no PEP) and 95% have a PEP less than one term old (24 with an older or no PEP). Although this performance is high and an improvement on the Autumn term it is slightly lower than usual due to a combination of the
adverse weather which meant that several PEPs had to be rescheduled, and the fact that it was a very short school term. Also, the figure includes LAC who either did not come into care until late in the term, or who we were notified had come into care, and where there wasn’t time to arrange a PEP meeting.

The quality of PEP and education planning is beginning to have an impact on educational planning with Key Stage 2 outcomes improving in 2017 as compared to 2016 and to a degree significantly above national and regional comparators. In respect of Key Stage 4 outcomes for 2017:-

- 3 young people achieving 9 A*-C including English & Maths.
- 1 achieved 8 A*-C including English but missed maths by 1 grade
- A further 2 achieved 5+ A*-C including English but missed maths by a grade.
- Another young person achieved 5 A*-C but missed maths and English by 1 grade.
- 3 young people achieved 4 A*-C: 1 including English and 1 including Maths.
- 10/30 had an EHCP, EHCP pending or a statement of SEN.
- 10 young people were not in mainstream schools. Of the 20 children in mainstream education:
  - 3/20 (15%) achieved 9 A*-C including English & Maths
  - 6/20 (30%) achieved 5+ A*-C
  - 9/20 (45%) achieved 4+ A*-C

Attendance for the whole LAC cohort currently stands at 94% but there are 26 young people who are currently receiving less than their 25 hours statutory entitlement. Some of these young people do not have the emotional resilience to manage any more than their current access but the multi-agency group, including Early Help, continues to meet on a monthly basis to support more of these young people towards their full entitlement.

Care Leavers

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

Despite an on-going increase in the number of Care leavers to 257 at the end of March 2018 compared to 223 in March 2017, the proportion with a pathway plan remains at high level of 97%. The timeliness of these plans also continues to improve with 83% of young people with an up to date plan compared to 69% earlier in the year. The service continues to focus on improving the quality of the plans so that they are meaningful for young people and the introduction of a new plan template is significantly supporting this.

The numbers of care leavers in suitable accommodation has declined, however, to 96.9% which is due to 2 more young people receiving custodial sentences. This places Rotherham in the top quartile in out of all the local authorities in England in respect of this performance measure.
Performance in respect of care leavers who are in Education, Employment or Training has improved after a recent decline in recent months, at 63.6% this measure currently stands at its highest level for 12 months. The Leaving Care Team are working closely with other Council Directorates to firm up the pre-apprenticeship offer (work experience and work placements) in order to achieve increased sustainability as only one young person from 2017 is still attending his apprenticeship placement. However, performance remains strong and once again places Rotherham back in the top quartile. There are currently 13 Care Leavers in Higher Education and one undertaking a PhD. A further care leaver completed their Masters degree in 2017 in Engineering.

Inspection Finding:

Ofsted Inspection Report (February 2018)

Rotherham achieves excellent outcomes for a great majority of its care leavers. Since the last inspection, councillors and senior leaders have invested significantly in the care leaving service, expanding its capacity and providing excellent new facilities, including a dedicated drop-in centre and good-quality housing. Highly effective partnership working has developed a broad range of services that give care leavers access to good-quality housing, and opportunities to receive education and training, and to gain employment.
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.

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

1. **The Performance & Quality Sub group** focuses on quality assurance through performance management and auditing, mainly at an aggregated level of information.
2. **The Practice Review Sub group** focuses on learning from individual cases.
3. **The Serious Case Review (SCR) Sub group** considers and monitors cases which meet the statutory criteria for a Serious Case Review.
4. **The Child Death Overview Panel (CDOP)** considers learning from all child deaths in Rotherham.
5. **The Learning and Improvement Sub group** draws the learning points from all reviews and oversees the changes to safeguarding practice through changes to procedures, training and monitoring of action plans.

Performance & Quality Assurance

Quality Assurance is a process that checks the quality of services and the difference they make for children. 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.

Professionals and organisations protecting children need to reflect on the quality of their services and learn from their own practice and that of others. Good practice should be shared so that there is a growing understanding of what works well. Conversely, when things go wrong there needs to be a rigorous, objective analysis of what happened and why, so that important lessons can be learnt and services improved to reduce the risk of future harm to children. (Working Together to Safeguard Children, 2015)

The Performance and Quality Assurance Sub Group meets on a six weekly cycle, with 8 meetings held per year. The meetings focus alternatively on the partners Performance Management Framework and auditing both of which are scrutinised and areas of concern reported to the Board. The Sub Group utilises quantitative and qualitative methodologies to provide an accurate position in relation to aspects of safeguarding children.
Quarterly LSCB Performance Management Framework
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 with 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 and audits triangulated with feedback from other agencies and external processes

Multi-agency audits completed in 2017/18

- Domestic Abuse - MASH Response to Domestic Abuse referrals (MADA), Longitudinal study
- S47 Enquiries - Appropriate multi-agency judgements are made about risk of significant harm and procedures are followed.
- Parental Contact with Children in Hospital with Safeguarding Concerns - Procedures followed to ensure children not at risk

Audit: Parental Contact with Children in Hospital where there are Safeguarding Concerns.
This audit was held as a result of the Child R serious case review. Child R was admitted to hospital with a suspected non-accidental injury and was then injured again by his father while on the ward. The serious case review recommended the development of a specific protocol in relation to parental contact with children in hospital and. The findings of the audit evidenced that social workers and ward staff were using the protocol and were clear about what arrangements for family contact were in place for the children.

Audit: Partnership response to Domestic Abuse.
The partnership commissions a good range of services for victims of domestic abuse, including those assessed as lower risk and these are used well by victims. However, there are concerns about waiting times for some services.
There is a gap in the provision of services for perpetrators of domestic abuse who are not convicted and this has the potential to undermine the good work that is developing.
Safeguarding Self Assessment

Joint Adult and Children Safeguarding Self-Assessment

Section 11 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. In addition the Care Act (2014) requires Local Authorities to set up Local Safeguarding Adults Boards (LSAB’s). The 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 Rotherham Local Safeguarding Children and Adults Boards have committed to and are developing a joint safeguarding children and adults self-assessment. The purpose of the joint assessment is to provide all organisations in the Borough with a consistent framework to assess monitor and improve their Safeguarding Children’s and Adult’s arrangements in line with statutory requirements and best practice. The joint self-assessment tool will be finalised in November 2018 and be implemented from January 2019.

Voluntary and Community Sector – Safeguarding Self-Assessment

Voluntary and Community Sector (VCS) organisations in Rotherham also undertake a safeguarding children self-assessment bi-annually to provide assurance in relation to their arrangements to safeguard children. Unlike statutory agencies the Voluntary and Community Sector Organisations are not currently statutorily obliged to conduct a self-assessment.

Progress by Voluntary and Community Sector Organisations (members of the Children, Young People and Families Consortium) towards completion of the Self-Assessment as at October 2017 included 5 organisations out of 24 that had registered to complete the assessment, that have fully completed 90-100% of the self-assessment. A further 13 organisations have completed over 50% and six organisations had not started the assessment by the end of December. The LSCB continues to work with the sector to support them in completing their self-assessment.

In February 2018 the self-assessment tool was reviewed in consultation with the members of the Children, Young People and Families Consortium and a revised version is to be launched during 2018/19.

Schools – Safeguarding Self-Assessment (Section 175)

Schools are expected to complete the S175 on-line safeguarding self-assessment. 129 Rotherham schools, including children centres, colleges and special schools in Rotherham, are registered to
complete the self-assessment. The progress towards completion of the self-assessment, as at October 2017 is that 67 schools/education settings that have completed 90-100% of the self-assessment with a further 41 having completed over 50%.

The LSCB engages with the school and children’s centres community via the termly Education Safeguarding Forum. This is a positive and well received opportunity for two way discussion, awareness raising and information sharing between the education sector and the LSCB. In 2017 the S175 self-assessment progress was discussed and it was reiterated that school governing bodies and trustees of Multi Academy Trusts are to be involved with and have ownership of their safeguarding children arrangements.

Section 175 self-assessment report (October 2017): Overall for a majority of schools in Rotherham returned positive responses, scoring highly in most areas:

- 79% of schools have a consistent child protection policy in place
- 81% of schools actively promotes the role of named or designated safeguarding lead (DSL) person and undertakes a number of initiatives to champion a safeguarding culture
- 88% of schools reported their DSL have received appropriate safeguarding training within the last two years
- 83% of schools encourage pupils / students to talk about their feelings and deal assertively with social/relationship pressures.
- 66% of schools in Rotherham having fully compliant recruitment and selection processes in place.
- Over 70% of schools in Rotherham do have a policy on child welfare and safeguarding / child protection record keeping.
- 74% of schools reported that the governing body is actively involved with safeguarding children within school through designated / nominated governor

Serious Case Reviews and Lessons Learned Reviews

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

One of the features of both types of review is that they involve agencies, staff and families in a collective endeavour to reflect up and learn from what has happened in order to improve practice in the future.

A Serious Case Review (Child J) was undertaken jointly with Sheffield LSCB and the report was signed-off at an extraordinary meeting of the RLSCB on the 11/05/2017. The agencies that were involved in the review will be required to take forward the recommendations and action plan.
There are no firm dates or plans for publication of the report due to the criminal investigation which is still ongoing. Some of the key recommendations from the Serious Case Review which have now been implemented were:

- The Local Authority to introduce a conflict of interest form to ensure clarity of responsibility to the child, for Childcare Practitioners (child minders) to cover circumstances where they are caring for a family member’s child.
- Re-issue the statutory framework to all child minders highlight to them their responsibilities contained within the child protection section.
- To use the learning from this specific case in the safeguarding training for all new childminders.

A further Serious Case Review (Child AR17) was undertaken during 2017/18. A key message from this case was the importance for professionals in keeping the child’s lived experience at the centre of their thinking.

The emerging learning points from this review which are now included in an action plan include:

- Over-reliance on medical evidence when assessing risks to the child.
- Recognition of risks and vulnerabilities in relation to young motherhood and need for framework of early support.
- Importance of high quality record keeping and information sharing
- A further review protocol for contact between parents and their children in hospital where there are safeguarding concerns

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 a Serious Case Review (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 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 practitioners involved in a case, to a larger multi-agency challenge event.

Eight cases were reviewed by the Practice Review Group using a variety of methods including, desk top reviews and practitioner event. All cases had reports submitted to the Performance and Quality sub-group with recommendations and appropriate actions subsequently taken, eg:

- Inclusion of good practice examples in training and in the RLSCB newsletter.
- Multi-Agency Assessment to include invisible adult males figure within assessments of risk.
- Adult services working more closely with children’s services.
- Review of the bereavement pathway.
- Use of Graded Car Profile in neglect cases.
In February 2017 a multi-agency review was undertaken on a case where an infant had received an injury. At the heart of this case was a clear missed opportunity for the child to have been referred to a paediatrician and the Multi Agency Safeguarding Hub for consideration of section 47 enquiries. As a result work has been undertaken with GPs and 0-9 practitioners re-enforcing that any non-mobile infant with a bruise should trigger a safeguarding referral and a full medical examination. A new safeguarding procedure was developed supported by a key message of:

‘Babies that don’t cruise, rarely get bruised’

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 aged from 0-18 yrs who is normally resident in the borough. The purpose is to see if there are any areas of learning or changes to practice to prevent a similar child 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 required 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.

In reviewing the death of each child, the CDOP should consider modifiable factors in relation to the individual child, the environment, parenting capacity or service provision, and consider what action, if any, could be taken locally and what action could be taken at a regional or national level.
Child Death Reviews 2017-18

During 2017-18 CDOP met on five occasions, with a total of 11 deaths being reviewed.

<table>
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<th>Age Range</th>
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<th>Ethnicity</th>
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<td>7</td>
<td>28-364 days</td>
<td>Female</td>
<td>White British</td>
<td>Expected</td>
<td>Non-modifiable</td>
<td>Chromosomal, Genetic and Congenital anomalies</td>
</tr>
<tr>
<td>8</td>
<td>28-364 days</td>
<td>Male</td>
<td>White British</td>
<td>Expected</td>
<td>Non-modifiable</td>
<td>Perinatal / Neonatal event</td>
</tr>
<tr>
<td>9</td>
<td>&lt;28 days</td>
<td>Male</td>
<td>White British</td>
<td>Expected</td>
<td>Non-modifiable</td>
<td>Perinatal / Neonatal event</td>
</tr>
<tr>
<td>10</td>
<td>1-4 yrs</td>
<td>Male</td>
<td>White Other</td>
<td>Expected</td>
<td>Non-modifiable</td>
<td>Chromosomal, Genetic and Congenital anomalies</td>
</tr>
<tr>
<td>11</td>
<td>&lt;28 days</td>
<td>Male</td>
<td>White Other</td>
<td>Expected</td>
<td>Non-modifiable</td>
<td>Chromosomal, Genetic and Congenital anomalies</td>
</tr>
</tbody>
</table>

* A modifiable factor is one where one or more factors may have contributed to the death of the child and which by means of locally or nationally interventions could be modified to reduce the risk of future child deaths.

CDOP Priorities for 2018-19

The new Working Together guidance (2018) will from 2019 require the responsible Child Death Review Partners to review a minimum of 60 deaths per year and report the findings from these to a national government data base. This will require the Rotherham CDOP to work cooperatively on a sub-regional basis to establish new arrangements to review the minimum requirements of 60 deaths.
Key Learning Points from 2017-18

A safe sleep for infants audit was undertaken by The Rotherham NHS Foundation Trust and reported to CDOP. This identified that the safe sleep questionnaire used with parents was not fully embedded with the 0-19 (health visiting) Service. As a result a programme of learning sessions was provided for health staff with agreement that audits would continue to take place at regular intervals to monitor improvements in practice and outcomes for children.

Most front line professionals will never become involved with the child death process and a series of awareness raising sessions for frontline health staff were held to provide information about the process. The feedback has been very positive and these sessions are now to be offered to professionals and volunteers from across the partnership.

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. Learning and development is delivered through a blended approach with face to face training, conferences, briefings, webinars 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. The aim is to support individuals and organisations to undertake their safeguarding roles and responsibilities in a committed, confident and competent manner.

Throughout 2017/18 the LSCB website was fully reviewed and updated for all audiences including, Professional and Volunteers, Children and Young People, Parents and Carers. New content included, Guidance for Section 175 safeguarding self-assessment for schools; for children and young people – ‘Know your Rights’ and E-safety advice; and improved guidance and navigation on how to report abuse ‘if you are concerned about a young child or person’. The website was also made accessible in 103 languages. Visits to the website increased by 65% during 2017/18, including a small increase in March 2018 from Social Media referrals – in particular Facebook.
**Safeguarding Children Training**

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 lessons learned. In September 2017 the LSCB launched e-learning as part of its training offer and the 8 courses were launched. Over 350 e-learning courses were completed in the 6 monthly period Oct 17 – March 2018 by partner organisations.

**E-Learning courses:**

- An Awareness of Domestic Violence including the Impact on Children and young People
- An Introduction to FGM, Forced marriage, Spirit Possession and Honour-based Violence
- Awareness of Child Abuse and Neglect – core
- Awareness of Child Abuse and Neglect – Foundation
- E-Safety Guidance for Practitioners working with children
- Keeping them Safe – Protecting Children from Child Sexual Exploitation
- Safeguarding Children in Education
- Self-Harm and Suicidal Thoughts in Children and Young People

During 2017/18 the LSCB provided 20 different themed training courses and 2,410 professionals attended these courses from across partner organisations. All RLSCB courses (both e-learning and face to face) are free of charge to all partner agencies and non-profit organisations.

**Themed Training:**

Designated Safeguarding Lead Workshop
Attachment Training
Group 3 Safeguarding Core Workshop
Graded Care Profile
Safeguarding Young People at Risk of Child Sexual Exploitation - A Multi-Agency approach to Supporting Young People at Risk
Safer Recruitment for Schools
Child Death Review Process
Digital Safeguarding Training
Early Help Pathway Workshop
Working with Resistant Families
Prevent Training
Safer Recruitment (evening)
The Toxic Trio, Safeguarding Children – Parental Domestic Abuse, Substance misuse and Mental Health

**Partnership newsletter:** In January 2018 the LSCB launched its ‘digital newsletter’ to 495 subscribers, devoted to single and multiple news items, including information on serious case reviews, procedure changes and learning and development opportunities. All services and organisations are encouraged to submit news items relevant to safeguarding children.
Attendees are asked to provide evidence of the impact of the training both on their practice and for children and families. The evidence shows that the majority of attendees report increased confidence, improved skills and the fact that having attended the training they felt it had impacted positively on their safeguarding practice. The following offers an insight into some of the feedback received:

**Safeguarding Children at Risk of Sexual Exploitation**

Early Years Worker, Rotherham Council

*The indicators to abuse – I feel more confident in making referrals and what actions to take*

**Working with Resistant Families**

Support Worker, Rotherham Hospice,

*Remain child focussed, never give up. No matter how small, all my actions can make a difference*

**Group 3 Core Workshop, Working Together on 13th February 2018**

Early Years Support worker, Rotherham Council

*Improved confidence in knowing an injury can be investigated through safeguarding processes*

*We are going to use the 1-10 scale in after school club, e.g. asking children about their day, re: bullying ‘*

**The Toxic Trio Safeguarding, Children and Mental Health on 23rd March 2018**

Foster carer – Rotherham Council

*My understanding of parental mental health has improved*

In January 2018 a training evaluation event analysed 84 multi-agency training courses which were delivered between Apr-Dec 2017 and attended by 1,987 people. The event looked at the impact
of the training after 3 months of attending the course and how it has improved practice with children and young people. The response overall was respondents could evidence improvement in their practice; there were improved outcomes for the child, young person and family and they had shared their learning back in the workplace which had supported their colleagues.

Safeguarding Children 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 2017/18 there were two updates to the online multi-agency safeguarding children procedures which included:

Group 3 Core Workshop

When asked to explain how their practice had improved, the respondents stated:

‘Greater awareness of safeguarding issues’

‘Discussions with staff in supervisions and at clinical review meetings’.

‘It helped me to realise that my understanding of safeguarding procedures is in line with local authority policy’

Training for Designated Leads in Schools and Colleges

When asked to give an example of how outcomes for a specific child had improved, the respondents stated:

‘My understanding of sources of support available for parents experiencing DA meant that support could be signposted more effectively which impacted on the decisions the parent made in order to safeguard her children’

Safer Recruitment Workshop

When asked to explain how their practice had improved,

‘Had issues in next recruitment drive and the training supported me in working through these’

When asked to give an example of how outcomes for a specific child had improved, the respondent stated:

‘More vigilant when recruiting new staff members’
New procedures -

- 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

The following procedures were reviewed and amended -

- Protocol for Safeguarding Children in Whom Illness is Fabricated or Induced
- Allegations Against Staff, Carers and Volunteers
- 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
- E-Safety
- Safeguarding Children Subject to Private Fostering Arrangements
- E-Safety – 2 new documents added as links
- Prevent – link to new document
- Supporting children who are bereaved
- Gang activity
- Domestic abuse
- FGM - link to new document
- Forced Marriage and Honour Based Violence
- Children who go missing from home or care

Work has commenced on the safeguarding procedures update which will go live in June 2018. The Learning and Development sub group have given priority to updates to procedures that needed to incorporate Signs of Safety language and terminology, any changes required from serious case reviews and the anticipated changes from the revised Working Together statutory guidance.
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 (updated in 2018) requires that each Local Authority has a designated officer or team of officers, to deal with allegations made against professionals who are a part of the children’s workforce.

In practical terms, the role of the Local Authority Designated Officer (LADO) is to:

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

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

- Cause or potentially cause harm to a child;
- Commit a criminal offence against or related to a child; or
- Indicate that he or she would pose a risk of harm if they were to work regularly or closely with children.
During the year 1st April 2017 – 31st March 2018, 96 enquiries progressed to the LADO process. This represents an increase in the volume from the previous year from 77 enquiries. In addition to these, there were a number of other LADO enquiries which did not meet the LADO criteria or that required intervention from another Local Authority LADO. An additional 739 of this type of query were taken in the year but they lacked the detail or content to be formally recorded as LADO investigation but advice and guidance was provided. A new improved recording system was introduced in 2017-18 which now includes all enquires of a LADO nature and accounts for the apparent increase in volume from 2016-17.

Of the 96 enquiries that progressed to a full LADO investigation, the nature of the allegation was as follows:

**Caterogies of abuse - reported 2017/2018**

- Historical Abuse: 23%
- Physical Abuse: 16%
- Physical Restraint: 10%
- Child Sexual Exploitation: 8%
- Sexual Abuse: 6%
- Historical Sexual Abuse: 4%
- Person Posing Risk: 2%
- Neglect: 2%
- Emotional Harm: 2%
- Conduct Issues: 9%
The highest figures of abuse category are physical and emotional harm.

LADO contact covers a wide range of professionals over the children’s workforce, over 2017/2018 the majority of professionals where LADO allegations were made covered secondary education and Local Authority Foster Carers.

The highest figures in relation to employee’s has been in relation to foster carers and secondary education staff, where physical restraint is an area that is been repeatedly considered by LADO from professionals working in environments with young people who can present with challenging behaviours.

**Procedure for dealing with allegations against staff, volunteers and foster carers.** A new LADO procedure was developed and implemented for all partners in April 2017. This procedure strengthens the interface between the Local Authority Designated Officer (LADO) and the Multi Agency Safeguarding Hub (MASH). All referrals and contacts are now screened and progress through the MASH and the application of the threshold for a LADO investigation is strengthened.

**Ofsted Inspection Report (February 2018)**

Allegations against professionals are robustly managed. All referrals to the designated officer are made through the MASH, which ensures that risks to children are identified at the earliest opportunity and are appropriately managed. Evidence was seen of effective information sharing through allegations management meetings that resulted in clear actions, which are reviewed as required.
Of the 96 enquiries that progressed to Allegation Management Meeting, the outcome of the investigations was as follows:

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substantiated</td>
<td>15</td>
</tr>
<tr>
<td>Unsubstantiated</td>
<td>9</td>
</tr>
<tr>
<td>Unfounded</td>
<td>2</td>
</tr>
<tr>
<td>Malicious</td>
<td></td>
</tr>
<tr>
<td>Incomplete</td>
<td>70</td>
</tr>
</tbody>
</table>

Within the current reporting year, there are 70 incomplete outcomes and these cases remain under investigation. A large number of LADO’s do remain in under investigation status due to ongoing police investigations which take a significant period of time to conclude. It is to be noted that where LADO investigations are reliant on the outcome of forensic examination of internet devices, the investigation can be delayed for several months whilst results are awaited, again this is both a national issue and area of ongoing challenge. The majority of cases referred were completed in the same year.

8 Conclusion

Services provided to children by Rotherham Council have gone through a period of rapid improvement, strongly supported by the wider partnership. With reducing resources the challenge for the local authority and partners will be to sustain and further improve services to and outcomes for children who are at risk of harm within the community, those who need to be looked after by the local authority and those with emerging needs or problems within their lives.

Because effective partnership working is needed to keep children safe it is imperative that we build on the good work achieved, remaining focussed and utilise assurance and challenge mechanisms within and between organisations that help to resolve areas of service delivery that are both complex and sometimes constrained by competing priorities.

The high numbers of children subject to a Children Protection Plan and those who are Looked After will mean that the statutory and resource responsibilities towards these children will be high. It is, therefore, even more important for those children who have emerging or early difficulties in their lives to receive the right help and support at the right time before problems escalate and become more complex. For these children the importance of receiving early help is crucial and all organisations, including schools and the voluntary sector will need to continue to play a proactive role.
9 Strategic Priorities for 2016-18

The LSCB priorities for this period have been:

- Engagement with practitioners and the local community
- Child Sexual Exploitation and Missing
- Listening to and acting on the voice of children and their families
- Safeguarding Looked After Children.
- Performance, Quality assurance & Learning and Improvement
- Neglect
- Partnerships, Governance and Communication
- Effectiveness of Early Help

Partnerships governance and communication

The local strategic partnership boards have now established mechanisms for collaborating on safeguarding issues and this area of work continue to be a priority into 2019 as partners develop the new multi-agency safeguarding arrangements required by the Working Together (2018) statutory guidance.

Neglect

Children who are neglected continue to constitute a high percentage of those children requiring safeguarding services and the implementation of the neglect strategy will need to be driven forward to tackle the neglect of children in the borough.

Engagement with practitioners and the local community

The local safeguarding partners need to do more in terms of engagement with local communities, including faith groups, sports clubs and other community based groups.

The voice of children and their families

The voice of children and their families need to be taken into account when evaluating the effectiveness of services and outcomes for children. Rotherham is wholly committed to this with the vision to become a child friendly borough.
Effectiveness of early help

There is evidence that partner agencies are becoming more involved in early help and undertaking early help assessments. The LSCB will continue to encourage this wider engagement and to monitor the effectiveness of early help in improving outcomes for children and families.

Child Sexual Exploitation and Missing

There is evidence, supported by inspection of significantly improved practice in preventing and responding to child sexual exploitation and in reducing the number of episodes of children going missing in the borough. The LSCB is committed to ensuring continuing improvement in this area, but is also considering children and young people’s vulnerability to a wider range of risks.

Safeguarding Looked After Children

Progress is noted in this area, particularly in relation to children going missing and the board will continue to monitor all aspects of safeguarding for this group.

Performance, Quality Assurance and Learning and Improvement

The work of the sub groups covering these areas has been strengthened and partners are committed to developing the functions of these in the new safeguarding arrangements.

As the new multi-agency safeguarding arrangements are developed, partners will review the current priorities and a new business plan will be produced and published in 2019.
## Appendix 1 – Board Member attendance 2017-18

<table>
<thead>
<tr>
<th>Attendance at RLSCB</th>
<th>May</th>
<th>June</th>
<th>Sept</th>
<th>Dec</th>
<th>Mar</th>
<th>% Attendance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent Chair</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Statutory members</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult services, RMBC</td>
<td>D</td>
<td>Aps</td>
<td>D</td>
<td>D</td>
<td></td>
<td>75%</td>
</tr>
<tr>
<td>CAFCASS</td>
<td>✓</td>
<td>✓</td>
<td>Aps</td>
<td>Aps</td>
<td></td>
<td>50%</td>
</tr>
<tr>
<td>Rotherham CCG</td>
<td>D</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>Councillor – Cabinet Member, CYPS</td>
<td>Aps</td>
<td>Aps</td>
<td>Aps</td>
<td>Aps</td>
<td></td>
<td>0%</td>
</tr>
<tr>
<td>CYPS consortium</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>50%</td>
</tr>
<tr>
<td>CYPS, RMBC</td>
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<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>Housing, RMBC</td>
<td>x</td>
<td>Aps</td>
<td>Aps</td>
<td>Aps</td>
<td></td>
<td>0%</td>
</tr>
<tr>
<td>Lay members</td>
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<td>✓</td>
<td>Aps</td>
<td>Aps</td>
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<td>100%</td>
</tr>
<tr>
<td>National Probation service</td>
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<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>NHS England</td>
<td>Aps</td>
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<td>✓</td>
<td>D</td>
<td></td>
<td>75%</td>
</tr>
<tr>
<td>Public Health, RMBC</td>
<td>✓</td>
<td>D</td>
<td>D</td>
<td>D</td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>Rotherham Doncaster &amp; South Humber NHS Foundation Trust</td>
<td>Aps</td>
<td>D</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>75%</td>
</tr>
<tr>
<td>Schools &amp; colleges</td>
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<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>SY Community Rehabilitation Company</td>
<td>Aps</td>
<td>✓</td>
<td>✓</td>
<td>D</td>
<td></td>
<td>75%</td>
</tr>
<tr>
<td>SY Fire &amp; Rescue</td>
<td>Aps</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>75%</td>
</tr>
<tr>
<td>SY Police</td>
<td>Aps</td>
<td>✓</td>
<td>D</td>
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<td></td>
<td>75%</td>
</tr>
<tr>
<td>Rotherham NHS Foundation Trust</td>
<td>Aps</td>
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<td>✓</td>
<td>D</td>
<td></td>
<td>75%</td>
</tr>
<tr>
<td>Youth Offending Service, RMBC</td>
<td>✓</td>
<td>✓</td>
<td>D</td>
<td>✓</td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td><strong>Professional Advisors to the Board</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LSCB Business Manager</td>
<td>✓</td>
<td>D</td>
<td>D</td>
<td>D</td>
<td></td>
<td>CANCELLED</td>
</tr>
<tr>
<td>Head of Service, CYPS, RMBC</td>
<td>x</td>
<td>✓</td>
<td>✓</td>
<td>D</td>
<td></td>
<td>75%</td>
</tr>
<tr>
<td>Designated Nurse, CCG</td>
<td>✓</td>
<td>D</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>CANCELLED</td>
</tr>
<tr>
<td>Legal Services, RMBC</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Aps</td>
<td></td>
<td>75%</td>
</tr>
<tr>
<td>Comms Team, RMBC</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>100%</td>
</tr>
</tbody>
</table>

### Key

- **x**: Agency is not invited or does not have a current representative
- **Aps**: Apologies were tendered with no deputy attending
- **✓**: Attended
- **D**: Deputy attended
- *****: Extraordinary meeting held
## Appendix 2 – Financial Statement 2017-18

<table>
<thead>
<tr>
<th>Budget Statement 2016/17 Outturn</th>
<th>Funding Formula</th>
<th>Budget 2017/18</th>
<th>Outturn 2017/18</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>£</td>
<td>£</td>
</tr>
<tr>
<td><strong>Income</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual Contributions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rotherham MBC</td>
<td>48%</td>
<td>163,432</td>
<td>163,432</td>
</tr>
<tr>
<td>Rotherham CCG</td>
<td>22%</td>
<td>75,315</td>
<td>75,315</td>
</tr>
<tr>
<td>South Yorkshire Police &amp; Crime Commissioner</td>
<td>13%</td>
<td>44,475</td>
<td>44,475</td>
</tr>
<tr>
<td>National Probation Service</td>
<td>&lt;1%</td>
<td>1,077</td>
<td>-6472</td>
</tr>
<tr>
<td>CAFCASS</td>
<td>&lt;1%</td>
<td>550</td>
<td>1100</td>
</tr>
<tr>
<td>South Yorkshire Community Rehabilitation Company</td>
<td>&lt;1%</td>
<td>300</td>
<td>-300</td>
</tr>
<tr>
<td>Surplus from previous year</td>
<td>3%</td>
<td>10,000</td>
<td>10,000</td>
</tr>
<tr>
<td>Rotherham CCG - L&amp;D contribution</td>
<td>6%</td>
<td>22,000</td>
<td>22,000</td>
</tr>
<tr>
<td>Rotherham MBC - L&amp;D contribution</td>
<td>6%</td>
<td>22,000</td>
<td>22,000</td>
</tr>
<tr>
<td>Delivered Training to GP’s</td>
<td>&lt;1%</td>
<td>0</td>
<td>400</td>
</tr>
<tr>
<td><strong>Total Income</strong></td>
<td></td>
<td><strong>339,149</strong></td>
<td><strong>331,950</strong></td>
</tr>
</tbody>
</table>

| **Expenditure**                 |                 |                |                 |
| LSCB Salaries & Staff Costs     |                 | 233,344        | 232,806         |
| Public Liability Insurance      |                 | 1,600          | 1,356           |
| IT & Communications             |                 | 1,000          | 1,513           |
| Printing                        |                 | 3,000          | 3,171           |
| Stationery and Equipment        |                 | 330            | 63              |
| Learning & Development          |                 | 33,425         | 18,879          |
| Independent Chair & Other Independent Consultants | | 49,000 | 64,959 |
| Software licences & maintenance contracts | | 13,500 | 19,600 |
| Memberships & Conferences       |                 | 3,000          | 1123            |
| Miscellaneous                   |                 | 950            | 131             |
| **Total Expenditure**           |                 | **339,149**    | **343,600**     |
| **Deficit**                     |                 |                | **11,650**      |
Appendix 3: 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
People of Rotherham are able to live a life free from harm, where all organisations and communities…

- Keep people safe from abuse
- Knows what to do when abuse happens
- Work together to prevent abuse
As Independent Chair of the Rotherham Safeguarding Adults Board I am pleased to present the Annual Report for 2017/18 and to report on the continued commitment from all partner agencies. Partners consistently show their strong support to help deliver the priorities of the board and ensure that vulnerable adults are protected and safeguarded. As a Board we maintain our commitment to the citizens of Rotherham and have a zero tolerance to adult abuse.

This year the board has prioritised work to publicise Safeguarding so that people are aware of how to report abuse, that the public have a knowledge of what safeguarding means and the different types of abuse that are covered by Safeguarding Adults. The board is committed to continue to raise public awareness through Safeguarding Awareness Week, public consultation, further work with the voluntary sector and public forums and ensuring the public voice is heard at Board level.

Together the partners of the board are keen to learn from Safeguarding Adult Reviews. We recognize that by reviewing where we have not achieved best practice in the past, we can learn for the future and use the information to help improve services and implement change when needed. We celebrate good practice and positive outcomes for the residents of Rotherham and will support people to make informed choices to live safely and free from harm.

In the year ahead the Rotherham Safeguarding Adults Board will prioritise raising the voice of people in receipt of Safeguarding services and ensuring that staff have sufficient guidance and support to undertake their responsibilities. A work plan has been developed which will continue our commitment to make Rotherham a safe place and contribute to make vulnerable adults free from abuse.
Message from Cllr David Roche
Chair of the Health and Wellbeing Board

This Safeguarding Annual Report for 2017/18 highlights the strong partnership working from all board partners and gives reassurance that safeguarding is embedded in all organisations and at all levels.

The work of the board needs true partnership working across all agencies and the Rotherham Safeguarding Adults Board ensures that partners are held to account by assessment and challenge and each agency provides the board with regular updates on their developments.

Safeguarding is everyone’s business and only by working together will we raise the awareness of safeguarding and ensure that the vulnerable and those who lack the mental capacity to make the right decisions are supported, safeguarded and protected from harm.

May I take this opportunity to acknowledge the commitment of all the board partners including the statutory, independent and voluntary community sector. Rotherham needs everyone to work together to safeguard its citizens and to continue to raise awareness of safeguarding.

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

Types of abuse:
Physical abuse
Hitting, kicking, punching, kicking, inappropriate restraint

Domestic abuse
Psychological, physical, verbal, sexual, financial or emotional abuse by a current or former partner or family member

Organisational abuse
Poor treatment in a care setting

Financial or material abuse
Theft, fraud, misuse of someone else’s finances.

Sexual abuse
Being made to take part in a sexual activity without consent

Discriminatory abuse
Harassment based on age, gender, sexuality, disability, race or religion

Neglect
Failure to provide care or support

Psychological abuse
Shouting, ridiculing or bullying

Modern slavery
Human trafficking and forced labour

Self-neglect
Declines essential care support needs, impacting on their overall wellbeing

Doing nothing is not an option!
During 2017/18 Rotherham’s Safeguarding Adults Board (RSAB) has been continuing to work to promote and protect vulnerable adults in Rotherham, another busy and successful year building and developing the board. The board continued to meet bi-monthly to ensure the hard work of the previous year was built upon and all partnership working was developed and strengthened in the sub groups.

August 2017 saw two Safeguarding Adults Reviews published and recommendations made by the independent authors were developed into action plans. The board will monitor the action plans through the Performance and Quality sub group to ensure learning is shared and all actions are completed. The board also contributed to a review led by NHS England following the death of a young man in a Learning Disabilities care home. The review will be published early in 2018/19 and Rotherham will embed the learning identified and work with partners to ensure safeguarding is embedded in all Learning Disability services.

Rotherham have been working with Sheffield, Doncaster and Barnsley to revise and relaunch the South Yorkshire Safeguarding Procedures, working in consultation with all partners across the borough and South Yorkshire to ensure the procedures are fit for purpose and fully encompass the Care Act. Work will continue into the new financial year and will hopefully see a launch early in January 2019.

September 2017 the board appointed a permanent Board Manager after having an interim manager for in post since January 2016.

Work began in January 2017 to plan for a South Yorkshire Safeguarding Awareness Week in July 2017. The four Safeguarding Adults Boards, Rotherham, Sheffield, Barnsley and Doncaster along with the four Children’s Boards planned a week of activities to promote and raise awareness of Safeguarding.

Priority was given to develop strong links with other Boards in Rotherham including the Health and Well Being Board, Children’s Safeguarding Board and Safer Rotherham Partnership. The chairs of these Boards are now meeting on a regular basis to discuss cross cutting themes and ensure we are working together. A planned development will be the development and implementation of a joint self-assessment and challenge programme between the Children’s and Adults Safeguarding Boards, this will benefit all partners and remove duplication.

The Board continued to focus on customers and their experience during safeguarding processes, the Independent Chair has spent time attending meetings with the Voluntary Services and local action groups including the Rotherham Older Peoples Forum. This work will continue into the future and the board will encourage representation and participation from customer groups to help shape the work of the board.

Discussions at board during 2017/18 have brought experts to discuss issues including:

- LeDer (Learning Disabilities Mortality Review)
- Self Neglect
- Suicide Prevention
- Operation Stovewood (Historical Child Sexual Exploitation)
- Care Quality Commission, Roles and Responsibilities
The priorities for the board were:

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<th>Priority</th>
<th>Resulting Action</th>
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| Development of policy and practice in the consistent application of thresholds for safeguarding alerts. | The Board held a Development Day in May 2017 that brought together partners to examine the current thresholds. Resulting in:  
  • Threshold guidance developed  
  • Escalation policy introduced  
  The group also looked at the need for clear information around Lasting Power of Attorney  
  Healthwatch Rotherham will work together with the Rotherham Safeguarding Adults Board to improve and promote customer involvement and participation at board meetings and sub group meetings as appropriate. A Customer Involvement Charter has been agreed at board with plans for implementation during 2018/19. |
| Increase the voice of users and carers in the work of the Board.       | Healthwatch Rotherham will work together with the Rotherham Safeguarding Adults Board to improve and promote customer involvement and participation at board meetings and sub group meetings as appropriate. A Customer Involvement Charter has been agreed at board with plans for implementation during 2018/19. |
| Identification of joint work with the Community Safety Partnership concerning human trafficking/modern day slavery. | Rotherham Safeguarding Adults Board and the Safer Rotherham Partnership will receive written updates to present to their boards. RSAB board manager will set up update reminders and ensure a regular agenda item on future RSAB Agendas. |
| Adopt and adapt information sharing protocols to ensure the Boards implementations of Safeguarding Procedures are fully and appropriately informed. | Rotherham has developed a Safeguarding Protocol that was signed off at the Children’s and Adults Safeguarding Boards and the Safer Rotherham Partnership and the Health and Wellbeing Board. All Boards have agreed to work together to promote Safeguarding and the vulnerable. |
The Safeguarding Adults Board has four sub groups to ensure the priorities of board are actioned, the Sub-Groups each have a work plan and during 2017/18 they were able to deliver the following specific pieces of work:

### Performance and Quality Sub Group

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| Continue to develop the annual self-assessments of all member organisations. | A Peer Review took place in May 2017. The review concentrated on Making Safeguarding Personal (MSP) and how partners have embedded MSP into their day to day working. Examples of good practice were:  
• Safeguarding Champions across the RMBC workforce  
• SYFR – Risk assessment questions are available on hand held tablet to prompt all officers  
• Good working relationships between the Vulnerable Persons Unit (SYP) and Safeguarding teams. |

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| Commission an Independent Case File Audit. | In January 2018 an independent review was commissioned to carry out the case file audit, recommendations included:  
• RSAB should undertake research with people who have been subject to a safeguarding enquiry to establish whether they consider that they were appropriately supported or would have benefitted from an advocate  
• Rotherham Safeguarding Adults Board should consider how the outcome of safeguarding enquiries should be categorised and include clear guidance regarding this within the procedures. |

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<td>Continue to develop the performance reporting framework for Safeguarding.</td>
<td>Work continued during 2017/18 to develop the Performance Dash Board and the new style report will begin for in 2018 /19.</td>
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### Training and Development

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<tr>
<td>Continue to identify areas where cross sector training would enhance the application of the safeguarding process and achieve improved outcomes for Service Users.</td>
<td>The safeguarding training plan and strategy was published in April 2017. The decision to begin a Training Needs Analysis was made in January 2018 and this work will continue into 2018 /19.</td>
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### Policy and Procedures

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<td>Work across the South Yorkshire Region to develop an easy read guide to Safeguarding Procedures.</td>
<td>During 2017/18 the South Yorkshire Region made the decision to revise the South Yorkshire Procedures, work has begun to rewrite an overarching policy that the four boards and local authorities will sign up to.</td>
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### Safeguarding Adults Review

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<td>Commissioning and overseeing Safeguarding Adults Reviews (SAR’s) and any other reviews agreed by the Chair.</td>
<td>During 2017/18 1 Safeguarding Adults Review was completed and published. The board worked in co-operation with NHS England following the death of a young man placed by a neighbouring authority in Rotherham. The case was extremely complex involving three local authorities and three Clinical Commissioning Groups. A further complex case was held in abeyance awaiting the coroner’s inquest decision.</td>
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| Ensure that recommendations arising from each SAR are communicated to all agencies and are subject to review of implementation. | 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. Recent action plans have addressed issues such as:  
- Test out using auditing processes that communication between professionals, service users and their families is robust  
- Look at a range of mechanisms and develop protocols for the use of care coordinators in complex cases in the community setting  
- There are appropriate written communication tools in use between care homes and GP practices. |
| Develop a Safeguarding Adults Review Protocol. | The Safeguarding Adults Review Protocol was signed off at the RSAB in July 2017. |

Do you know the signs of adult abuse?

- The family member who spotted signs
- The nurse who noticed at surgery
- The neighbour who was worried
- The bank cashier concerned about his customer
- YOU
Looking forward to 2018/19

The Rotherham Safeguarding Adults Board and its sub groups will now meet every quarter and have introduced an Executive Sub Group that will meet in between the board meetings, they will work to set challenging and relevant agendas for the board and will ensure the members of the board are working together to achieve priorities.

A review of the position of the Deprivation of Liberty’s (DoL’s) Sub Group has resulted in the group no longer being a formal subgroup of the Safeguarding Adults Board but will continue to report performance and any relevant issues to the Board through the Performance Dashboard.

Rotherham Safeguarding Adults Board in 2018 have committed to the following actions which we will continue to progress to conclusion in 2018/19.

These are:

- Refresh the Rotherham Safeguarding Adults Board Strategic Plan for 2019/21.
- Ensure the South Yorkshire Procedures and Local Safeguarding Procedures are up to date and embedded in service.
- Develop a ‘Story Board’ to share with RSAB. Using partners case studies, bring the customer story to RSAB using video, actors or consider bring the customer to the board meeting.
- Develop a Public Involvement strategy. Promote Safeguarding Awareness Week across Rotherham.

The board’s responses in respect of performance, training, policy and practice and learning lessons from SAR’s will be taken forward through the sub group structure with the following priorities.

Performance and Quality

- Work with Children’s Services to develop a joint assessment tool for the partners of the Adults and Children’s Safeguarding Boards.
- Continue to develop the RSAB Issues Log, ensuring all partners are aware of any risk that may impact on the performance of the board.
- Ensure the Advocacy Service offered to the residents of Rotherham is appropriate and is being utilised correctly.
- Developing intelligence led analysis of key safeguarding priorities to inform future action planning.
- SAR action plan monitoring.

Training and Development

- Complete a Training Needs Analysis to inform the RSAB of the safeguarding Training needs and identify multi agency training.
- Develop a mechanism to measure the success of Safeguarding.

Policy and Practice

- Work with the South Yorkshire Region to finalise a South Yorkshire Safeguarding Procedure.
- Develop guidance, policy and practice in respect of Self-Neglect.
- Ensure Safeguarding is embedded within the Learning Disability service.

Safeguarding Adults Review

- Continue to make timely recommendations to the Chair in respect of whether a review should be commissioned.
- Commissioning and overseeing SAR’s and any other reviews agreed by the Chair.
- Continue to ensure that recommendations arising from each SAR are communicated to all agencies and are subject to review of implementation.
Safeguarding Adults Investigation Team

The specialist team of highly qualified social workers track and manage all safeguarding concerns from initial concern, screening, decision making meetings, further enquiries and outcome meeting, ensuring risk is reduced or removed and individual outcomes are achieved.

To achieve best practice and outcomes for our service users, the safeguarding adult team work closely and have good strong professional relationships with the Clinical Commissioning Group, Rotherham Hospital leads, the Public Protection and Safeguarding Adults Team, Police, Fire and Rescue, the Ambulance Service and our counterparts in the mental health sector (Rotherham, Doncaster and South Humber RDaSH) to name a few.

The Safeguarding Adults Team remain focused delivering outcomes for the adults at risk and ensuring the source of harm is held accountable using legislation, supporting disciplinary/practice sanctions, referring to the disclosure and barring service and other governing bodies such as the HCPC or NMC etc.

The Safeguarding Adults Team recognises the importance of family life, where cases of abuse occur they will conduct investigations with sensitivity and proportionality.

The Safeguarding Adults Team are all experienced qualified social workers who, through experience have honed skills in their chosen area such as 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.

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.

In 2017/18 2,113 alerts were reported to the safeguarding team. 724 of these alerts became section 42 enquires, this is where an investigation begins and further enquires are made. From the investigations that progressed to a Decision Making Meeting (DMM), 10 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. To achieve this, the team work closely with contracting compliance officers as well as the commissioning sector and the Care Quality Commission (CQC).

Bi monthly meetings with Safeguarding, Commissioning, Contracts, CQC, Health and RDaSH ensure information is shared to support with raising standards of providers and supporting with the prevention of providers declining in their duty of care thus resulting in Safeguarding concerns being raised.
Case Study

The Safeguarding Team received contact from a CQC officer requesting an urgent meeting, a meeting was pulled together the same day. The CQC officer disclosed that after a visit to a residential unit, they have serious concerns for the safety of the residents. Details were shared and an emergency risk assessment was completed.

Social workers and district nurses were dispersed into the home to carry out urgent welfare checks, ensuring people were safe, supported and risk was mitigated. Due to findings at the home, several individual safeguarding concerns were logged and an organisational safeguarding concern was screened.

The home agreed to work to a Special Measures Improvement Plan (SMIP) developed by the Contract Compliance Officers (CCO) and a default and suspension of placements made.

Within 24 hours staffing rotas were addressed, dependency tools were being used and all required referrals for the residents were made. A decision Making Meeting was held and attended by all relevant professionals as well as family members and advocates. Due to the engagement of the home and the support of the CCO and Safeguarding, the organisational concern was able to close along with many of the initial individual concern, only two individual cases were required to be investigated.

Due to the partners and providers engaging well and supporting practice, the residents of the home were safe and well cared for, mitigating any neglect and acts of omission and supporting the ethos of prevention.
Contract Compliance Team

During 2017/18 the Strategic Commissioning Team in the Adult Care, Housing and Public Health Directorate was restructured with 4 Heads of Service leading 4 commissioning strands under the themes of; Prevention and Early Intervention; Housing Related Support and Mental Health; Learning Disability and Autism and Adults and Older People. The Commissioning and Quality and Performance Team that sits under the Public Health Directorate is now aligned to the Strategic Commissioning Team.

The Contract Compliance Team is situated in strand 4 of the Strategic Commissioning Team, the Prevention and Early Intervention Theme. This Team is headed by a Principle Contract Compliance Officer leading 4 Contract Compliance Officers who work to ensure that services commissioned and contracted by the Council remain compliant with agreed standards of quality and safety throughout their contract term. The team is made up of officers who are knowledgeable, skilled and experienced in adult care and support.

Quality Assurance Framework:

Following the restructure the work of the Contract Compliance Team was reviewed and a Quality Assurance Framework was developed. The work of the Contract Compliance Team is now effected through an intelligence led framework which comprises; contract concerns reporting database, reported risk matrix, focused audits, a range of service specific toolkits and information gleaned from surveys and customer experience testimony. The Contract Compliance Team collaborates with colleagues throughout social care, safeguarding and health to increase the scope of intelligence available. The intelligence gleaned is utilised by the Contract Compliance Team to inform a proportionate response to regain compliance when deviation from agreed standards has occurred.

The Quality Assurance Framework supports the reviewing process of providers using a risk based approach and predominately focuses attention on providers who are cause for concern. There is regular contact with all providers who self-report and this forms part of the Quality Assurance Framework to ensure light touch monitoring approach. This allows an appropriate use of the contract monitoring team resource and reduces the reviewing burden on providers where it is not necessary.

A range of new toolkits, auditing tools and survey tools have been developed and are being implemented and assist a wide range of stakeholders to provide feedback on service/provider quality. A number of multi-disciplinary meetings have taken place to discuss failing providers and agree further actions.

During 2017/18 the Contract Compliance Team has maintained its risk based programme of monitoring. The Team continues to work closely with the Adult Safeguarding Team and monthly Quality Assurance and Safeguarding Team meetings have been formalised. These meetings are attended by Commissioning Officers and Safeguarding to share information and intelligence about contracted services.

A number of focussed audits has been undertaken in response to trends identified through intelligence gathering from the Contract Concerns database, provider risk Matrix and the Safeguarding database. These have allowed preventative actions to be identified and implemented to address service shortfalls with regards to quality issues.

Compliance Issues:

In 2017/18 contract enforcement action as a result of quality issues in the independent sector undertaken:

- Contract Default = 6 Care Homes, 3 Community and Home Care Services.
- Contract Termination = 1 Care Home, 1 Community and Home Care Service provider.

The Contract Compliance Team dealt with 611 Contract Concerns which involved providers across all care sectors. This is an increase of 41% on the previous year and is as a result of increasing collaborative work with colleagues throughout social care, safeguarding and health to increase the scope of intelligence available.
The majority of these concerns had multiple threads which required investigation by the Contract Compliance Officer and the Provider. Of the 611 concerns received approximately:

- 47% (289) related to Community Home Care Services (CHCS).
- 31% (191) related to Adult Residential and Nursing Care Providers.
- 6% (38) related to Specialist Day Services.
- 6% (37) related to Specialist Residential and Nursing Care.
- 10% (58) related to the remaining provider groups including the Voluntary and Community Sector (VCS).

The top 4 categories for Contract Concerns for 2017/18 were:

- **Late/Missed calls** – 116 concerns reported (all CHCS), *an increase of 68% on 2017/18*.
- **Quality** – 166 concerns reported (Residential/Nursing 89, CHCS 46, Others 61), *an increase of 66% on 2017/18*.
- **Medication** – 63 concerns reported (Residential/Nursing 32, CHCS 13, Others 28), *an increase of 34% on 2017/18*.
- **Staffing** – 50 concerns reported (Residential/Nursing 25, CHCS 13, Others 12), *an increase of 28% on 2017/18*.

**Other Contract Compliance Activity:**

- **Members Seminar:**

  A Members Seminar took place in June 2017 to respond to concerns expressed by Elected Members regarding the quality of four care homes in Rotherham. Members were advised by the Strategic Commissioning Team about the contract monitoring and enforcement activity that is undertaken and offered context on the limitations of the Council in terms of enforcement of care home closure. The Care Quality Commission attended a later member’s seminar to present to members details about their regulatory function. An update on the outcomes of contract enforcement activity on the four care homes was requested in April 2018 and at that time members were informed of the termination of contract with a care home in Maltby. The updates and information imparted were well received by members.

- **Focussed Audit:**

  The contract compliance team have carried out a number of focused audits over the year. An audit took place in December 2017 on the arrangements in place for the use of restraint in care homes which scrutinised:

  - Restraint Policies,
  - Training (MCA/DoLS and use of restraint)

  The audit covered a number of areas and specific to Older People’s Residential and Nursing providers, the following applied:

  - 87% were able to provide copies of their Restraint policy and the remaining
  - 13% did not have a specific restraint policy in place, but had appropriate guidance in place within their MCA and DoLS policies and within their Safeguarding procedures.

  Providers who delivered care and support to people experiencing the symptoms of dementia were able to provide comprehensive references within their Violence and Aggression policy, in particular the appendix “Distressed Reactions De-escalation and Safe Holding Standard Operation Procedures”.

  100% were able to evidence, through Training Matrix’s and Internal reports, appropriate training for all staff. This included the initial training provided during induction periods, and the subsequent ongoing and refresher training. Topics included MCA and DoLS training and Safeguarding Training (at levels relevant to the post holder’s responsibility). Providers report that varying numbers of staff have attended Positive Behavioural Support Training, focusing on diversion and de-escalation techniques and activities that promote positive behaviours is preferred, with this being a common “thread” throughout other training, such as
Dementia, Dignity, Equality and Diversity and Person-Centred care training.

Where providers fell short of the standard actions these were undertaken through action plans specific to each provider.

- **Public Health:**

  Work undertaken by Contract Compliance and Public Health colleagues, in response to Infection Prevention and Infection control issues has seen the development of a local network of Infection Prevention Champions. Work with these representatives of our commissioned providers will continue to develop and improve this aspect of care provision.

- **Quality Board:**

  Led by the Strategic Commissioning Team, the Quality Board was established in September 2017, meets bi-monthly and has met 4 times to date. The Quality Board has a focus on the quality, safety and effectiveness of independent sector and voluntary sector who deliver regulated services commissioned by Rotherham Metropolitan Borough Council and Rotherham CCG.

The Board has the responsibility for the monitoring of commissioned services relating to adults and systematically brings together the different parts of the system to share information and will be a proactive forum for collaboration. The main purpose of the Quality Board is to encourage:

- a shared view of risks to quality through sharing intelligence;
- an early warning mechanism of risk about poor quality;
- opportunities to coordinate actions to drive improvement,
- ongoing strategic and operational liaison between organisations and
- a conduit between the statutory bodies and the provider market.

The Quality Board aims to enhance integration and partnership between bodies from the Rotherham Council, Rotherham NHS Foundation Trust, Public Health and Rotherham CCG.
Vulnerable Persons Team

The Vulnerable Person’s Team work to and promote the prevention and wellbeing principles of The Care Act (2014). In summation, The Vulnerable Person’s Team seek to ensure an individual’s physical, mental, and emotional wellbeing as well as protection from abuse and neglect. The team also works with carers/families, providing the required support. The Vulnerable Person’s Team act as change agents by seeking to improve the lives of those they work with, connecting people to the necessary support, often working with partner agencies including the voluntary sector.

The Vulnerable Person’s Team promote a positive engagement model which seeks to reduce multiple negative contacts with services. The ultimate aim is for good outcomes built on a partnership, helping to reduce chaotic lifestyles and subsequent risks to vulnerable people.

Archetypically, The Vulnerable Person’s Team work includes working with individuals who may need assistance with the following, repeat non-engagers, issues with finances or debts, risk of eviction/ASB issues and or homelessness, supporting those leaving prison, issues of self-neglect/hoarding, concerns regarding current/historical CSE, substance misuse and those who may have mental health issues or a learning disability.

The Vulnerable Persons Team is looking to work more closely with housing, specifically with the co-located neighbourhood teams which also includes anti-social behaviour officers and neighbourhood policing teams in order to provide a collaborative response.

Furthermore The Vulnerable Persons Team are looking to work more closely with younger adults who have been known to leaving care as it has been acknowledged that there is a service gap and this links in to the ongoing work of Vulnerable Care Leavers Risk Management Pathway which was initiated by children’s services.

The Vulnerable Persons Team continues to prove itself as a valuable resource and has supported many individuals to improve their lives by providing wrap-around support; the case study example is testament to this.

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**What happens after abuse is reported?**

- When you report abuse, people will:
  - listen to you
  - take your concerns seriously
  - respond sensitively
  - make enquires about the concern
  - consider the wishes of the adult at risk
  - talk to the police if it is a criminal matter
  - support the adult at risk to achieve the changes they want, whenever possible
  - develop a plan with the adult at risk to keep them safe in the future
  - consider if anyone else is at risk.

**How to report abuse**

- To report a crime: In an emergency, call the police on: 999
- If the person is not in danger now, call the police on: 101
- To report a safeguarding concern or seek advice:
  - Call Adult Social Care on: 01709 8222330
  - Out of hours call 01709 8222330
- You can complete an online form to report Adult Safeguarding by visiting the website at www.rotherham.gov.uk.
- For further information on how to access Safeguarding Adults Training please contact the Directions Team, directions@rotherham.gov.uk. Tel: 01709 255903.

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Today you spoke to: ____________________________________________________________

Contact number: ____________________________________________________________

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Keeping people safe from abuse is everyone’s business

Recognise • Respond • Report

Adult abuse can happen anywhere

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The neighbour who was worried

The bank cashier concerned about his customer

The family member who was concerned

The nurse who noticed at surgery

YOU
Case Study

D first came to the attention of Adults Safeguarding via a referral from another local authority. D had been receiving bereavement counselling for the last 4 years and during this time disclosed historical sexual abuse by deceased family members and members of the public (alleged to be professionals) he also reported regular taunting by his mother and physical abuse from siblings whom he lived with.

D has a mild learning disability and is dyslexic.

D has never at any point spoken to the police in spite of Public Protection Unit being made aware of the disclosures. Background checks were completed on family members who D had alleged as his abusers. D also disclosed that he was regularly assaulted by his brother and his friends. His brother had previously spent time in prison for attempted murder of a former wife. A referral was completed by The Vulnerable Person’s Team (VPT) and D also received support from an Independent Domestic Violence Advocate. His case was heard at a Multi-Agency Risk Assessment conference (MARAC), the outcome of this was the police required more information to put a safety plan in place, but unfortunately D refused talk to them. From the police point of view, little could be done without more information/disclosures from D himself.

D was formally assessed as having mental capacity to make a decision regarding his residence and who he should live with, this left Adult Services with a dilemma making it difficult to exercise a duty of care to keep him safe. He was supported by VPT to find alternative accommodation; he was made a priority by housing. D was offered numerous properties which he declined stating he didn’t deserve it (a house of his own) and he “can’t imagine it”, but continued to speak of the abuse he was experiencing. His counsellor informed us that he had previously attempted suicide which were described as serious attempts.

Following legal advice the Local Authority commenced court proceedings to seek an inherent jurisdiction, D was represented in court and agreed to move to a safe house with the support of VPT. The court also granted an order preventing the family of D making contact with him.

D resided in the safe house for approximately 8 months and has recently been offered a tenancy of his own in an area of his choice. During this time D has grown in confidence and engages well with support from the VPT and is currently engaging which mental health services following a referral from VPT. D was supported to attend appointments to help address his Post Traumatic Stress Disorder, something which he previously refused to do. D is currently settling into his new accommodation, making plans to decorate and purchasing new furniture.
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.

The Independent Domestic Violence Advocates (IDVA’s) have 4 SafeLives qualified IDVA’s of which 3 work full-time and also a part-time IDVA support worker. Furthermore, the IDVA team hold trainer qualifications and deliver the training program. The training explores what domestic abuse is and its impact on its victims, to introduce good practice and risk assessment. It also explores and challenges 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.

More recently, Rotherham IDVA’s are working with their counterparts in Doncaster and Sheffield in order to develop a generic training package, incorporating recent government guidelines. The IDVA’s are committed to promoting awareness amongst partner agencies in order to enhance the safety of individuals and the support they receive. Additionally the IDVAS will visit services offering advice, guidance and support to other agencies to recognise domestic abuse and how to complete risk assessments.

The IDVA’s are looking to enhance the skills of the service; it has been identified that it would be beneficial 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. All IDVA’s will be taking part in accredited SafeLives training relating to responding to older people affected by domestic abuse as research shows that older people are underrepresented in domestic abuse services.

Between April 2017 and March 2018 the service received 435 referrals and supported 436 Multi Agency Risk Assessment Conference cases (MARAC). The IDVA’s also provide court support to individuals in which they seek to make the court process more understandable as well as providing emotional support, putting special measures in places and supporting clients to express their wishes to the court.

Case Study

C, 56 was referred into IDVAS in February 2018 following a high risk repeat incident with her ex-partner. The abuse has been ongoing for 15 years and involved physical violence and persistent stalking and harassment. C is disabled and has epilepsy, diabetes, arthritis, deformity in her feet; she requires carers daily. She reported feeling low in mood relating to the abuse she has suffered.

C didn’t feel safe where she was living due to her ex-partner attending her property uninvited and she also reported feeling isolated in her current location. IDVA contacted the housing officer and advocated for her to be re-housed, her case was referred to the housing panel and she was awarded priority. C has now moved to a safe location, she is closer to her family and friends and feels safer and happier. IDVA has completed a referral for extra security on this home. C’s ex-partner was charged with breach of restraining order and pleaded guilty; IDVA liaised with magistrate’s court to establish the outcome and passed this onto C.

IDVA has referred her to Rotherham women’s counselling service and Rotherham Rise for continued support for the abuse she has experienced. IDVA has liaised with C’s social worker to ensure they are aware of the situation and in order to offer support where required.
Rotherham NHS Foundation Trust

TRFT’s Adult Vulnerabilities Team provide a service across all Trust disciplines to ensure that adults that we care for are safe and are protected from harm.

To achieve this, it is our role to ensure that our staff receive appropriate training to equip them with the skills and knowledge that they need to enable them to recognise and respond to concerns regarding an adult at risk. Training is provided which addresses all aspects of adult safeguarding, including the Mental Capacity Act and Deprivation of Liberty Safeguards, Learning Disability, Dementia, the Mental Health Act and Prevent, which is the Government’s response to reducing the risk of vulnerable people being drawn into supporting or committing acts of terrorism.

Partnership Working

TRFT Adult Vulnerabilities Team is an active partner in ongoing work 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 Multi-Agency Risk Assessment Conference (MARAC) and has been involved in working toward improved services for victims of domestic abuse in Rotherham as a partner in the Safer Rotherham Partnership.

Support

The Adult Vulnerabilities Team offer advice and support to all TRFT staff in managing adult safeguarding concerns about vulnerable people.

Governance

A significant amount of work has been undertaken to embed a robust Trust safeguarding and external governance structure. As part of the Trust’s governance arrangements, an internal audit of adult safeguarding was undertaken, which identified strong assurance regarding these arrangements with extremely positive feedback received. No recommendations were made following the review.

Policies have been developed which clarify the responsibilities of all TRFT staff and volunteers. These are updated as required to reflect changes in legislation and practice.

Key Performance Indicator (KPI) information is shared with our partner agencies quarterly, who have the opportunity to scrutinise and question Trust practices.

Development

The position of Lead Nurse in Learning Disability is now embedded and continues to contribute to improvements in this service area.

TRFT have completed several projects designed to improve the implementation of the Mental Capacity Act throughout the Trust, including the provision of training in addition to the mandatory requirement.

The Lead Nurse in Learning Disabilities was nominated by the Sheffield Hallam University students she mentors for an Inspirational Mentor award. This nomination was successful and the Lead Nurse received the award.
Case Study

Mr Y had a hospital inpatient stay for unstable diabetes. The District Nurse (DN) visited 3 days after discharge and found that he had a pressure area to his buttock. The DN had not been informed of the discharge by the ward but when they visited Mr Y he did have a pressure relieving cushion at home and was independently mobile.

He did explain to the DN that whilst on the ward he had been receiving regular treatment for the pressure ulcer, which was present on admission, from the nursing staff.

DN’s noted Mr Y to have capacity to make decisions regarding his care. They commenced an individualised care plan, made a referral to the Tissue Viability Nurse, completed an internal incident report and with Mr Y’s consent, a safeguarding concern was raised as per policy.

In response to the safeguarding concern the Ward Manager from the discharging ward was asked to complete a section 42 enquiry and document the outcome of this on a safeguarding form 2.

The Ward Manager contacted Mr Y by telephone to discuss the concern that follow up care by the DN had not been arranged by the ward as would be expected.

She apologised to Mr Y and explained that when he was discharged from hospital a DN should have been arranged to visit him at home. Mr Y accepted the apology but noted that the ward was very busy however he said the staff “were lovely” and he was pleased with the quality of care he had received and said that staff had provided treatment to the wound whilst he was on the ward. He explained that he already had a pressure relieving cushion in place at home and that DN had now provided a mattress for him.

Mr Y accepted that the lack of referral to DN was an oversight but that he had received appropriate care whilst he was in hospital and that follow up care for the wound was in place from the DN team now that he had returned to the community.

Mr Y expressed he had no on-going concerns that he felt required further investigation. As Mr Y’s outcomes had been met and he was in agreement, the concern exited the safeguarding process at this point.

This process is consistent with the principles laid out in the Care Act 2014 which highlights the Making Safeguarding Personal approach.
NHS England Yorkshire and Humber

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

NHS England 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), Child Sexual Exploitation, Children Looked After, Mental Capacity Act (MCA), Modern Slavery and Trafficking and Prevent. NHS England Yorkshire and the Humber works in collaboration with colleagues across the North region on the safeguarding agenda. A review of the Yorkshire and the Humber safeguarding network has established local safeguarding network meetings bi-annually in the 3 Sustainability and Transformation Partnerships areas (some now named Accountable Care Partnerships) in addition to a bi-annual safeguarding commissioners and providers network event.

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. A North region newsletter is now circulated weekly to safeguarding professionals. Learning is also shared with GP practices via quarterly Safeguarding Newsletters, and annually safeguarding newsletters for pharmacists, optometrists and dental practices across Yorkshire and the Humber are produced.

An annual North region safeguarding conference is hosted by NHS England North for all health safeguarding professionals, this year’s event included learning on neglect, hoarding and asylum seekers. Due to the success of last years named GP conference in Yorkshire and the Humber NHS England North also held a conference for named GPs to share good practice and learning; topics included homelessness, domestic violence, travelling families and safeguarding.

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). NHS England works in collaboration with CCG designated professionals to ensure a robust oversight of all incidents, recommendations and actions from reviews. Prior to publication of any reviews NHS England communication team liaise with the relevant local authority communications team regarding the findings, recommendations and publication.

Training and 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, in 2017/18, 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. A training needs analysis has also been undertaken to ensure all NHS England employees receive appropriate levels of safeguarding training.

A number of leadership programmes for designated safeguarding professionals have been commissioned by NHS England in addition to a 2 day resilience course. The CSE training provided by BLAST ‘Not Just Our Daughters’ has also been provided for front line health professionals.

Link below to the safeguarding app:- http://www.myguideapps.com/nhs_safeguarding/default/
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. An online version has been piloted in 2017/18 by NHS England in order to develop a national assurance tool for CCG’s. A primary care version of the online assurance is also being piloted by a couple of CCGs in Yorkshire and the Humber.

Specialised Commissioning

NHS England North Specialised Commissioning service providers are, via the contracting process, required to demonstrate compliance with all relevant safeguarding policies and legislation and work in partnership with other agencies regarding all aspects of safeguarding.

Within Specialised Commissioning the Heads of Quality review all serious incidents and liaise with the appropriate CCG to review all incidents and work through actions with the provider. Where NHS England North Specialised Commissioning is the lead or sole commissioner they work directly with the provider, monitor actions and share outcomes with other commissioners.

Health and Justice

NHS England North Health and Justice service providers are, via the contracting process, required to demonstrate compliance with all relevant safeguarding policies and legislation and work in partnership with other agencies e.g. Prison, Police regarding all aspects of safeguarding.

In addition, there is a Quality Framework in place which requires all providers to report on a quarterly basis regarding any safeguarding concerns, incidents, reviews (including themes and trends). An annual audit of Combined Adults and Children’s Safeguarding Standards and an annual safeguarding report are also submitted for review to the NHS England local office Quality Surveillance Group.

Care Homes

NHS England Yorkshire and the Humber have appointed an Independent Care Sector (ICS) Lead to support organisations in the delivery of the Enhanced Health in Care Homes framework. The key work streams in this programme for the ICS leads are the delivery of the red bag scheme and the roll out of an electronic bed state tool.

Complaints and Concerns

NHS England Customer Contact Centre review all complaints and concerns received and identify those containing a safeguarding element for appropriate action. Following receipt of complaints and concerns at NHS England North local offices these are reviewed again and any safeguarding concerns identified are referred to the safeguarding lead for review and appropriate action.

Priorities in 2017/18 around complaints were:

- NHS England North regional safeguarding team in partnership with NHS England local offices reviewed and agreed a standard process for the management of safeguarding concerns within complaints.
- NHS England North regional safeguarding team has delivered safeguarding training to the required standard and level to all complaints staff in accordance with relevant national guidance.

Prevent

NHS England North have two Regional Prevent coordinators who work across the North region to support Prevent implementation, they are part of the National and regional safeguarding and Quality team. This year has seen an increased focus and scrutiny on Prevent implementation within health and safeguarding.

A national task and finish group has been established chaired by the Director of Nursing for NHS England to oversee the progress that is being made with Prevent implementation. Particular focus has been on training with an expectation that all organisations will be able to demonstrate 85% compliance by the end of March 2018.
We are working closely with providers, commissioners and regulators to support and monitor the work being undertaken to ensure that all health care organisations can meet their statutory duty for Prevent.

Across the Yorkshire and Humber we have funded a number of projects to enhance understanding of Prevent and to support staff including work with partners in North Yorkshire in the development of a graphic novel titled ‘Hurt by Hate’ an interactive training package designed to raise awareness of a variety of issues surrounding Prevent and safeguarding .

Following a regional research project to scope the current, attitudes, awareness and practice amongst GP colleagues we are now working with the Home Office to extend the research nationally.

We have worked to develop a Prevent training framework and e learning packages specifically for health and have shared guidance across the network for mental health practitioners.

In December 2017, the 3rd North Regional Prevent conference was held in Harrogate; delegate feedback demonstrated the positive attitude to Prevent in health agencies and their commitment to continue to develop their knowledge.

### Transforming Care

In April 2015 The Transforming Care national programme announced a radical transformation of the delivery of Learning Disability and Autism services. This model included significant reductions in learning disability inpatient beds and a greater focus on the provision of early intervention and crisis preventative community services. The collective vision and ambition to deliver an integrated co-produced set of principles and standards was fundamental to delivering care closer to home, avoidance of unnecessary hospital admissions and the prevention of missed opportunities for people with a Learning Disability and or Autism to have happy and productive lives within the community of their choice.

The 6 Transforming Care Partnerships across Y&H continue to work collaboratively to achieve Building the Right Support for patients in our area.

### Learning Disabilities Mortality Review (LeDeR) Programme

In November 2016 the national LeDeR Programme was introduced in to the Transforming Care Programme 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.

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. A number of learning events have taken place in Yorkshire and Humber to share the early findings of the reviews already completed.
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 NHSR CCG will continually develop the organisation’s Safeguarding arena, with Safeguarding Adults high on that agenda.

Robust governance arrangements are in place to ensure that the CCG’s own safeguarding structures and process are evident and that the agencies from which they have commissioned services meet the required standards. A plethora of measures are utilised 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 NHSR CCG continues in its commitment to safeguarding and promoting the welfare of all residents in the Borough. NHSR 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.

NHSR CCG continues to work within NHS England’s key document “Safeguarding Vulnerable People in the NHS Accountability and Assurance Framework (2015)” which underpins the CCG’s responsibilities for Adult Safeguarding. The much awaited Safeguarding Adults: Roles and competences for health care staff – Intercollegiate Document was not published during the year 2017/18 and is still eagerly awaited.

Training

Sub groups of the Safeguarding Adult Board continue to grow and develop with NHSR CCG remaining a committed and active member to all five groups. The CCG advisor to the Board member continues to chair the Training and Development sub-group with achievements of the RSAB Training Strategy and Plan agreed in the summer 2017.

August 2017 saw the CCG complete its yearly Safeguarding Update (Children and Adults) as per NHS England guidelines. Topics covered include CSE (Child Sexual Exploitation) and Operation Stovewood, Modern Slavery and Human trafficking and Prevent. The update was delivered to all CCG staff including Governing Body members.

Key Achievements 2017/18

- NHSR CCG has remained firm in its commitment to the board at a senior and executive level.
- Participation at regional and local Safeguarding Networks to share best practice.
- Participation at RSAB and sub groups, including chairing the Training and Development sub-group.
- Safeguarding assurance sought at provider Contract Quality meetings.
- Attendance at TRFT Strategic Safeguarding meetings.
- Updates made, in line with legislation, to the Safeguarding Policy to incorporate FGM, Prevent and Modern Slavery.
- Participation in Domestic Homicide Review meetings requirements.
- Domestic Abuse – facilitated peer review and safeguarding supervision sessions, supporting GP practices to take steps to safeguard vulnerable people.
- Professional Challenge/Discussion forum addressing health and wellbeing of alleged perpetrators and their families.
In November 2017 NHSR CCG addressed a politically sensitive area – the health and wellbeing of alleged perpetrators. The National Crime Agency’s Stovewood agenda has seen a combination of investigations both for historic and emerging abuse continue to progress at a level and pace understood by those involved directly, but what about those indirectly involved? From the start of the Stovewood investigation agencies have worked together to highlight and deliver on support systems, processes and services for victims/survivors of this horrific abuse. We are now starting to see increasing numbers of identified perpetrators and our GPs tell us that they are seeing survivors and perpetrators and respective family members almost side by side in their waiting rooms which must be the same for many services.

In Rotherham we have often felt that we are leading the way with a lot of this work in the absence of a clear evidence base and this prompted the professional challenge session entitled “Perpetrator Challenges, Understanding our responsibilities and limitations”. Previously we have hosted sessions for GP practice staff and multiagency groups covering aspects of recognising signs of abuse/referral pathways for survivors and the focus should continue to be on survivors, keeping them at the centre of what we are trying to achieve for them.

24 multi-agency staff attended this event with excellent feedback. Discussion points included:

- Joint working
- On-going investigations
- Survivors and their families
- Perpetrators and their families
- Why does it take so long to get to court?
- Why do some alleged perpetrators need to move out of the family home and some don’t?
- What are GPs seeing and what the impact of health and welfare is?

A plan was put together from the event and actions have been taken forward.

In 2017 NHSR CCG undertook a 3 step learning process focusing on “Domestic Abuse”. This approach significantly supported GP practices in assessing their processes for recognition and signposting/ referral of individuals affected by domestic abuse. Recognising that GPs, as frontline practitioners, are ideally placed to identify or have someone disclose that they are suffering domestic violence or abuse, the GP quick reference guidance was updated and shared with practices, providing information to increase knowledge and skills when responding to domestic violence or abuse.

### Domestic Abuse 3 Step Learning Process:

- **Step 1** – self-assessment - 30 practices out of 31 completed (97%).
- **Step 2** – GP Peer Review to share learning and respectfully challenge practice and processes. This developed into a shared learning event with Domestic Abuse experts providing direct support. 70 staff covering 27 GP practices attended the event.
- **Step 3** – GP Safeguarding Leads attended supervision sessions with the Named GP for Safeguarding for Vulnerable Clients.
- **Continuity** – The Named GP for Safeguarding continues to provide on-going safeguarding supervision to GP Safeguarding Leads within practice, to enable them to provide education, support and supervision to peers and junior colleagues in practices. The sharing of best practice information also continues to take place.
Our work around domestic abuse has been shared across South Yorkshire and Bassetlaw and was extremely well received. Other areas are now planning to do a similar audit.

In 2017/18 NHSR CCG furnished staff and GP practices with information on key developments in the safeguarding arena. Safeguarding updates and current trends/information were shared via the CCG Newsletter (circulated to GP practices and CCG staff) along with emails to safeguarding leads and practice managers.

Prevent

The Prevent Duty remains a high priority for the CCG with mandatory Healthwrap training for all staff with 3 yearly updates as stipulated in the NHS England Prevent Framework. GP practices receive regular updates regarding their training requirements and how to access the NHS England Prevent eLearning package. NHS England set a target for providers (not including primary care) of 85% compliance with Healthwrap training by March 2018. NHSR CCG are assured that all providers achieved this. Monitoring of training and other Prevent data via Unify 2 will be compulsory from April 2018 for all providers to NHS England and shared with the Home Office.

Safeguarding Adult Reviews

The past year has seen the publication of two Safeguarding Adult Reviews (SARs) to which the CCG have been involved. Action plans are monitored via the Performance and Quality sub group with the CCG engaged as appropriate.

Learning Disabilities Mortality Review

(LeDeR) Programme was commenced in November 2016 following the Confidential Enquiry into the Premature Deaths of People with Learning Disabilities. During 2017/2018 NHS RCCG have established a LeDeR process with 11 Rotherham residents referred onto the programme. The reviews will highlight best practice; potentially avoidable contributory factors and action plans/lessons learnt necessary to change health and social care service delivery for those with a learning disability.

Next Steps

The world of Adult Safeguarding is constantly developing in terms of case law, legislation and categories of abuse. NHSR CCG will continue to work in conjunction with statutory partners and be responsive to changes and developments. 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 2016/20 Your life, Your health:


- For the year 2018/19 plans are already underway for an NSHR CCG Safeguarding Event primarily for GP practice staff focusing on issues that affect males in our society including male domestic abuse, modern slavery / trafficking and sexual exploitation.

NHSR CCG will continue to be an engaged partner to ensure that statutory duties are met, keeping Safeguarding very much on the agenda of all we do.
Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH)

Safeguarding is at the heart of everything we do within RDaSH. In order to prevent or minimise the risk of abuse occurring and to help protect those most at risk in our communities we believe a partnership approach is essential. We are represented at a senior level on all key forums providing specialist health and safeguarding advice and as a Trust we remain fully committed to ensuring we meet our statutory duties and responsibilities for safeguarding. We continue to ensure that our staff listen and respond to what adults with care and support needs (and their carers) tell us about what they want to happen to safeguard them and live their lives as independently as possible in their own homes.

A culture of “Safeguarding is everybody’s responsibility” permeates across the teams and individuals within Rotherham Care Group and the wider Trust. Over the last 12 months a significant amount of work has been undertaken to ensure there is a robust safeguarding adults governance structure. The capacity of Safeguarding Adults Lead Professionals has been strengthened and a Nurse Consultant for Safeguarding has been recruited into post, this has resulted in greater visibility and the forging of stronger relationships across partnerships within Rotherham. The Safeguarding Adults Leads have also provided guidance and supervision in respect of the wider safeguarding agenda including PREVENT, Modern Slavery, Female Genital Mutilation (FGM), Hate/Mate Crime and Self-Neglect. The governance arrangements oversee and facilitate the implementation of safe practice across our workforce. There is a strong culture of learning and sharing of good practice based on appreciative enquiry and safeguarding training is delivered in line with research and best practice. There continues to be a clear vision to achieve the highest standards of quality and safety and to embed safeguarding principles, dialogue and a culture of early intervention / prevention in safeguarding into all areas of practice.

There continues to be established oversight, assurance and governance mechanisms for managing safeguarding issues with the Safeguarding Adults Leads working closely with all staff to ensure that safeguarding incidents are reported and effectively managed to keep patients safe and protect their human rights. The Safeguarding Adults Team has oversight of serious incidents via STEIS and IR1 reports, these are all reviewed to ensure safeguarding is threaded through investigations and wider subsequent learning. In response to the Department of Health and Social Care – safeguarding adults protocol “Pressure Ulcers and the Interface with a Safeguarding Enquiry” (Jan 2018) a member of the Safeguarding Adults team is now a member of the Trust’s pressure ulcer forum and contributes to the learning and development in this area.
South Yorkshire Fire and Rescue Service (SYFR)

GOVERNANCE

South Yorkshire Fire and Rescue has completed a number of Self-Assessments and attended Challenge Meetings across the county to provide evidence and assurances that the service is compliant with statutory safeguarding requirements.

An internal SYFR Safeguarding Executive Board and Reference subgroup continues to provide internal governance and a number of related action plans demonstrate ongoing learning and improving in our multiagency working e.g. Child Fire Setters, Business Fire Safety relating to care homes, coordination of referrals from IDVAS and SYP Domestic Abuse Advisors and High (Fire Risk) Practice group.

AUDIT AND CASE MANAGEMENT

A newly created Case Tracker can now be used for quarterly auditing and the adult related internal case – work has increased three fold in the last 4 years. Less than a third of cases meet the criteria for a Safeguarding Enquiry, the majority are concerns about health and wellbeing. Over half of the cases are related to fire risks and self- neglect and SYFR has contributed to the development of the Hoarding and Self Neglect policies across the county.

TRAINING

A new SYFR Safeguarding Concern form together with an e learning support package has been developed to enable the workforce to differentiate between safeguarding, fire risk, health and wellbeing and to gather the required information to make effective referrals or raise concerns.

PLANS AND PRIORITIES


The Safeguarding priorities for the coming 12 months:

- Preparation for HMICF&R Inspection – there is a specific theme of enquiry relating to the identification of those with vulnerabilities
- Ongoing preparation for GDPR
- Contribution to the National Fire Chief Council Safeguarding work stream
South Yorkshire Police

Vulnerability, including adults are prioritised through our daily tasking process and allocated to resources accordingly. This is a priority in all of our tasking and led by Rotherham Borough Command Team on a daily basis. South Yorkshire Police are fully engaged with the statutory referral process and case management in cases of identified adult vulnerability.

The re-establishment of dedicated Neighbourhood resources to strengthen the PCSO teams are now embedded in all areas within Rotherham. This gives us the best opportunity to take community feedback, identify cases of vulnerability and to protect potential victims of crime and anti-social behaviour. The co-location of these local Police enforcement services with Local Authority counterparts has been achieved in the Central Neighbourhood area and will be completed for the North area based at Rawmarsh and in the South at Maltby in September 2018. Once embedded, the development of these services will look to expand the teams to include other partners where it is sensible to do so.

A new innovation also on line since May 2018 is the Safer Neighbourhood Service whose vision is to work in partnership, to listen to and work with the public, community groups and businesses to reduce crime, protect the vulnerable and enhance community safety through integrated problem-solving approaches. This fully supports the mission of the Safeguarding Adults Board and its’ key objectives. The Safer Neighbourhood Service is very much about early identification and intervention in cases where vulnerability is found. Working with partners to case manage and appropriately problem solve the case, bringing a sustainable solution using all partnership resources.

Vulnerable adult victims of crime are prioritised, within that cohort of victims there may be particular features that need focussed attention. Hate crime, sexual abuse, financial abuse, missing persons and repeat and vulnerable victims of anti-social behaviour, all have dedicated staff case managing and problem solving to reduce vulnerability protecting victims and bring perpetrators to justice.

Case Studies

**Financial exploitation.** An elderly victim had carers going into his home every day, he had a fall and went into hospital and then into a care home and had dementia. The Social Worker alerted the Police months later that someone had been withdrawing thousands from his bank account during the last year. The Vulnerable Persons Unit investigated around 10 carers who had access to the victim’s home prior to the victims fall. Eventually identified one carer as suspect and secured a conviction at Crown Court for burglary and fraud.

**Financial exploitation.** An elderly victim had a carer who came once a week to help with chores and was supposed to withdraw £100 a week and give to the victim. The carer had the victim’s bank account for 4 years, withdrawing cash every week totalling over £20,000 without consent. The carer was spending the money on gambling. The Vulnerable Persons Unit investigated and secured a conviction of fraud x 2 at Crown Court.

**Suicide Prevention.** A young adult male whose younger brother and mother had took their own lives and was living a chaotic lifestyle was identified as a tangible risk of suicide. A number of emergency meetings were held with partners leading to quick responses to any information from his home address, an active suicide attempt was prevented and he was further supported by the partnership to help him get through a very tough period of his life.

A vulnerable trans female exhibiting sustained criminal behaviour and anti-social behaviour especially at local transport hubs was identified by the team. The relevant partners were engaged including the Transport Interchange at Rotherham to put in place a Criminal Behaviour Order to help curb her behaviour and reduce the vulnerability to herself and others. This young and vulnerable female is now engaging with various services to provide long-term solutions to her behaviour and reduce her vulnerability.
Rotherham Voluntary and Community Sector:

Achievements:

1. 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.

2. 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-to-date on safeguarding issues and encourage and support their contribution to this important area of work.

3. Each of the Safeguarding Adults sub-groups has representation from the voluntary and community sector. RSAB – Lesley Dabell, Training – Liz Bent, MSP – Karen Smith. Reports from subgroups are shared with the wider Voluntary and Community sector via ASC Strategic Representative meetings.

4. VCS organisations continue to contribute to the Safeguarding Board and Development Days as partners; in addition they act as alerters referring concerns appropriately.

5. Individual VCS organisations have continued their work internally in respect of their own policies and procedures for Safeguarding, linking in to the wider Safeguarding Procedures in the Borough. Staff and Volunteers have attended training sessions raising awareness of Adult Safeguarding throughout the Borough.

6. The Adult Services Consortium and Voluntary Action Rotherham have been promoted safeguarding week, and VCS groups are taking an active part during the week.

7. VAR acts as an ‘umbrella body’, for administering and processing the ‘Disclosure and Barring Service’ (DBS) checks

8. VAR promotes DBS and provide related advice and support, including carrying out the ‘Enhanced DBS checks’

9. VAR supports VCS with the development of Safeguarding Policies and procedures; including ‘Safer Recruitment’ support

Recognise • Respond • Report
Learning and development

In 2017/18 the Training Sub-group ran a rolling programme of supportive 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. 1,058 learners attended training courses, as detailed by agency in the table above.

<table>
<thead>
<tr>
<th>Local authority</th>
<th>423</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent/ Voluntary sector</td>
<td>580</td>
</tr>
<tr>
<td>Health</td>
<td>28</td>
</tr>
<tr>
<td>Police/Probation</td>
<td>0</td>
</tr>
<tr>
<td>Service Users / Carers</td>
<td>21</td>
</tr>
<tr>
<td>Students</td>
<td>6</td>
</tr>
<tr>
<td>Other/Housing Partner</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1058</strong></td>
</tr>
</tbody>
</table>

The Training Sub-group finalised its Training Strategy and Training Plan for 2017/2020 to lead and manage training arrangements across Rotherham. The Strategy now provides 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 sets out the vision, goals and principles for training and how these will be taken forward. The Plan supports and drives 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.

The Training Sub-group’s objectives and priorities 2018/2019 are:

- Assessing multi-agency and specialist training needs /analysing gaps
- Development of an multi-agency and/or specialist training framework
- Development of models for evaluating training impact.
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:

This year the Safer Rotherham Partnership has undergone two independent reviews. The first of which related to overall governance and assurance with the second being specific in relation to Domestic Abuse. Both reviews provided broad assurance, alongside valuable learning, some of which will require continued efforts to strengthen links amongst the key partnerships, including the Safeguarding Adults Board.

There has been a continued rise in crime (20%), as reported in the previous year and this is due to crime reporting standards improving not just in South Yorkshire, but nationally. This has also caused a reduction in outcomes (-3 %), as a percentage of the crime recorded. There has however been a slight (1 %) increase in general satisfaction levels. The specific priority areas over the previous year were;

- Preventing Child Sexual Exploitation

This year has seen a reduction of 11 % in current offences (not including historic offences) and a 100 % completion of taxi licensing safeguarding requirements. There has additionally been an 8 % increase in the use of abduction notices.

- Building Confident and Cohesive Communities

As a result of the continued work of partners and a commissioned project, there has been a 33 % rise in reported hate crime, which is seen as positive, though is still likely to reflect under-reporting. Thousands of hours of awareness raising has been competed to hundreds of individuals.

- Reducing the Threat and Harm of Domestic Abuse

A strategy has been agreed by all partners and the SRP Board in relation to Domestic Abuse. There has also been a significant reduction in the waiting list for standard and medium risk victims, down to 0. The independent peer review in to this area again provided broad assurance however further work is required around training and data alongside assurance and governance. This work will link closely with the Safeguarding Adults Board.

- Reducing and Managing Anti-Social Behaviour
There has been a 27% reduction in Ant-Social Behaviour over the previous year. This is mainly due to a number of incidents that would have previously been classified as ASB, now being classified as crimes, which is positive in regards to more effective support for victims. There has however been an increase in deliberate fires and further work will be done on this matter. The Partnership has reviewed and strengthened partnership structures that support officer to tackle this type of behaviour. Additionally, enforcement services have moved to a co-located model. This will make the team more effective and better support victims and in particular, vulnerable victims.

- Reducing Violent Crimes and Sexual Offences

There has been a 42% increase in Violence against the Person and a 23% increase in sexual offences. Again this is linked to crime recording however does present a concern and work continues to seek to address these areas of work.

Following a refined process, taking in much wider data set, the Safer Rotherham Partnership has adopted headline priorities as follows:

- Protecting Vulnerable Children
- Protecting Vulnerable Adults
- Building Confident and Cohesive Communities
- Reducing the Threat and Harm of Domestic Abuse
- Tackling Serious Organised Crime

Clearly the work of both partnerships continues to overlap and the SRP will seek only to enhance work where possible and cooperate with the Safeguarding Adults board in relation to the delivery of relevant priority areas.
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 2,113 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.

724 Section 42 enquiries began 2017-18

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.

53 DMM’s convened in 2017-18

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.

10 Outcome Meetings Convened 2017-18
**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 2017-2018**

0 SAR’s was commissioned in 2017/18

**Number of SAR’s Completed 2017-2018**

1 SAR was completed in 2017/18

Published August 17 (Margaret)
SAR Margaret

Margaret was a 92-year-old who was a resident in a Nursing Care Home 2012 until her death in February 2015. Margaret had significant health needs with hypothyroidism, depression, dementia, contracture of lower limbs and anaemia.

In February 2015 Margaret was admitted by the GP to The NHS Foundation Trust Hospital due to concerns regarding her poor condition. It was believed she was at this point in a myxoedema coma and was critically ill. Her temperature was unnaturally low and she was slightly blue. Margaret died nine days after admission.

Margaret’s death certificate stated:

• Myxoedema coma
• Hypothyroidism
• Alzheimer’s dementia

Subsequently the NHS Foundation Trust made a safeguarding referral due to concerns that Margaret was in a coma due to a thyroxine crisis and suggestions that she had not had her essential thyroxine medication for over 2 years and that this was more likely to be the cause of the poor physical condition that Margaret was in on admission. The outcome of the ensuing Section 42 Enquiry was that neglect by omission in respect of the medication that was not received by Margaret, led to her death.

Findings/Recommendations

1. Recommendations for the Local Authority:

That the Local Authority social care and contracts compliance team, in partnership with other agencies where appropriate, ensure:

a. Contract Compliance will be conducted through a targeted approach to contract compliance visits based on risk. For high risk settings contract compliance officers will identify that care plans and medication records within care homes are fit for purpose and demonstrate they are in keeping with the needs of the individual.

b. Social Care reviews of residents in care homes involves health and care staff where appropriate

c. Where clients are resident in settings that are non-compliant with CQC regulations and/or contracts, consideration should be given to review of care needs of residents dependent on the severity of the concern. This must include an audit trail that provides evidence that no resident has been missed. Consideration must be given to providing families with relevant information when appropriate

d. A review of the Local Authority Home Closure and Provider failure protocol to ensure that it remains fit for purpose in light of the above recommendations

2. Recommendations for the CCG:

a. management of long term conditions by GP’s within residential and nursing homes are subject to robust processes of monitoring and review.

b. there are appropriate written communication tools in use between care homes and GP practices.

c. the system for notification of the changed funding arrangement for an individual is reviewed and audited to ensure that any failure to successfully transfer responsibilities is flagged.

d. The CCG should provide support to GP practices across Rotherham to develop processes that take account of legislation, guidance and case law for when it is deemed clinically necessary to administer covert medication. Guidance should also include that Best Interest decisions are supported with agreed multi agency covert medication plans which are reviewed regularly.

3. Recommendation for CCG and Local Authority:

The CCG and Local Authority Contract compliance should gather information from relevant partners, including CQC, NHS Providers and local Care Home providers to establish whether there is evidence of uncertainty of roles and responsibilities in the provision of nursing care to nursing homes in the Borough. Dependent upon findings further recommendations should be made to address any issues found.
NHS England in Yorkshire and Humberside should:

a. Publicise the safeguarding learning from this review amongst GP’s in the region.

b. Ensure the learning from this review is shared with the safeguarding lead nurses and GP’s in the region.

5. Recommendations for Rotherham Safeguarding Adults Board (RSAB).

a. Where agencies have made their own recommendations in their review of Margaret’s care, RSAB should seek assurance that action plans are underway and outcomes are impact assessed within those organisations.

b. RSAB to write to NHS England to request the consideration of project funding to incentivise medicines management support to care homes. This would be consistent with work in other areas to provide oversight and scrutiny by medicines management staff especially where there are medicines management compliance issues flagged by LA CC teams and/or CQC.

c. That the DoLs subgroup of RSAB, consider the learning from this review and ensure that where medication compliance is an issue and covert medication is being considered, these cases should be included in the list of cases that require prioritisation. I.e. Challenging behaviour requiring significant restrictions should be prioritised for full assessment for DoLs authorisation. Scrutiny of the prioritisation of DoLs applications will ensure the priorities are compliant with ADASS guidance.

www.adass.org.uk/media/5297/additional-dols-safeguards-final.pdf

d. Arrangements should be made to share the learning with the Local Pharmaceutical Committee and CQC.

e. The RSAB Making Safeguarding Personal sub group should share the learning from this review in the form of a briefing across all its member agencies. Assurance should be sought as to how this has been disseminated to professionals in those organisations followed by case audit to provide evidence of impact e.g. change of practice or policy/procedure etc.

f. Evidence and assurance should be provided to RSAB performance sub group on the completion and/or ongoing audits of the recommendations as appropriate.

The actions have been developed into an action plan that is monitored by the Performance and Quality Sub Group, the chair of the group will report to the RSAB on progress and when all actions are completed.
Mental Capacity Act and Deprivation of Liberty Safeguards

The DoLS continue to challenge the local authority in terms of numbers of referrals, however, this does reflect that care arrangements which amount to a deprivation of liberty are being acknowledged and the appropriate authorisation is being sought by the relevant managing authority’s. Support in the form of advice and training needs to continue with care providers to ensure all deprivations of liberty are recognised and managed in line with statutory duties.

As can be seen in the table, the number of authorisations granted and not granted has gone down in the last reporting year, this can be attributed mainly to two factors:

- Changes to the tax regulations in April 2017 relating to independent assessors meant their employment status had to be reviewed, the result being that some assessors chose to no longer provide services to the local authority. Work to recruit independent assessors is ongoing, with positive results;

- A comprehensive audit of the quality of DoLS assessments took place between July and December 2017, the outcome of the audit found the quality of reports fell below that expected by the Supervisory Body. The allocation of assessments was pared back to allow for re-training of assessors.

<table>
<thead>
<tr>
<th>Year</th>
<th>No. of Applications</th>
<th>Authorised</th>
<th>Not Authorised</th>
<th>Screened unallocated cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013/14</td>
<td>56</td>
<td>44</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>2014/15</td>
<td>565</td>
<td>165</td>
<td>111</td>
<td></td>
</tr>
<tr>
<td>2015/16</td>
<td>957</td>
<td>190</td>
<td>350</td>
<td></td>
</tr>
<tr>
<td>2016/17</td>
<td>1128</td>
<td>452</td>
<td>524</td>
<td>480</td>
</tr>
<tr>
<td>2017/18</td>
<td>1190</td>
<td>227</td>
<td>4</td>
<td>738</td>
</tr>
</tbody>
</table>

In March 2018, Parliament responded to the Law Commission’s proposals on the Liberty Protection Scheme to replace DoLS. The local authority is aware of the proposals and preparing for any impact on current policies and procedures.
The Context of Safeguarding in Rotherham – 2017/18 data

No of concerns received - **2113**
No which progressed to enquiry - **724**

Concerns received have **decreased** in 2017/18 by approx. **16%** (2113 - 2017/18), (2455 - 2016/17)

No of S42 Enquiries commencing in year has **increased** by approx. **12%** (719 - 2017/18), (640 - 2016/17)

Rotherham’s conversion rate has **increased** to **34%** from **24%** (National Average 2016/17 was **41%**)

No of S42 Enquiries completed in year have **increased** by approx. **48%** (645 - 2017/18), (435 - 2016/17)

**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**

The table below shows % change in abuse types

<table>
<thead>
<tr>
<th>Concluded S42 Enquiries</th>
<th>2017/18</th>
<th>2016/17</th>
<th>% change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Abuse</td>
<td>155</td>
<td>80</td>
<td>93.8%</td>
</tr>
<tr>
<td>Sexual Abuse</td>
<td>37</td>
<td>25</td>
<td>48%</td>
</tr>
<tr>
<td>Psychological Abuse</td>
<td>90</td>
<td>35</td>
<td>157%</td>
</tr>
<tr>
<td>Financial or Material Abuse</td>
<td>138</td>
<td>80</td>
<td>73%</td>
</tr>
<tr>
<td>Discriminatory Abuse</td>
<td>2</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Organisational Abuse</td>
<td>28</td>
<td>15</td>
<td>87%</td>
</tr>
<tr>
<td>Neglect and Acts of Omission</td>
<td>340</td>
<td>210</td>
<td>62%</td>
</tr>
<tr>
<td>Domestic Abuse</td>
<td>32</td>
<td>11</td>
<td>191%</td>
</tr>
<tr>
<td>Sexual Exploitation</td>
<td>5</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Modern Slavery</td>
<td>3</td>
<td>1</td>
<td>200%</td>
</tr>
<tr>
<td>Self-Neglect</td>
<td>16</td>
<td>5</td>
<td>220%</td>
</tr>
</tbody>
</table>
## Rotherham Safeguarding Adults Board Attendance

### Date of Safeguarding Adults Board Meeting (excludes e-learning)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>South Yorkshire Police</td>
<td></td>
<td>Apologies</td>
<td></td>
<td></td>
<td></td>
<td>Apologies</td>
</tr>
<tr>
<td>The Rotherham Foundation Trust</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Clinical Commissioning Group</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Apologies</td>
</tr>
<tr>
<td>RMBC Director of Social Services</td>
<td>✔</td>
<td></td>
<td>Apologies</td>
<td></td>
<td></td>
<td>✔</td>
</tr>
<tr>
<td>RMBC Children’s Service</td>
<td>✔</td>
<td>Apologies</td>
<td>Apologies</td>
<td>Apologies</td>
<td>Apologies</td>
<td></td>
</tr>
<tr>
<td>South Yorkshire Fire and Rescue</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>Apologies</td>
<td>Apologies</td>
</tr>
<tr>
<td>NHS England</td>
<td>✔</td>
<td>✔</td>
<td>Apologies</td>
<td></td>
<td></td>
<td>Apologies</td>
</tr>
<tr>
<td>RDASH</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td></td>
<td>✔</td>
</tr>
<tr>
<td>RMBC Services</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td></td>
<td>✔</td>
</tr>
<tr>
<td>Healthwatch</td>
<td>✔</td>
<td>✔</td>
<td>Apologies</td>
<td></td>
<td></td>
<td>Apologies</td>
</tr>
<tr>
<td>Voluntary Sector</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Apologies</td>
</tr>
<tr>
<td>National Probation Service</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>Apologies</td>
</tr>
<tr>
<td>Community Rehabilitation Company</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Apologies</td>
</tr>
<tr>
<td>Cabinet Member for Adult’s Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Apologies</td>
<td>Apologies</td>
</tr>
</tbody>
</table>

Rotherham Metropolitan Borough Council’s Cabinet Member for Adults Services supports the work the Safeguarding Adults Board with a visible presence at events and discussions throughout the year and is provided with monthly updates on all safeguarding adults issues as well as the work of the board.
Do you know the signs of adult abuse?

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

Physical
Emotional
Financial
Institutional
1. Summary

1.1. The current Rotherham Joint Strategic Needs Assessment (JSNA) is due a refresh. This provides an opportunity to consider rationalising the content, making it a better fit to drive current priorities and ensuring it is more meaningful to commissioners, service providers and partners.

1.2. The purpose of a JSNA is to capture and share data and analytical context about the population of Rotherham with regard to the wide range of influencers on health and wellbeing. The JSNA should inform and influence strategy, particularly that of the Health and Wellbeing Board, and thereby drive improvement in health and wellbeing of the population.

1.3. To fit with an asset-based approach, there is a need to re-balance ‘needs’ versus ‘strengths’ based indicators (by including what is strong, not just what is wrong) and to better include community voice by actively involving more partners in co-production.

1.4. In order to determine what the refreshed JSNA should look like, all partners are actively encouraged to participate in a consultation process to shape the design. It is expected that every organisation represented at the Health and Wellbeing Board will give a considered response to the consultation.

2. Recommendations

That the Health and Wellbeing Board:

- Agree that a refresh of the JSNA is desirable
- Comment on the proposed consultation plan
- Actively encourage senior managers involved in strategic and policy design and commissioning or service delivery from a wide range of partner organisations to take part in the consultation to ensure the revised JSNA is meaningful, well used and fit for purpose.
Proposals and details

3. Background

3.1. The purpose of a JSNA is to drive improvement in the health and wellbeing of the local community and reduce inequalities for all ages. It is not a stand-alone product, but a continuous process of strategic assessment, which should then inform planning, in order to develop local evidence-based priorities for strategies and commissioning and ultimately help to determine what actions the Council, local NHS organisations and other partners need to take to meet health and social care needs, and to address the wider determinants that impact on health and wellbeing.

3.2. In the statutory guidance\(^1\), it is clear that local authorities and CCGs have equal and joint duties to prepare JSNAs through the Health and Wellbeing Board. The responsibility falls on the Board as a whole and their success depends upon all members working together throughout the process. However, best practice involves co-production with a range of partner organisations, such as the voluntary/community sector and including public voice.

3.3. The Rotherham JSNA was refreshed as an online resource in 2013, replacing the former fixed document format of 2011. Following a period of consultation, the Health and Wellbeing Board signed off the final version of the JSNA in February 2014. The JSNA was subject to a review in 2015/16 and in June 2016, the Board agreed that it be subject to further review to improve the content and format in 2016/17.

4. The current JSNA

4.1. The JSNA website is hosted by the Council’s website at: [http://www.rotherham.gov.uk/jsna/](http://www.rotherham.gov.uk/jsna/)

4.2. The online format allows for updates of information so that the content is continually evolving in response to new data becoming available or additional content being required. Contributors from a range of service areas have been asked to provide any updates required on a quarterly basis.

4.3. The content is arranged under the home page and 7 sections:

- Home page – provides background to the JSNA, a link to the Health and Wellbeing Strategy, priorities, overview of key issues and downloads.
- People – information about Rotherham’s population including numbers, age, gender, ethnicity and information about specific communities of interest.
- Places – information about the environment, housing, transport, and profiles of the borough, wards and other localities.
- Economy – information on poverty, deprivation, economy and labour market.
- Staying Safe – safeguarding for children and adults, crime, domestic abuse, sexual abuse and CSE.

• Healthy living – epidemiological information about lifestyles and behaviours such as tobacco use, alcohol misuse, substance misuse, teenage pregnancy, obesity (inc. eating habits and physical activity) education, and inequalities
• Ill health - epidemiological information about the major causes of disease and infirmity in Rotherham
• Services – describes a range of health and social care services with information on performance and user satisfaction

JSNA users can drill down from each of these sections to find relevant information, for example information on Education can be accessed under ‘People’ then ‘Children and Young People’. There is a search tool to help users find information using key words. For every topic, the JSNA provides answers to three questions:

• Why is this an issue?
• What is the local picture and how do we compare?
• What is the trend and what can we predict will happen over time?

5. Key Issues: Why review the JSNA?

5.1. The time seems right to refresh the JSNA, considering the content, format and production since anecdotal evidence suggests the current JSNA is not widely used, presumably because it is not meeting the needs of commissioners, service providers or the voluntary/community sector.

5.2. The launch of the Thriving Neighbourhoods strategy\(^2\) sets out a new asset-based way of working which places communities at the heart of everything we do. To work in a truly asset focused way, would require a change in emphasis from ‘troublesome’ indicators (needs and problems) to include a better balance of ‘heartening’ indicators (assets, strengths, social capital, protective factors). By simply changing the way in which indicators are presented, such as talking about emotional wellbeing rather than mental illness, changes the starting point for strategy and policy development from focusing on need to starting with building on existing strengths.\(^3\) The original JSNA proposal in 2013 included a “register of assets” which was never implemented so now would be the opportunity to re-dress that gap.

5.3. Previously the JSNA has been primarily owned and maintained by RMBC. It is really important that if it is to be meaningful and used by a wider audience, that partners are actively involved in contributing data and contextual analysis. We are not currently for example, using the wealth of data collected by the voluntary sector that could better help us understand our communities. Alongside this, the JSNA should provide a rich resource of information to support the voluntary sector in evidencing information about their local community for funding bids etc.

5.4. It is now more popular to present data and analysis in a more pictorial format, using infographics rather than paragraphs of text and tables. This can help

\(^2\) Thriving Neighbourhoods Strategy
make information more accessible to a wider audience, more impactful and quicker to assimilate.

5.5. The JSNA and data and intelligence provision, such as producing health needs assessments, needs to be a joined up and sustainable approach. Having information available online enables users to access easily and keeps resources in a common location. It also enables links to be made to other key documents, such as strategies, and resources, such as the Rotherham Gismo directory⁴.

6. Options considered and recommended proposal

6.1. It is proposed that all partners participate in a consultation to determine the best design and content of the revised JSNA. In particular those who would most benefit from use of the JSNA, such as senior managers involved in strategic and policy design and commissioning or service delivery from a wide range of partner organisations, including the voluntary sector.

6.2. No specific design is proposed at this stage, as the consultation is crucial in determining the most appropriate design to meet the needs of users. Components of the design to be decided include the structure of sections, the type of content display (photographs, maps, infographics, spinecharts, graphs, tables, text preferences) and the thematic content.

6.3. It is proposed that key interested representatives from organisations are identified or confirmed through the consultation who will then form part of a working group of authors who contribute to the JSNA on an ongoing basis.

6.4. In order to provide the required level of data and accompanying contextual information within current capacity, it is suggested that the JSNA comprises of strategic overview of key areas at a Rotherham level and as ward profiles, and that depth for certain priority topics is added according to priority. It is proposed that the JSNA author group will support the provision of more in-depth data (such as through a needs assessment process) where a priority is agreed. Prioritisation will be determined where there is a defined current use and demand for information, where there is a sponsor who can lead a topic-specific working group to support collation of the required information.

7. Consultation

7.1. Proposed consultation questions are attached in appendix A.

7.2. The consultation will be available to complete online through the RMBC consultations section of the website⁵.

⁴ https://www.rotherhamgismo.org.uk/
⁵ https://www.rotherham.gov.uk/consultations
8. Timetable and Accountability for Implementing this Decision

8.1. The proposed timeframe for revision of the JSNA is as follows:

<table>
<thead>
<tr>
<th>Date</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>November 2018</td>
<td>Draft consultation to Health and Wellbeing Board</td>
</tr>
<tr>
<td>December 2018</td>
<td>Consultation launched</td>
</tr>
<tr>
<td>January 2019</td>
<td>Consultation closes</td>
</tr>
<tr>
<td>January 2019</td>
<td>Working group established</td>
</tr>
<tr>
<td>March 2019</td>
<td>Draft structure of new JSNA design finalised and</td>
</tr>
<tr>
<td></td>
<td>timetable of content confirmed</td>
</tr>
<tr>
<td></td>
<td>Approval of final content and process of JSNA by</td>
</tr>
<tr>
<td></td>
<td>Health and Wellbeing Board</td>
</tr>
<tr>
<td>May 2019</td>
<td>Revised JSNA published online (not all content</td>
</tr>
<tr>
<td></td>
<td>will be available at this time)</td>
</tr>
</tbody>
</table>

8.2. Accountability for the JSNA is the Health and Wellbeing Board. However, responsibility for oversight of the redesign and content will be the Public Health team at RMBC.

9. Financial, Workforce, Equalities and Partner Implications

9.1. No additional costs are anticipated for the refresh of the JSNA, which will be produced under current work programmes with current staff capacity and utilising the RMBC website and IT capabilities. However, additional support will be required from RMBC IT to facilitate new website hosting capabilities.

9.2. It is envisaged that the new JSNA would have improved intelligence on equalities and support continued efforts to improve equalities for residents in Rotherham.

9.3. All partners would be actively encouraged to engage with the JSNA, contributing data and adding contextual analysis as appropriate and by using the intelligence provided to drive strategy, plans and service delivery to ultimately improve the health and wellbeing of people in Rotherham.

10. Contacts

Gilly Brenner, Consultant in Public Health
Gilly.Brenner@rotherham.gov.uk

Terri Roche, Director of Public Health
Teresa.Roche@rotherham.gov.uk
Appendix 1. Consultation questions

1. When did you last look at the JSNA?
   A. Never, as far as I can remember
   B. A long time ago, probably over a year ago
   C. Within the last year
   D. Fairly recently
      - Please explain why or for what purpose you used it last or haven’t used it:

2. The JSNA is unfortunately unlikely to fulfil everyone’s requirements in terms of providing detailed local data on a huge range of themes. Therefore it is important that we gain consensus on the main purpose of the JSNA in Rotherham and how it will be used.
   What do you think is the most important use for the JSNA?
   A. Informing strategy and high level planning
   B. Informing service commissioning and detailed service planning
   C. As a single place in which to look for any data about Rotherham
   D. Other – please give an example
   E. I’m not sure I really think it is important to have a JSNA

3. The current proposal is to change the emphasis of the JSNA to better fit with the ‘Thriving neighbourhoods’ approach, considering what is already strong in Rotherham communities. This helps us to consider how we can build on that, rather than starting from the point of trying to meet perceived need.
   How important is it to you that the JSNA captures assets as well as needs (what is strong, as well as what is wrong)?
   A. Very important – I think assets should be a key component
   B. Important
   C. Not important
   D. I think it should continue to focus solely on need

4. Currently the JSNA is text based, with some downloadable reports that also contain maps or graphs, such as the ward profiles. It is important that the JSNA provides accessible and meaningful information in a way in which it can be easily used.
   What is your preferred format for the presentation of the data and contextual information? Please rank in order of preference
   A. Text with tables
   B. Infographics
   C. Graphs
   D. Maps
   E. Spinecharts
   F. Other – please give details
5. In order to provide the required level of data and accompanying contextual information within current capacity, it is suggested that the JSNA comprises of strategic overview of key areas at a Rotherham level and as ward profiles. Depth for certain priority topics will then be added according to priority. It is proposed that the JSNA author group will support the provision of more in-depth data (such as through an assets/needs assessment process) where a priority is agreed. Prioritisation will be determined where there is a defined current use and demand for information, and where there is a sponsor who can lead a topic-specific working group to support collation of the required information.

Do you agree with this proposal?
A. Yes
B. No

Please describe an alternative proposal or your objections if you said No.

6. There are lots of different influencers of the health and wellbeing of the population. Whilst we will endeavour to ensure a good search function is included, the JSNA needs to have an overall structure that is intuitive to make it easy to find what information you are looking for. What structure would you find easiest to navigate?
A. Current structure (People, Places, Economy, Staying Safe, Healthy Living, Ill Health and Services) with enhancements (such as inclusion of assets)
B. A simpler headline structure, such as Population demographics, Communities of interest (children, vulnerable/equality-related groups), and Influencers on health (economy, education, crime etc)
C. Sections relating to the theme boards that sit under the Rotherham Together Partnership (Community Safety, Children and Young People, Business Growth, Strategic Housing, Building Stronger Communities, Ambition Rotherham Place, Integrated Health and Social Care Place)
D. Other – please describe

7. We would like to have a good understanding of what indicators and data we hold locally as partners that could be shared or would add context and value to a Rotherham JSNA. Please give examples of any useful information you, as a service or organisation, collect that could potentially be analysed and shared.

8. In order to develop the headline strategic overview it would be helpful to better understand the priorities and needs of those who intend to use the JSNA. Please give your contact details if you would like to be further involved in redesign process, or as an author or data provider for future content.

9. Please add any other comments.
1. Summary

Rotherham’s Health and Wellbeing Strategy 2025 was signed off in March 2018.

Following approval, a set of plans were developed to outline how the aims and priorities within the strategy will be delivered. It should be acknowledged that these are live documents and will continue to be updated as required. The strategy was also agreed for a seven year period (until 2025). The action plans will be presented as two year plans to deliver this; therefore not all activity will be included or completed in each two year cycle.

The Health and Wellbeing Board was presented the full suite of plans in July 2018 and it was agreed that updates on the progress made for each aim would come to future board meetings. As part of the November board meeting, updates will be received on:

- Aim 1: All children get the best start in life and go on to achieve their potential
- Aim 3: All Rotherham people live well for longer

2. Recommendations

That the Health and Wellbeing Board:

a. Note the updates on progress made against the aim 1 and aim 3 action plans
b. Consider what’s working well and the key challenges to delivering on each aim and the priorities

3. Background papers

Aim 1: Action Plan
Aim 3: Action Plan

4. Name and contact details

Terri Roche, Director of Public Health
Teresa.roche@rotherham.gov.uk

Becky Woolley, RMBC Policy and Partnerships Officer
Rebecca.woolley@rotherham.gov.uk
## Aim 1: All children get the best start in life and go on to achieve their potential

**Board Sponsor: Jon Stonehouse**

<table>
<thead>
<tr>
<th>2025 Strategic Priority this will contribute to</th>
<th>Actions 2018-20</th>
<th>Who will do it</th>
<th>By when (Include any relevant milestones)</th>
<th>Update November 2018</th>
<th>Indicators the activity will contribute to</th>
</tr>
</thead>
</table>
| 1. Ensuring every child gets the best start in life (pre-conception to age 3) | Reduce the number of parents (and significant others) smoking during pregnancy and immediately after birth by having a quit smoking support offer in each children’s centre across the borough, and support pre-birth in place. | Collette Bailey RMBC (Ann Berridge/Sue Smith) | April 2018 | • Early Help and Health have an agreed smoking in pregnancy pathway and data reports are being developed.  
• At the 12-week pregnancy statutory assessment stage women who smoke are referred to the midwife smoking in pregnancy team (SIP) team and are supported to make a quit attempt using nicotine replacement therapy.  
• 17 staff across Children’s Centres completed training around motivational techniques and smoking cessation.  
• Women who complete the seven-week stop smoking plan with the SIP team are then referred into their local children centre for ongoing support to continue to be smoke-free. They are then also registered with the children centre for other support and attendance at the centre. | • Reduction in smoking in pregnancy  
• Reduction in babies being born with low birth weight and/or at risk of health conditions linked to smoking |
# Health and Wellbeing Strategy Action Plan 2018 – 2020

| Increase the numbers of mothers breastfeeding and the number of trained peer supporters | Audra Muxlow/ Amanda Edmondson | April 2019 | • All twelve Children’s Centres have a breastfeeding support programmes and breast buddies recruitment is ongoing.  
• A campaign led by the 0 to 19 Health team was held in May to recruit Peer supporters to be “Be a breast buddy” | • Increase in breastfeeding initiation rates  
• Increase in number of babies breastfed for longer  
• Increase in number of peer supporters trained |
|---|---|---|---|---|
| Children’s Centres and Public Health Nursing to work collaboratively with schools and settings to develop and close the gap in speech, language and communication | Collette Bailey/Amanda Edmondson | April 2019 | • As of April 2018 all Children’s centres have Speech and Language trained practitioners  
• Talking Tables are being offered across nine Children’s Centres  
• 940 families have accessed a Book-Start activity (April to September 2018)  
• Early Help assessment training has been delivered to health colleagues so that they are able to lead on assessments | • Improved early identification of speech and language concerns  
• Increased number of children accessing two year old EEF  
• Increased school readiness |
| Increase the use of evidenced-based and evidenced informed interventions including sleep programmes, introducing solid foods, talking tables, baby box university and Bookstart and 5 Ways to Wellbeing | Collette Bailey (Ann Berridge), RMBC | Sept 2018 | In terms of the evidenced-based / informed programmes:  
• Sleep programmes are being offered on a regular basis throughout the borough as part of the Early Help parenting offer  
• Introducing solid foods sessions are being delivered regularly in children’s centres by colleagues in 0-19 health team, supported by Children’s Centre staff. During period April to September 302 families have accessed these sessions | • Reduction in child obesity  
• Increased school readiness  
• Improved emotional well-being and mental health for parents and children |
### Health and Wellbeing Strategy Action Plan 2018 – 2020

<table>
<thead>
<tr>
<th>All partners to work collaboratively on a Joint Strategy / Action Plan around Childhood obesity</th>
<th>TBC</th>
<th>TBC</th>
</tr>
</thead>
</table>

- Talking tables – Staff in children’s centres were offered training regarding this but this is in pilot stage at Coleridge and will be rolled out across the piece subject to evaluation.
- Baby box university has been rolled out through the O-19 Health Team and are currently being piloted in some children centres with a view to rolling it out to the remainder in January session. 71 families have collected a Baby Box from one of our Centres.
- Book start – Children’s Centres are able to sign up to this offer.
- The 5 ways to well-being has been disseminated to all Early Help staff and when planning family activities workers take account of and incorporate different themes.
- Early Help staff have received a short presentation on Make Every Contact Count (MECC).

- Work has not yet commenced. Update at year end.
## 2. Improving health and wellbeing outcomes for children and young people through integrated commissioning and service delivery

**Children & Young People’s Partnership & Transformation Priorities:**

- CAMHS
- 0 to 19
- Acute and Community Integration
- SEND
- Signs of Safety model
- Transitions

<table>
<thead>
<tr>
<th>Action</th>
<th>Responsible Person</th>
<th>Due Date</th>
<th>Details</th>
</tr>
</thead>
</table>
| Develop a Joint Commissioning approach between the Council and the CCG that integrates commissioning activity. Refreshed Joint Commissioning Strategy (Sep-18) | Jenny Lingrell RMBC | Sept 2018 – new timescale of April 2019 proposed. | - A SEND Sufficiency Strategy has been completed and includes proposals for future commissioning priorities. Stakeholder Consultation is currently underway  
- SEND Sufficiency work based on education data has been completed and includes projections of future need in the borough; this will inform the joint commissioning strategy for the borough  
- The annual refresh of the Local Transformation Plan was published in October 2018; this sets out the local area’s response to Future in Mind for the next 12 months  
- Work to develop a local area Social Emotional and Mental Health Strategy has commenced; a draft strategy will be ready for consultation in January 2019.  
- Work is underway to provide transparency in relation to financial contributions made by partners to high-cost placements for children with complex needs  
- Work is underway to provide transparency in relation to financial contributions made by partners in relation to co-production work in the borough  
- The Joint Assistant Director for Commissioning, Performance & Inclusion started in post in September 2018; it is proposed that the timescale to deliver this milestone is changed to April 2019. |

<table>
<thead>
<tr>
<th>Action Plan</th>
<th>Owner(s)</th>
<th>Date</th>
<th>Description</th>
</tr>
</thead>
</table>
| Develop a neighbourhood model of service delivery across all services.    | David McWilliams, RMBC | February 2019 | • In October 2018 Cabinet approved the implementation of Phases Two and Three of the Early Help Strategy incorporating the development of locality Family Hubs. Early Help Team staff will be co-located and based in a shared space with RMBC services, social care and health partners to provide delivery points for the 0-19 Offer. Work is ongoing with the Asset management team to support development of the new hub locations.  
• The recruitment will commence in November across the Early Help Service with full implementation of the new structure by the end of February |
| Building on the co-location of services at the SEND Hub (Kimberworth Place) - stage 2 of the project will focus on more efficient and effective joint working across the whole SEND / CAMHS system. | Jenny Lingrell, RMBC; Anders Cox, CAHMS | April 2019 | • Regular meetings between all Service Managers based at Kimberworth Place are scheduled to commence in December 2018.  
• Design process for partners from CAMHS and community-based health services to contribute to EHCPs and SEND Panel has commenced  
• SEND Strategic Board meets regularly  
• SEND Health Focus Group meets monthly  
• Improved integration of services enabling reduced duplication  
• Improved service for children and young people |
| SEND training roll out across Children and Young People agencies.          | Jenny Lingrell, RMBC    | July 2018 | • The SEND training rollout commenced in April 2018 and will be completed by December 2018.  
• The SEND training will familiarise CYPS and staff in partner agencies with the legal requirements and expectations of the Special Educational Needs and Disability reforms (2014) Education Health and Care  
• Increased understanding of SEND, EHCP and graduated Response  
• Reduction in number of children with EHCP |
### Health and Wellbeing Strategy Action Plan 2018 – 2020

<table>
<thead>
<tr>
<th>Plans, the graduated response and implications for Education, Health and Social Care colleagues.</th>
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</thead>
<tbody>
<tr>
<td>- New dates were published in October 2018 and targeted to the Health and Social Care workforce.</td>
</tr>
<tr>
<td>A new outcome-based performance framework for the delivery of 0-19 services.</td>
</tr>
<tr>
<td>Helen Leadley, RMBC</td>
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<tr>
<td>December 2018</td>
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<tr>
<td>- A performance framework has been developed alongside a 0-19 scorecard. Quarterly meetings take place which include Health, Commissioning, Public Health and CYPS Performance teams to review progress and present challenge where appropriate.</td>
</tr>
<tr>
<td>- Improved accountability and services</td>
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<tr>
<td>- Improved contract monitoring arrangements</td>
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Page 120
<table>
<thead>
<tr>
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<tbody>
<tr>
<td><strong>LSCB Priority</strong></td>
</tr>
<tr>
<td><strong>Children &amp; Young People’s Partnership &amp; Transformation Priorities: Signs of Safety Implementation</strong></td>
</tr>
<tr>
<td><strong>3. Reducing the number of children who experience neglect or abuse</strong></td>
</tr>
<tr>
<td>To improve workforce understanding of the key characteristics of neglect in Rotherham. To provide staff with the tools and skills to intervene effectively, so that less children are placed on CP plans due to neglect - Graded Care Profile</td>
</tr>
<tr>
<td>Rebecca Wall/Susan Claydon, RMBC</td>
</tr>
<tr>
<td>April 2018</td>
</tr>
<tr>
<td>Graded Care Profile (GCP)</td>
</tr>
<tr>
<td>● GCP training is delivered by a dedicated pool of Practitioner/trainers from the multi-agency Partnership.</td>
</tr>
<tr>
<td>● The Learning and improvement subgroup has led on a review of the training in recognition that GCP assessments are not readily visible on files or around influencing decision making around Neglect.</td>
</tr>
<tr>
<td>● Audits have been completed over a three month period in Social Care (SC) and Early Help (EH) regarding current practice in relation to Neglect. This led to a summary on a page around key messages and supported a whole day learning event which explored the importance of the GCP; Chronologies to evidence cumulative harm and toxic stress and its impact on children</td>
</tr>
<tr>
<td>● SC are moving towards single category for CP plans in order to have a clearer understating issue of Neglect as a primary concern for children in Rotherham and to support evidencing impact of the refreshed GCP implementation plan</td>
</tr>
<tr>
<td>● A regional Neglect conference is being planned for early 2019</td>
</tr>
<tr>
<td>● The LSCB have a Neglect strategy and a Multiagency Audit will be completed before the end of March 2019, to consider the impact of the refresher training</td>
</tr>
<tr>
<td>● Reduction in CP due to neglect</td>
</tr>
<tr>
<td>● Increased confidence across the partnership in identifying neglect</td>
</tr>
<tr>
<td>● Increased evidence through multiagency audits of the use of graded care profile</td>
</tr>
<tr>
<td>● Reduction in CP due to Emotional Harm &amp; Neglect</td>
</tr>
<tr>
<td>To improve joint working between adult/children's workforce.</td>
</tr>
<tr>
<td>Rebecca Wall</td>
</tr>
<tr>
<td>Ongoing</td>
</tr>
<tr>
<td>● The Head of Safeguarding for Children and Adults are working together to maximise training opportunities</td>
</tr>
<tr>
<td>● Audits have been completed in SC and EH around Mental health and Domestic abuse as standalone issues, with further work is planned to consider the</td>
</tr>
<tr>
<td>● Increased confidence across the partnership and between Adults and CYPS in identifying the impact</td>
</tr>
</tbody>
</table>
### Health and Wellbeing Strategy Action Plan 2018 – 2020

| Addressing the 'toxic trio': drugs/alcohol, mental health and domestic abuse. | interconnection with adults.  
- A focused approach delivered through Signs of Safety mirrors the Strengths-Based Approach which is being implemented in adults RMBC.  
- Both programmes are included in the wider partnership roll out of the Rotherham Family approach, which will include how we work to maximise strengths for children and their parents, affected by MH, Substance misuse and DA. | of the Toxic Trio and Cumulative harm  
- Evidenced via audit – explore joint audit with adults services |
<table>
<thead>
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</thead>
<tbody>
<tr>
<td>Increase the number of children supported through Early Help Assessments by all partners</td>
<td>Susan Claydon, RMBC</td>
<td>Ongoing Performance reported monthly</td>
</tr>
</tbody>
</table>
| Over the past year Early Help Assessment Training has been rolled out to our partners in schools, health and the voluntary and Community Sector.  
Early Help Integrated Working Leads in each locality provide training and support to partners to complete Early Help Assessments and Team Around the Family meetings.  
Partner completion of the EHA, was 20.4% in September with 27.7% year to date performance profile. When compared with the same period in previous years this highlights the transformation that has occurred within the service to increase the embedding of early help approaches across partners. In the same period of 2016 there were 5.9% of EHA’s completed by partners and in September 2017 this figure rose to 11.3%, highlighting substantial change in this area of practice and with it, a move towards a much more healthy, shared early help system across the borough.  
Health uptake still remains an issue and as a result a discussion is taking place to re-challenge the low performance and implement changes to the way that the 0-19 service operate to accommodate the | Increased Early Help Assessments completed by partners and quality assured |
### Health and Wellbeing Strategy Action Plan 2018 – 2020

<table>
<thead>
<tr>
<th>Action</th>
<th>Embedding of EHA’s</th>
<th>Jenny Lingrell, RMBC</th>
<th>July 2018 - Expansion of Edge of Care, Family Group Conferencing and the implementation of Pause</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Edge of Care, Family Group Conferencing and the Pause are now fully operational.</td>
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<tr>
<td>• Staff in Early Help youth offending Service have been trained in FGC to provide additional capacity to this programme</td>
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<table>
<thead>
<tr>
<th>Action</th>
<th>Jenny Lingrell, RMBC</th>
</tr>
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<tbody>
<tr>
<td>• 20 new vulnerable births prevented by PAUSE intervention</td>
<td></td>
</tr>
<tr>
<td>• Reduction in number of children becoming LAC</td>
<td></td>
</tr>
<tr>
<td>• Reduction in CP and CIN and reduction in demand on statutory services</td>
<td></td>
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<tr>
<td>• Reduction in CP linked to Neglect</td>
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</table>

<table>
<thead>
<tr>
<th>Action</th>
<th>Rebecca Wall, RMBC</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The Neglect strategy Action plan has been updated and presented at the September RLSCB board to reflect the work undertaken around GCP, Training and Audits</td>
<td></td>
</tr>
<tr>
<td>• The planned Neglect JTAI did not progress as planned as a decision was taken to refocus to familial sexual abuse.</td>
<td></td>
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<tr>
<td>• A multiagency RLSCB adult will be completed by the end of March 2019.</td>
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<thead>
<tr>
<th>Action</th>
<th>Rebecca Wall, RMBC</th>
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<td>• Higher level of referrals linked to neglect showing increase awareness</td>
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<tr>
<td>• Early identification and intervention form EH and universal service to prevent neglect</td>
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<tr>
<td>• Multiagency understanding the impact of cumulative Neglect and what works to support families and improve children’s outcomes</td>
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<table>
<thead>
<tr>
<th>Action</th>
<th>Rebecca Wall, RMBC</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Work with the Rotherham LSCB in developing the Strategy for responding to Childhood Neglect</td>
<td></td>
</tr>
<tr>
<td>• Multiagency JTAI and learning event to be completed by October 2018</td>
<td></td>
</tr>
<tr>
<td>• Training roll out from September 2018</td>
<td></td>
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<table>
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<tr>
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<th>Rebecca Wall, RMBC</th>
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<td></td>
</tr>
</tbody>
</table>
### Health and Wellbeing Strategy Action Plan 2018 – 2020

#### 4. Ensuring all young people are ready for the world of work

<table>
<thead>
<tr>
<th>Children &amp; Young People’s Partnership &amp; Transformation Priorities: SEND Transitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>All 16 – 19 (25 with SEND) year olds who are NEET/Not Known to be followed up by the Early help Service and those who have RONI to be identified early by schools to enable targeted work to take place</td>
</tr>
<tr>
<td>Collette Bailey, RMBC</td>
</tr>
<tr>
<td>- As of September 1.4% of all 16-19-year-olds were NEET and 14.5% were not known, showing an improvement on the previous year (1.7% NEET and 15.7% Not Known) (CCIS)</td>
</tr>
<tr>
<td>- Staff have been deployed by EH Service to find SEND NEETS/Not Known aged 20-24. Work is ongoing with figures significantly reduced from Dec 2017 and outperforming national, regional, statistical neighbours</td>
</tr>
<tr>
<td>- As of September 2% of young people with SEND aged 16-19 were NEET which is significantly better than the position at the same time last year last year (3.7%)</td>
</tr>
<tr>
<td>- September figures for young people aged 16-19 Not known with SEND was 20%, slightly higher than last year and an action plan is in place to bring this figure down</td>
</tr>
<tr>
<td>- Not Known figures are naturally high in September as destinations from post 16 providers are still being gathered as enrolments take place and are not included in targets</td>
</tr>
</tbody>
</table>

| Explore further work with SCR ESF Bid and the Development of Career Hubs |
| Collette Bailey/Simeon Leach, RMBC |
| ESF x 3 Bids May 2018 now at contracting stage |
| - The Council, in conjunction with the other Sheffield City Region (SCR) local authorities, has three applications for European Social Fund (ESF) funding approved by the Department of Work and Pensions projects (European Structural Funds programme 2013-20); |
| 1. Pathway to Progression- two strands supporting vulnerable young people and adults into education and employment, |
| 2. Pathways to Success aimed at adults with significant health needs or disabilities to prepare |
| - Reduction in the number of young people 16 / 17-year-old who have SEND who are NEET |
| - Reduction in the number of young people 18/19-year-old who have SEND who are NEET |
| - Reduction in the number of young people 20-24-year-old who are NEET |

| Increase in vulnerable groups accessing the labour market |
| Reduction in 16-18 year old NEET |
| Increased employer engagement in schools to support transitions at 16 |
| Careers Hub | June 2018 | for and enter employment.  
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>3. The Business Education Alliance project to increase employer engagement.</td>
<td></td>
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<tr>
<td>- Discussions are in train with Public Health, Adult Services and Early Help to develop local delivery plans and targets.</td>
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<tr>
<td>- The three ESF strands will lever in circa £1.6 million over the next three years.</td>
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<tr>
<td>The Careers Hub bid to Career Enterprise was unsuccessful. However the SCR Local Enterprise Board are exploring the potential to provide some addition sub-regional capacity to the existing Enterprise Adviser Network</td>
<td></td>
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</tbody>
</table>
### Aim 3 All Rotherham people live well for longer

**Board sponsor: Richard Cullen**

<table>
<thead>
<tr>
<th>2025 Strategic Priority</th>
<th>Actions 2018-20</th>
<th>Lead/s</th>
<th>By when (include relevant milestones)</th>
<th>Progress / areas of concern (include date when updated)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Preventing and reducing early deaths from the key health issues for Rotherham people, such as cardiovascular disease, cancer and respiratory disease</td>
<td>Support the use of Making Every Contact Count across Health and Wellbeing Partners.</td>
<td>Health and Wellbeing Board (Phil Spencer, RMBC PH)</td>
<td>MECC training for front-line workers: 2017/18 smoking and alcohol 2018/19 loneliness</td>
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<tr>
<td></td>
<td>Continue to improve identification and management of cardiovascular risk factors in primary care.</td>
<td>Nick Leigh-Hunt, RMBC PH</td>
<td>TBC</td>
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</tr>
<tr>
<td></td>
<td>Ensure Rotherham Active Partnership works to ensure physical activity is targeted where appropriate to those who are inactive (see also action in aim 4).</td>
<td>Rotherham Active Partnership (Polly Hamilton, RMBC)</td>
<td>Physical activity plan to be published April 2019</td>
<td>Oct 18 - First partnership meeting took place October 2018 – with vision/objectives agreed.</td>
</tr>
<tr>
<td></td>
<td>Delivery of the Physical Activity Clinical Pad pilot project</td>
<td>Gilly Brenner, PH &amp; CCG lead</td>
<td>TBC</td>
<td>6 GP practices delivering pilot project.</td>
</tr>
<tr>
<td></td>
<td>Develop a local obesity strategy to reduce the rise in obesity levels across the life-course. Including developing a Health in All Policies approach to addressing obesity.</td>
<td>Jacqui, Wiltschinsky &amp; Kate Green, RMBC PH, Gill Harrison, PH</td>
<td>Strategy/action plan to be published April 2019 (aligned to physical activity plan)</td>
<td>Oct 18 - Discussions starting to take place in relation to a ‘call to action’ for obesity &amp; EoI for childhood obesity trailblazer programme</td>
</tr>
</tbody>
</table>
### 2. Promoting independence and self-management and increasing independence of care for all people

<table>
<thead>
<tr>
<th>Social prescribing</th>
<th>TBC</th>
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</thead>
<tbody>
<tr>
<td>Place Plan deliver:</td>
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<tr>
<td>Integrated Point of</td>
<td></td>
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<tr>
<td>Contact Service</td>
<td></td>
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<tr>
<td>Home First</td>
<td></td>
</tr>
<tr>
<td>Safe and Well visits</td>
<td>South Yorkshire Fire and Rescue</td>
</tr>
</tbody>
</table>

### 3. Improving health and wellbeing outcomes for adults and older people through integrated commissioning and service delivery; ensuring the right support at the right time

<table>
<thead>
<tr>
<th>Place Plan delivery:</th>
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<tbody>
<tr>
<td>Integrated rapid response service</td>
<td>Urgent and Community Care Transformation Group</td>
</tr>
<tr>
<td>Integrated discharge model</td>
<td></td>
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<tr>
<td>Integrated care in the community (the village model)</td>
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<tr>
<td>Care home support</td>
<td></td>
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<tr>
<td>Ensure a coordinated approach across the partnership in relation to ‘healthy ageing’ and Rotherham being a great place to grow older.</td>
<td>HWbB</td>
</tr>
<tr>
<td>End of life care</td>
<td>TBC</td>
</tr>
</tbody>
</table>

### 4. Ensuring every carer in Rotherham is supported to maintain their health, wellbeing and personal outcomes, so they are able to continue their vital role and live a fulfilling life

| Overseer and monitor the priorities in the Rotherham Carers’ Strategy: |       |
| Priority 1. Health and Wellbeing |       |
| All carers will be supported to make positive choices about their mental and physical health and wellbeing |       |
| Priority 2. Access to information |       |
| Accessible information about the services and |       |
| Adult services, RMBC | TBC |
| (inc. relevant leads from carers’ strategy) |       |

TBC = To Be Confirmed
Support available will be provided for all carers in Rotherham

- Priority 3. Access to services
  All carers will be offered and supported to access a range of flexible services that are appropriate to their needs
- Priority 4. Employment and Skills
  All Carers will be able to take part in education, employment and training
1. Summary

Rotherham’s Health and Wellbeing Strategy 2025 was signed off in March 2018.

A performance framework is being developed to measure the delivery of the strategy. The board is presented with a first draft of this performance framework, which includes a longlist of potential indicators.

The vision is that the final performance framework will be in the form of a scorecard and will include approximately three high-level indicators for each aim, with clear targets set for 2025.

2. Recommendations

That the Health and Wellbeing Board:
   a. Endorse the approach of the performance framework
   b. Recommend the indicators that should be included in the final performance framework and identify any gaps in the list of proposed indicators
   c. Agree to receive the full performance framework in January 2018 and updates on performance to future board meetings

3. Background papers

Draft performance framework

4. Name and contact details

Terri Roche, Director of Public Health
Teresa.roche@rotherham.gov.uk

Becky Woolley, RMBC Policy and Partnerships Officer
Rebecca.woolley@rotherham.gov.uk
### Rotherham Health and Wellbeing Strategy

**A healthier Rotherham by 2025**

### Aims (outcomes), priorities and indicators

<table>
<thead>
<tr>
<th>4 aims</th>
<th>17 priorities</th>
<th>Key indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. All children get the best start in life and go on to achieve their potential</td>
<td>1. Ensuring every child gets the best start in life (pre-conception to age 3)</td>
<td>• Smoking status at time of delivery (1) (PHOF 2.03)(2017/18)</td>
</tr>
<tr>
<td>Board sponsor: Jon Stonehouse</td>
<td>2. Improving health and wellbeing outcomes for children and young people through integrated commissioning and service delivery</td>
<td>• Breastfeeding prevalence at 6-8 weeks (1) (no data recently)</td>
</tr>
<tr>
<td>Lead officer: Collette Bailey</td>
<td>3. Reducing the number of children who experience neglect or abuse</td>
<td>• Breastfeeding initiation (1) (PHOF 2.02i)(2016/17)</td>
</tr>
<tr>
<td></td>
<td>4. Ensuring all young people are ready for the world of work</td>
<td>• Vaccination coverage (MMR for one dose (by 2 years old) (1) (PHOF 3.03viii)(2017/18)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Vaccination coverage (DTaP/IPV/Hib) for 3 doses (by 2 years old) (1) (PHOF 3.03iii)(2017/18)</td>
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<td></td>
<td></td>
<td>• Proportion of 5 yr olds free from dental decay (2) (PHOF 4.02)(2014/15)</td>
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<td></td>
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<td>• Hospital admissions for dental caries (0-4 years) (2) (Child Health)(2014/15-2016/17 (3yrs))</td>
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<td>• Children in Need due to neglect or abuse – rate per 10,000 (3) (CYP MH&amp;W)(2017)</td>
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<td>• Child excess weight in 4-5 / 10-11 yr olds (2) (PHOF 2.06)</td>
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<td>• School readiness: percentage achieving good level of development</td>
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<td>• GCSEs achieved (4) (Child Health Profile)(2015/16)</td>
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<td>• 16-17 year olds not in education, employment, or training (NEET) or activity not known (4) (PHOF 1.05)(2016)</td>
</tr>
<tr>
<td>2. All Rotherham people enjoy the best possible mental health and wellbeing and have a good quality of life</td>
<td>5. Improving mental health and wellbeing of all Rotherham people</td>
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<tr>
<td>Board sponsor: Kathryn Singh</td>
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<tr>
<td>Lead officer: Ian Atkinson</td>
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<td></td>
<td>6. Reducing the occurrence of common mental health problems</td>
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<td></td>
<td>7. Improving support for enduring mental health needs (including dementia)</td>
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<td></td>
<td>8. Improving the health and wellbeing of people with learning disabilities and autism</td>
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<td></td>
<td>• Self-reported wellbeing – happiness/satisfaction/ anxiety (5) (PHOF 2.23)</td>
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<td></td>
<td>• Depression – recorded QOF prevalence (6) (Common MH Disorders)</td>
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<td>• % of adults who are receiving secondary mental health services on the CPA recorded as living independently, with or without support (7) (PHOF 1.06ii)</td>
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<tr>
<td></td>
<td>• Mental Health service users on CPA (Care Programme Approach) (quarterly data) (7) (Severe Mental Illness)(2017/18 Q4)</td>
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<tr>
<td></td>
<td>• Suicide rate</td>
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<td></td>
<td>• Dementia diagnosis</td>
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<td></td>
<td>• Prevalence of mental health disorders</td>
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<td></td>
<td>• Premature deaths in adult with mental illness</td>
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<tr>
<td></td>
<td>• Proportion of eligible adults with learning disabilities who are having a GP Health Check (8) (LD)(2016/17)</td>
<td></td>
</tr>
<tr>
<td>3. All Rotherham people live well for longer</td>
<td>9. Preventing and reducing early deaths from the key health issues for Rotherham people, such as cardiovascular disease, cancer and respiratory disease</td>
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<td></td>
<td>10. Promoting independence and self-management and increasing independence of care for all people</td>
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<td></td>
<td>11. Improving health and wellbeing outcomes for adults and older people through integrated commissioning and service delivery; ensuring the right support at the right time</td>
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<tr>
<td></td>
<td>12. Ensuring every carer in Rotherham is supported to maintain their health, wellbeing and personal</td>
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<tr>
<td>Board sponsor: Richard Cullen</td>
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<tr>
<td>Lead officer: Nicholas Leigh-Hunt</td>
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<td></td>
<td>• Healthy life expectancy for men/women (9) (PHOF 0.1i) (2014-16)</td>
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<td></td>
<td>• Mortality rate from causes considered preventable (9) (PHOF 4.03) (2014-16)</td>
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<td></td>
<td>• Smoking-attributable mortality (9) (Tobacco Control) (2014-16)</td>
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<tr>
<td></td>
<td>• Prevalence of smoking (9) (PHOF 2.14) (2017)</td>
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<td></td>
<td>• Percentage of physically active adults (9) (PHOF 2.13i) (2016/17)</td>
<td></td>
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<td></td>
<td>• Percentage of adults classified as overweight or obese (9) (PHOF 2.12) (2016/17)</td>
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<tr>
<td></td>
<td>• Proportion of people who receive self-directed support</td>
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<tr>
<td></td>
<td>14. Ensuring everyone is able to live in safe and healthy environments.</td>
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<td></td>
<td>15. Ensuring planning decisions consider the impact on people’s health and wellbeing.</td>
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<td></td>
<td>16. Increasing opportunities for people of all ages to participate in culture, leisure, sport and green space activity in order to improve their health and wellbeing</td>
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<tr>
<td></td>
<td>17. Mitigating the impact of loneliness and isolation in people of all ages</td>
<td></td>
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<tr>
<td>Board sponsor: Rob Odell</td>
<td></td>
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<tr>
<td>Lead officers: Sam Barstow / Sarah Watts / Bronwen Knight / Polly Hamilton / Ruth Fletcher-Brown</td>
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</tbody>
</table>

- People in employment (16-64) (13 - but not specifically healthy, sustainable employment) (PHOF 1.08iv) (2016/17)
- Proportion of people who use (adult) services who feel safe (14) (ASCOF) (2015/16)
- Affordability of home ownership (15) (Wider determinants) (2016)
- Outdoor space utilised for exercise/health benefits (16 – not strictly increasing opportunities) (PHOF 1.16) (Mar 2015 – Feb 2016)
- People’s access to woodland (16) (Health assets) (2015)
- Percentage of people aged 16+ with sports club membership (16) (Health assets) (2015/16)
- Self-reported wellbeing (also in aim 2) Adult social care users who have as much social contact as they would like (aged 18+)
| To consider: |
| RELEVANT SRP INDICATOR |
| CULTURAL STRATEGY – PEOPLE PARTICIPATING IN CULTURE/LEISURE ACTIVITIES |
| HOUSING – E.G. GOOD QUALITY HOMES |
Quality Account 2018

Our care places the patient at the centre of everything we do.
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<td>5.2 Statement from Rotherham Health and Wellbeing Board</td>
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Part 1 - Introduction

1.1 Statement from the Chief Operating Officer

On behalf of the Board of Trustees and the Executive Team, I am pleased to present the Quality Account for Rotherham Hospice for 2017/18.

We welcome this opportunity to promote the high quality of services that we provide for our patients, families and carers and to demonstrate to all stakeholders our commitment to the highest quality care, delivered with dignity and compassion.

The account looks back on the progress that we have made during 2017/18, and outlines some of our key priorities for service improvement across all areas in 2018/19.

Rotherham Hospice is an independent charity that last year provided Palliative Care Support and End of Life Care to 2,148 people across the borough. This is the highest figure we have achieved and clearly shows a continued growth year on year. We are particularly proud of our growth and reach, across our Community Services with more than 1,072 patients and families being supported in both our Planned and Responsive services. The consolidation of our 24/7 Community Services allows an increased level of coordinated support to be provided ensuring that care is provided by the right people in the right place at the right time. This therefore allows appropriate use of our Hospice beds and prevents unnecessary hospital admissions. Our wider Services have also seen growth in referrals and provision, with 304 patients being seen in Day Unit or Day Therapy Services, and more than 220 patients being supported by Occupational and Physiotherapy. 1,462 hours of support have been provided by our Counselling and Psychology services, whilst the Inpatient Unit provided care to 345 patients with overall average bed occupancy at 82%. This is one of the highest nationally.

I am very pleased to report that whilst seeing such a significant increase in growth and breadth of services provided, the satisfaction level of patients and families who have experienced our services remains high, with an overall annual rating of 98.0%.

The Board and Executive Team would like to thank all our patients, their families and carers for their feedback. We listen to their views, comments and suggestions and use these to aid our continuous reflection on how our services could be improved.

Rotherham Hospice is highly respected and has an excellent reputation in the wider community. It has an engaging outlook, building strong relationships with public and business partners as well as those from the Health and Social Care Communities, working to provide an increased strength and independence to support sustainable growth in the future.

The Board and Executive Team would like to thank our Hospice staff and volunteers as all of the above can only be achieved through their commitment, hard work and dedication.

I believe that the information presented in this Quality Account is a true and fair representation of the quality of the Healthcare Services provided by Rotherham Hospice throughout 2017/18.

John Whaling
Interim COO
1.2 Introduction to this Quality Account

Rotherham Hospice has completed an Annual Quality Account since their introduction in April 2010, in line with the requirement of the Health Care Act (2009), the NHS Standard Contract and Organisational Best Practice. The purpose of a Quality Account is to enhance accountability to the public and engage the leaders of an Organisation in their quality improvement agenda. The Hospice Board of Trustees welcomes this responsibility and the opportunity to share its successes and learning opportunities identified throughout the year alongside their plans for future growth and service improvement.

The Quality Account should provide information about the quality of all services that the organisation delivers and its main purpose is to encourage providers to take a robust approach to quality. All providers of NHS Healthcare Services, including independent organisations such as Rotherham Hospice, should produce a Quality Account and in doing so, led by their Board, is committing to improve the quality of care it delivers locally and invites the public to hold them to account.

Therefore, Rotherham Hospice presents this Quality Account as its annual report to the public, as a provider of NHS commissioned Healthcare Services. In line with national requirements, it exercises our accountability to service users, stakeholders and the broader public and demonstrates how all aspects of the organisation have engaged in our quality improvement agenda, reflecting the three domains of quality: patient safety, clinical effectiveness and patient experience. Our improvements are also considered in line with NHS's five Domains of Quality.

We also guide our work in line with the six Ambitions for Palliative and End of Life Care, which have been formulated by the National Palliative and End of Life Care Partnership (NPELCP).

This quality account is both retrospective and forward looking, providing a review of services and initiatives delivered throughout 2017/18, explaining what is being delivered well and where service improvement can and has been made. It also looks forward, describing our three key priorities for improvement throughout 2018/19.

Finally this quality account demonstrates the engagement of service users, key stakeholders, staff and others with an interest in the organisation in determining the quality of our services and the priorities for improvement in the future.

As the discussion here concerns the quality of our provision of direct clinical care for patients and families (and relevant support services), the account does not discuss vital non-clinical aspects of Rotherham Hospice, such as working for financial sustainability, income generation and marketing and communications.

For further information on the content of this or any previous Rotherham Hospice Quality Account, please see the NHS Choices website:
http://www.nhs.uk/aboutNHSChoices/professional\s/healthandcareprofessionals/quality-\accounts/Pages/about-quality-accounts.aspx
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<th>Vision</th>
<th><strong>Compassion, choice &amp; dignity for all</strong></th>
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<tbody>
<tr>
<td><strong>Mission</strong></td>
<td>We will:</td>
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<tr>
<td></td>
<td>• Enhance our patients quality of life, delivering high quality care in the right place at the right time.</td>
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<tr>
<td></td>
<td>• <em>Provide appropriate trained and motivated staff, dedicated to patients wellbeing and dignity.</em></td>
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<td></td>
<td>• Be active in the community, engaging with partners and championing end of life care.</td>
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<tr>
<td></td>
<td>• <em>Be proudly independent, financially strong and remain innovative in our thinking.</em></td>
</tr>
<tr>
<td><strong>Strategic Objectives</strong> (Some Examples)</td>
<td>1. Better patient care through early intervention and education/integration of the network across the Borough.</td>
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<tr>
<td></td>
<td>2. <em>Continuous Improvement of HR processes and staff capabilities, including leadership skill, volunteer engagement and internal communication.</em></td>
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<td></td>
<td>3. Enhance the Hospice’s influence and profile in the Borough, with the community, local businesses and healthcare partners.</td>
</tr>
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<td></td>
<td>4. <em>Increase turnover and contribution from every revenue area and continuously seek new sources of income.</em></td>
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</table>
1.4 Overall Statement of Purpose

The purpose of Rotherham Hospice is to enhance the quality of life of patients and those important to them through the provision or direction of Specialist Palliative Care Services and Education. The Hospice is committed to achieving this by providing or influencing services for patients during the changing phases of their illness.

We aim to give the most appropriate and efficient treatment and care to our patients through a holistic approach, to assist in the relief of their physical and emotional suffering and to help them lead an acceptable, purposeful and fulfilling life in their home or in the Hospice.

In order to achieve this, we offer a safe, effective, caring, responsive and well-led multi-professional service, which integrates the Hospice Specialist Palliative Care Services with primary, secondary and tertiary Healthcare Services, other Voluntary and Independent agencies, Social Services and, in the case of children and young people, Education Services.

Our approach is non-judgemental and non-discriminatory and we consider it equally important to give support to those who care for our patients, whether they are professional carers, members of the family or friends.

1.5 Our Hospice

Rotherham Hospice is the only adult Hospice serving Rotherham and its surrounding communities. We offer a range of services that have been designed to respond to local need and work as an integral part of the wider Health and Social Care Community for Palliative and End of Life Care.

1.6 Our Philosophy of Care

Patients, families and friends are treated as individuals with compassion, humility, honesty and respect. We listen to them and always involve them in decisions about patient care and treatment. Their preferences, beliefs and customs are respected and their complete privacy and dignity assured through the use of single rooms, screens, discrete interview rooms and heightened awareness by staff of these requirements.

We ensure that we provide the same high quality supportive Palliative Care and End of Life Care to all patients and their families regardless of age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, gender, sexual orientation or civil partnerships.

In order to achieve this we:

• Encourage patients to maintain their identity, dignity and independence.
• Provide a welcoming and homely environment to all.

For patients who visit the Hospice we strive to provide a homely, welcoming environment, placing significant emphasis on an individual’s dignity, privacy and comfort. In the case of Community Services we aim to provide home-based services that reflect the same ethos, working to optimise the physical environment wherever care is delivered.

We provide or influence services to ensure that they support physical, psychological, social and spiritual needs of patients and their family members who require Palliative Care throughout the changing phases of their illness.

Our care places the patient at the centre of everything we do.
• Facilitate effective, meaningful communication between patients, staff and significant others through a multidisciplinary team approach.
• See the patient as a unique individual and plan with them their care management, whilst promoting their independence.
• Nurture the patient’s feelings of self-worth and promote a sense of still being able to actively live life.
• Support patients and their families in decision making and adapting to changes throughout their illness.
• Offer a continuation of care and support through the initial stages of loss and bereavement.
• Maintain standards of the highest quality, supporting staff and volunteers’ personal and professional development.
• Work together in developing a “Relationship based care environment” based on support and mutual respect not defined by a building or place.
• Provide education and information to Rotherham Healthcare Professionals and the general public regarding Palliative Care issues.

We believe interaction with families and carers is very important to those in our care, and we actively encourage an open visiting policy. Family members and carers are also more than welcome to use the family overnight accommodation. We have reclining chairs in patient rooms and if you wish to stay, beverage and snack facilities are available. We ensure that patients can stay in touch with loved ones through the use of telephones and wireless internet facilities in the patient areas.

The views and opinions of those using our service are very important to the Hospice. Members of staff seek comments and suggestions through patient and carer experience surveys that are provided during a patients stay on our Inpatient Unit, or upon discharge. Patients and families are also encouraged to share their views verbally or in writing. A leaflet with further information is available from Reception and the Complaints Procedure will be discussed with patients and families on admission to the Hospice. In the first instance, those wishing to raise a concern are requested to contact either the Head of Inpatient and Day Therapy Services or the Clinical Services Director, who is the Registered Manager. The Hospice has recently reinforced its ability to learn from feedback and experience with the introduction of a board level Patient and Family Engagement Forum. This has cross community and organisational representation and therefore facilitates the voice of all stakeholders, irrespective of their reason for engagement.
1.7 Our Services

Through a Multidisciplinary and partnership approach, Rotherham Hospice liaises with the wider Healthcare Teams to promote maximum continuity of support and care coordination for our patients.

- The Hospice is a resource for advice and support for Health Care Professionals who work in community and hospital settings.
- The Multidisciplinary Team provide a holistic package of clinical care, including symptom management and addressing the physical, psychological, emotional and spiritual needs of patients.
- Hospice Services also include the provision of complex symptom management, end of life care and specialist assessment.

The Hospice delivers Holistic Care through the provision of the following services:

- Palliative Medical Services – supporting both in-reach and outreach patients.
- Inpatient Unit – consisting of 14 single Inpatient bedrooms.
- Day Unit – Including Day Therapy Services and Traditional “Holistic” Day Care, Wellbeing services and Pre Bereavement work.
- Community Care – Including Hospice @ Home and Clinical Nurse Specialists.
- Patient and Family Support Services – including Occupational Therapy, Physiotherapy, Complementary Therapy, Counselling and Bereavement Support, Spirituality Support and a Child Bereavement Support Service.

Patients and Carers can find out more about the services the Hospice offers and how the charity operates by reading the Directory of Services and the leaflets available in the Hospice and on our website. As the need arises our members of staff will also discuss topics during the patient’s admission or attendance and on a daily basis. Our website www.rotherhamhospice.org.uk also provides further information for patients and families.

Rotherham Hospice is regulated by the Care Quality Commission (CQC). The CQC cannot get involved in individual complaints about providers, but is happy to receive information about our services at any time. They can be contacted at: CQC National Correspondence Citygate, Gallowgate, Newcastle upon Tyne, NE1 4PA. Telephone: 03000 616161.

The Care Quality Commission has a website at www.cqc.org.uk
Part 2 - Priorities for Improvement

2.1 Looking Back: achievement against our Priorities for Improvement for 2017/18

During 2016/17 the Hospice identified a number of quality improvements that could be made across Clinical Services. In selecting our 3 key priorities for improvement in 2017/18 we were mindful of National and Local policy as well as those issues which were of concern to our service users, our workforce, our partners and our Trustees.

Priority One – Individualised Care Planning

(Addressing patient safety, clinical effectiveness and patient/carer experience) partners and our Trustees.

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<td>Individualised Care Planning means that where they are able, people who use services should receive the assessment, care, treatment, advice and support they agree to. This should be evident by the clear procedures that are in place to ensure the engagement of all patients in their care assessment and planning even where they lack capacity to be directly involved themselves. Procedures to obtain and record consent to care and treatment need to be built into care planning processes and should be followed in practice, monitored and reviewed. Where needed, this would include the involvement of the patient’s family, or independent advocate.</td>
<td>Following a CQC inspection in August 2016 it was established that although patients received an excellent level of holistic care, this was not always evident in the documentation that was completed. It was found that it failed to reflect the explicit wishes and consent of patients in some instances, and therefore did not always provide a basis for patient centred personalised care planning. Although the Hospice has readily addressed these issues on the Inpatient Unit it is now keen to extend this learning opportunity across all of its services.</td>
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<th>How will this priority be achieved?</th>
<th>Monitoring and reporting methods</th>
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<td>All staff will receive training to increase their awareness of consent and personalised care planning. The assessment and multidisciplinary records will be revised to ensure written consent is obtained where possible and recorded accordingly when it is not. Care plans will be revised to allow a greater element of personalisation and reflect the patient as an individual at all times. This will be achieved using the “This is me” tool. Learning from these changes on the Inpatient unit will be transferred to allow improvements across all other Hospice Services throughout 2017/18. Challenges to address personalised care planning through electronic systems will be considered and where solutions cannot be found, paper records will be implemented.</td>
<td>Paper and electronic records and care plans will be audited on a weekly, fortnightly or monthly basis (dependant on the phase of the project). This will determine the success of the education and implementation process. It will also allow any performance issues to be identified so support can be provided. Service user feedback will be used to ensure the appropriate level of patient and family engagement and the monitoring of staff attendance at quality workshops and record keeping training. Reflection and supervision sessions throughout the year will also be monitored to ensure they support staff development in this area. Audit outcomes will be reported monthly to the Quality and Clinical Effectiveness Group who are responsible for the oversight of clinical Quality and Compliance. This information will then be reported to the Clinical Strategy Group on a quarterly basis as part of a broader quality matrix.</td>
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Records have been audited weekly since September with positive results, auditing is now completed fortnightly and results continue to be consistent. Feedback is given face to face when variances are found within the Audit and recorded on a clinical supervision form.

Learning from the work to enhance individualised care planning in 2016/17, the IPU has seen the completion of an action to address the areas for improvement and provide a strong foundation for the baseline for other care records in the organisation.

These records have been revised to allow continuity of our learning across our community team allowing one integrated care record across the services. These also allow for varied plans to be used dependant on the time or duration of care that a patient may receive.

The learning has also been transferred into Day Therapy and Treatment Services to allow a comprehensive approach to care planning across the Hospice.

Mental Capacity Assessment, Best Interest Decisions and Deprivation of Liberty Safeguards are all clearly addressed within the patient’s records with clear evidence of the engagement of the patient and or their family in the Assessment and Planning of Care and Lasting Power of Attorney is addressed with all patients and acted on accordingly.
Results
The number of documents reviewed since 14th September is 366 in total. Some of the patient notes are reviewed more than once if the patient is an inpatient for more than a week.

The following breakdown shows the level of compliance to date:

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Conclusion
The findings of the Audit have resulted in:
- Ongoing development of the assessment and care planning resources to facilitate clearer understanding of the document and its completion
- Identification of reasons why documentation can sometimes be incomplete
- Identification of Care Plans which need amending to better evidence the care being delivered
- Clarification of role for continued monitoring of documentation daily, especially newly admitted patients files
- Documentation training during MAST days will be reviewed and delivered in 2017/18 with an emphasis on Individualised/Personalised Care

What people told us about these improvements

Service user feedback:
Patient X felt there were no negative aspects to his admission. He states that he feels his wishes and needs were addressed and was happy to consent to the plan of care built around his care needs and personal choices.

Staff feedback:
Louise Bates – Senior Staff Nurse IPU
“From coming back from maternity leave I feel the paperwork is easy to follow and a lot more structured than previous, it flows better. I specifically like the ‘still to do’ sheets for admissions being on the front of the notes – I find it a very good prompt and reminder”

Sarah McCarthy – Senior Staff Nurse IPU
“The new documentation is much better and fit for purpose, less repetition and easier to follow. On a personal point I miss the prompt list where we sign when completed rather than listing what’s not completed”

Michelle Jacklin - Senior Staff Nurse IPU
“With reference to the new admission documentation I have found it much more user friendly, it flows better and feels less overwhelming to complete.”

Professional feedback:
RCCG Quality and Safeguarding Lead provided feedback regarding the completeness and quality of the records both in a formal review in 2017 and as part of a reflection and analysis session to inform the investigation of a fall.
Priority Two – Improved Hospice Community Services
(Addressing patient safety, clinical effectiveness and patient experience)

Standard

To ensure that the Hospice Community Service provision across Rotherham is accessible 24/7 by all who need it. To improve end of life care provision and coordination by greater integration between all Hospice services and with other community EOLC providers.

To see an increase in community volunteering to support respite/carer crisis and the wider spirituality needs of patients and their families.

To influence the procurement of EOLC domiciliary services looking to integrate the revised model with existing H@H services if sustainable, or providing improved integration with external providers as required.

To provide an enhanced level of responsive care home support to enable EOLC patients who live in care homes to die in their preferred place.

All of the above will create sustainability and increased quality and effectiveness overall.

How will this priority be achieved?

This priority will be achieved through the provision of a multi professional, integrated service that can provide all aspects of care to patients and their families at the end of life.

This will require workforce development and role revision to allow increased competency for some clinical staff.

The enhanced team will see the integration of a care at home support service, which can be provided based on need and replace the current domiciliary model. It will also see the increase in community volunteering and look at methods of exploring the scope of volunteering activities to provide bespoke support to individual families.

Finally it will see the introduction of EOLC Care Home Support pilot that will increase confidence to care for EOLC patients in crisis, through education and rapid response.

How was this priority identified?

This priority was identified through feedback from patients, family members, carers and professionals, who expressed frustration and disappointment in the duplication of services involved with individual families.

With the introduction of increased community provision within the Hospice, this has become increasingly apparent across Hospice services too.

It has also been a continuing theme in commission conversations and is a strong drive of the EOLC strategy group in order to reduce avoidable hospital admissions and enable patients to receive care in their preferred place.

The volunteering element of this priority was also identified in 2015/16 but still requires further focus in the future.

Monitoring and reporting methods

This will require the review of service activity data, referral and access trends, service user feedback surveys, the measurement of patient and family and staff experience and patient/family and organisation outcome measures (Preferred place of care/death, avoidable admissions to hospital, deaths outside hospital).

This data will be collected and presented on a monthly basis to the Clinical Governance Group to allow the service to be further developed in a way that continues to meet the needs of its users.

This information will then be reported to the Clinical Commissioning Group as part of a broader quality matrix. This information will also be shared on a bi-monthly basis at the borough wide EOLC strategy Group to ensure it influences future service design.

Performance against this priority in 2017/18

24/7 Responsive Services (including Care Homes)

The Responsive Team at the Hospice provides a fast response to calls from patients, families and professionals who support people in their own homes, including care homes, either by giving appropriate advice over the phone, a visit to assess and assist decision making or assistance with symptom management. This 24 hour advice line is available 24 hours a day, 7 days a week, 365 days a year.
Through the use of a “Family Facilitation Model” Hospice @ Home Rapid Response Services are now able respond immediately to calls from families and carers. This enables them to provide care and support for patients, ensuring that appropriate advice or physical care is provided in order to maintain the right care or care environment and prevent crisis from occurring.

Care Home staff may need support when they feel a patient is deteriorating, to assess the patients’ needs and to ensure everything that is needed for the patient is in place at the home. We can ensure any reversible factors are considered and if hospital admission would be appropriate or not. Hospice @ Home staff can liaise with other services to ensure the best supportive care is given. We can assist Care Home staff in having discussions with patients and families at these difficult times.

Care Homes also have access to the planned Clinical Nurse Specialist who can come to help with ongoing symptoms, give support and advanced care planning. This in turn assists the Responsive Team if wishes are known in advance. The Team has shown an increase in calls from Care Homes to give advice. There has also been an increase of responsive visits provided to Care Homes both day and night. It is also evident that the Responsive Team sees patients from different care homes than it did prior to the project commencing.

Education
Planned education is provided to all generic Palliative Care and EOLC providers including Nursing and Residential Homes, EMI and LD Home and mainstream District Nursing Teams. Following the principles of NHS England’s EOLC education streams it is broken into 6 sessions:
• Person Centred and End of Life Care
• Using Communication Skills
• Symptom Management
• Managing Dying (including Care after Death)
• Grief, Loss and Bereavement
• Law and Ethics

Also included in this education can be syringe driver training and NEMASTE Dementia training. In addition to the planned education, bespoke education is delivered working with Care Homes who may have specific educational needs around enhancing End of Life Care. This helps to understand why patients are being admitted to hospital and if this is the right course of action and highlights those residents who would not benefit from hospital admission in the event of deterioration. This bespoke education is targeted at Care Homes where admissions to hospital are high.

Throughout 2017/18 the planned education has provided 3 full courses. Each consists of 12 sessions giving overall 36 sessions provided. This has seen 36 Care Homes and Learning Disabilities staff supported through this route.

District Nursing courses have been provided bi-monthly supporting increased knowledge and confidence in relation to symptom management, dealing with loss and administration of medication via syringe drivers. In addition 12 courses for Nemaste dementia care have also been provided.

Finally 7 Care Homes have been supported through bespoke training and education, learning from individual situations as they arise.

Activity and Outcomes
The above changes to service structure and processes have seen a huge increase in not only activity, but also in effectiveness, responsiveness and overall outcomes. These include the following:
• 1662 Saved Avoidable Admissions – at a cost saving of £5,094,861
• 468 Saved GP visits
• 188 Facilitated early discharges
• 11,409 Advice Line calls
• 1,296 Calls responded to Out Of Hours
• Tripled number of Care Home patients being supported by their own care home teams
What people told us about these improvements

Service user feedback:

Mother of H@H patient
I’ve been meaning to write for a while and let you know just how important and valued you and your team were to us in the last weeks of my son’s life.

When it became clear that he wasn’t responding to the treatment and was becoming increasingly distressed his Oncology Nurse decided it was time to organise his palliative care. Our first visitor from Rotherham Hospice was the CNS. If I’m honest I was so convinced that his personal care was my responsibility as his Mum and I felt a little reticent and scared that I was going to be left out of things. The CNS was quietly assuring and insisted that his care would be done with all our best interests at heart.

It was a few days later when I realised we did need help and that my son would suffer without it. I picked up the phone and within a couple of hours we were visited by the loveliest most caring ladies who set about caring for his needs with such loving care and empathy my husband and I wept with relief.

Over the next few weeks the Hospice at Home Team were our absolute and total lifeline. In the midst of the horror of watching our beautiful 28 year old son concede to the ravages of brain Cancer. I don’t even want to imagine what we would have done without them.

The medical team were there as soon as we requested, the phone was always answered if we needed to query anything. My son’s personal care was amazing and I was always invited to be involved or sometimes I went and had a cup of tea. The team were our pillar of strength, they genuinely cared for his well-being and they gave us some light in those darkest days of our lives. They hugged us while we broke our hearts, they smiled and listened patiently to our stories of the beautiful man who he had been just a few short months before being struck down.

If we struggled with anything the team made sure it was communicated back to the appropriate area and it was sorted. They provided equipment and advice on a whole range of issues that couldn’t possibly be imagined by anyone whose world hasn’t been touched by cancer.

On the day my son passed away, a member of the Marie Curie night time team stayed with us at our request to make sure his passing was peaceful. To this day and forevermore our hearts burst with gratitude for how he helped us all through. Then a senior member of staff came to visit and at her suggestion we washed our wonderful son in his favourite and familiar toiletries, we brushed his hair and dressed him. It might sound a bit macabre but the memory of that is so cathartic for me to see him so rested and peaceful after his terrible ordeal.

I look back over this past year with absolute shock and horror but the one thing that I take consolation in is the care was given by the Rotherham Hospice at Home team. Because of them my son was able to remain in his own home in familiar surroundings with his family at his side and was able to endure this very worst of illnesses with his dignity still intact, he was a proud, young man and he would have been pleased about that. For this myself and my family will always remain indebted and truly grateful to you all.

With kindest regards, X

N.B. Names have been replaced with “My son” or “He”
Staff feedback:

**Jill Pearson – Responsive CNS**
The service has gone from a Specialist Palliative Care Team 8am-22.00 to a 24 hour service with the help of the Marie-Curie night service. Having the added support of the Domiciliary Care Team to allow patients to stay under the Hospice umbrella giving patients and families the added support.

I have now progressed in my role as a Responsive Clinical Nurse Specialist within the Hospice at Home Responsive Team. This allows me to assess complex patients and advice regarding symptoms management to prevent GP call outs and avoid hospital admissions. My other role is to take lead co-ordinating the Hospice @ Home Team, triaging new referrals and giving advice on the Hospice help line. I feel the change within our Hospice @ Home team as benefited the patients and families of Rotherham. We are now a rapid response team and offer advice and visits were needed over a 24 hour period. We also liaise with other health professional to advise them on palliative care.

**Rachael Clark – Responsive Band 5 nurse.**
I have worked in the Hospice Community Team for just over 2 years and have seen many changes. Since the re-design we have been given more support as Band 5 nurses from the responsive band 7's that are now in the Responsive Team.

**Vicki Gillepsie – Planned CNS**
Since the changes within the Community Team, the Responsive Team now visit any urgent CNS visits. This avoids cancellation of planned visits, or adjusting days/times of visits. It enables me to give more planned time to patients, which I feel is a more positive experience for our patients and families. As a CNS in this role I feel it is now easier to time manage and be more productive. CNS planned new patients also have the choice to be seen in a clinic at the Hospice, which enables patients to come into the Hospice and makes them more aware of other Hospice Services.

Professional feedback:

**Julie Dungworth – Community Matron**
Just a quick note to say thank you to all of the Hospice @ Home Team for all of their hard work looking after my patient. Their hard work (at times in challenging circumstances) and support made it possible for her to die peacefully at home with her family around her.

**Silverwood Care Home Manager**
“Silverwood Care Home received training from the Hospice team and my staff were encouraged and their confidence boosted especially around having difficult conversations with families and loved ones. My senior team came out of each session energised and eager to implement changes to their practises and were grateful of the chance to reflect on past situations and how they dealt with things. I feel the training supported my staff to team build and they work together a lot better and have more insight into the services you provide to help when before we mainly only worked with the District Nurse Team”.

**Sarah Smith Nurse Educator – Care Home Project**
I am delivering bespoke education to numerous Care Homes following audit of admission data. I recognise an unmet need regarding end of life education in all Care Homes and am glad of the opportunity for us to increase knowledge, skills and confidence around End of Life Care. I feel great progress has been made, although I recognise the challenges still that lie ahead. Engagement from Care Homes has been very positive and feedback from care staff regarding education has been very encouraging.
Priority Three – Improved focus on “Lasting Power of Attorney”, supporting families and increasing compliance
(Addressing clinical effectiveness and patient experience)

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<td>Increasingly, decisions relating to patient care at the end of life are challenging and complex due to the patient’s inability to demonstrate the cognitive awareness and mental capacity to make an informed choice. This has significant implications on the requirements for Mental Capacity Assessment (MCA), Best Interest Decision (BID) Making and the application of the national Deprivation of Liberty Safeguards (DoLS) process. It also creates an immensely distressing time for families and staff who try to manage this situation with compassion. Therefore it is widely acknowledged that all patients should be advised of the benefits of considering “Lasting Power of Attorney” for care and treatment prior to this stage occurring.</td>
<td>This priority has been identified based on national regulation and guidance, joint reflections across the Health and Social Care arena and direct feedback from families who have been involved in the complex decision making process at a time that is extremely difficult for them. It has also been identified due to the increasing number of situations that occur across the borough, where Mental Capacity Assessment (MCA), Best Interest Decision (BID) Making and the application of the national Deprivation of Liberty Safeguards (DoLS) could have been avoided if LPA was in place.</td>
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How will this priority be achieved?
This priority will be achieved in phases as follows:

Phase 1: Establishment of partnership working group, including cross organisational representation who will consider the frequency of meetings and broader terms of reference for their work. This is to be achieved at the beginning of quarter 2.

Phase 2: The development of a project plan to identify the key tools to be utilised by staff in all organisations to increase awareness and application of “Lasting Power of Attorney” for Care and Treatment. This is to be achieved before the end of quarter 3.

Phase 3: Concept testing across a variety of services to establish the viability and effectiveness of the model. This will be achieved during quarter 3/4.

Phase 4: Assessment of the findings to inform future work.

Monitoring and reporting methods
Performance against this priority will be measured as part of the Clinical Governance Framework. This will require the review of the timely performance against the project plan and the consideration of findings from Phase 3.

This data will be collected and presented on a quarterly basis to the Clinical Governance Group.

This information will then be reported to the EOLC Strategy group for consideration by partners in the project.

It is important to note that although it will be possible to measure engagement from patients and relatives it will not be possible to measure impact on service for some time.
Performance against this priority in 2017/18

Rotherham Hospice is working with Health Watch and Rotherham Metropolitan Borough Council to agree a consistent message about Lasting Power of Attorney and its effect on Advanced Care Planning and effective consent for care and treatment.

An agreement has been reached to use one leaflet to disseminate information across the Rotherham Borough. This will be shared with the whole MDT for dissemination and consistent use with patients and families in 2018.

Work has taken place this year internally to ensure that staff understand the statutory requirements and their role and responsibilities in relation to Mental Capacity Assessment/Best Interest Decision Making/Deprivation of Liberty Safeguards and Lasting Power of Attorney. Information has been provided in the staff workbook and some individual staff received training throughout the year. This work will be rolled out to all staff in 2018.

Individual work with patients and families continues to happen as part of other programs of work e.g. Carer Support and Pre Bereavement work. However this is not the proactive approach planned for this work and it is therefore acknowledged that although this is a key priority for the Hospice it is a competing priority for other organisations and therefore is something we may not be able to take forward borough wide at the moment.

It is acknowledged that further work to roll out borough wide use of the LPA leaflet is still needed in 2018/19.

What people told us about these improvements

Staff feedback:

**Diane Keeley – Head of Patient and Family Support Services**

The IPU admission paperwork now prompts the nurses and medical staff to ask the appropriate questions about the patient’s Mental Capacity and enquire if the patient has a registered Lasting Power of Attorney (LPA).

Having an LPA for Health and Welfare is so important to be aware of as the Attorney/Attorney’s need to be involved in all decisions that are being made regarding the patients care and treatment. Having a Health and Welfare LPA also eliminates the need for consideration of Deprivation of Liberty Safeguards.

**Kathy Walsh – Responsive Band 5 nurse (Hospice Community Team)**

As part of my involvement in the care of a complex community patient who was approaching the end of life, I was required to complete a Mental Capacity Assessment (MCA) and Best Interest Decision (BID). This was new territory for me. I was supported to complete both processes by our Head of Patient and Family Support Services which ensured the patient received the best and most appropriate care and treatment. Receiving the support in this way always us all to benefit from the wealth of knowledge and experience which gives us clarity to what can often be a complicated process.

Thank You

Remember:

‘People will forget what you said, people will forget what you did, but people will never forget how you made them feel.’

Maya Angelou
2.2 Looking Forward at Priorities for Improvement during 2017/18

Throughout 2017/18 we have utilised feedback from stakeholders in, or aligned to, the Hospice and identified 3 key quality improvements that need to be made throughout 2018/19. In selecting these priorities we have been mindful of national and local policy, as well as those issues which were of concern to all our stakeholders, including service users, our workforce, our partners and our Trustees. These priorities have been chosen for their impact on Patient Safety, Clinical Effectiveness and Patient/Carer Experience. They have also been considered against Domains 1-5 of the NHS framework (see part 4).
Priority One – Improved Hospice Community Services
(Addressing Patient Safety, Clinical Effectiveness and Patient/Carer Experience)

How was this priority identified?
This priority was identified through feedback from patients, family members, carers and professionals, who expressed frustration and disappointment in the duplication of services involved with individual families.

With the introduction of increased community provision within the Hospice, this has also become increasingly apparent across Hospice services.

It has been a continuing theme in commissioning conversations and is a strong drive of the EO L C Strategy Group in order to reduce avoidable hospital admissions and enable patients to receive care in their preferred place.

The volunteering element of this priority was also identified in 2015/16 but still requires further focus in the future.

Monitoring and reporting methods
This will require the review of service activity data, referral and access trends, service user feedback surveys, the measurement of patient and family and staff experience and patient/family and organisation outcome measures (preferred place of care/death, avoidable admissions to hospital, deaths outside hospital).

This data will be collected and presented on a monthly basis to the Clinical Governance Group to allow the service to be further developed in a way that continues to meet the needs of its users.

This information will then be reported to the Clinical Commissioning Group as part of a broader quality matrix. This information will also be shared on a bi-monthly basis at the borough wide EO L C strategy Group to ensure it influences future service design.

Standard
To ensure that the Hospice Community Service provision across Rotherham is accessible 24/7 by all who need it.

• To improve end of life care provision and coordination by greater integration between all Hospice services and with other community EO L C providers.
• To provide both planned and responsive care to all patients and families who need this, ensuring they receive the highest standard of Palliative and End of Life Care, delivered by the right staff, in the right place at the right time.
• To provide an enhanced level of responsive Care Home support to enable EO L C patients who live in Care Homes to die with dignity and respect in their preferred place.
• To see an increase in community volunteering to support respite/carer crisis and the wider spirituality needs of patients and their families.
• To influence the procurement of EO L C Domiciliary Services looking to integrate the revised model with existing H@H services if sustainable, or providing improved integration with external providers as required.

All of the above will create sustainability and increased quality and effectiveness overall.

How will this priority be achieved?
This priority will be achieved through the provision of a multi professional, integrated service that can provide all aspects of care to patients and their families at the end of life.

This will require workforce development and role revision to allow increased competency for some clinical staff.

The enhanced team will see the integration of a Care at Home Support Service, which can be provided based on need and replace the currently domiciliary model. It will also see the increase in community volunteering and look at methods of exploring the scope of volunteering activities to provide bespoke support to individual families.

Finally it will see the introduction of EO L C Care Home Support pilot that will increase confidence to care for EO L C patients in crisis, through education and rapid response.
**Priority Two – Utilising holistic methods to improve outcomes in relation to symptom management (increasing Complementary and Acupuncture Therapies)**

*(Addressing patient safety, clinical effectiveness and patient experience)*

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<tr>
<th>Standard</th>
<th>How was this priority identified?</th>
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<tr>
<td>Patient Related Outcome Measures (PROMS) have formed part of national service evaluation for some time now. Although these are recognised as essential tools to measuring service quality and effectiveness, in the field of Palliative / End of Life Care it is also important to have an understanding of what patients and their families are feeling physically and emotionally. Specific PC Outcome measures are also widely researched and established as Best Practice in order to achieve positive patient experience. This priority will see the development of two specific areas to enhance our delivery of the SPC Outcome measures locally, ensuring that alternatives to pharmacology are provided and all of the above is addressed when measuring both quality and effectiveness of service interventions.</td>
<td>Measurement of physical symptoms such as pain is well established, but practitioners in Palliative Care sometimes challenge these assessments with the argument that feedback from the patient on how they are feeling today, is more important than a numerical score on a symptom scale. Some staff have been using the IPOS system to good effect, whilst other services feel that this is not suitable for the variety of services that the Hospice provides. Staff want to establish standardised tools and improved service in relation to Complementary Therapy and Acupuncture in order to improve patient experience of symptoms, without the use of pharmacology.</td>
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<tr>
<th>How will this priority be achieved?</th>
<th>Monitoring and reporting methods</th>
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<tr>
<td>This priority will be achieved through the development of a task and finish group to explore the introduction of these services and their ability to be assessed and delivered in line with the IPOS principles. This work will then be concept tested across a variety of Hospice services allowing us to introduce increased service, through the growth of Complementary Therapy Volunteers and Qualified Nurse Competency and Training in relation to (Plaster) Acupuncture Therapy. The work will look at the tools required for effective assessment and outcome measures and consider implementation into every day practice, providing practitioners with practical tools that are easily interpreted, understood and delivered.</td>
<td>This priority will be measured in phases as follows: Phase 1: Establishment of the group, including multidisciplinary representation, frequency of meeting and terms of reference for the work and a project plan. This is to be achieved before the end of quarter 1. Phase 2: The development of services and scoping of training including consideration of national requirements and best practice. This is to be achieved before the end of quarter 2. Phase 3: Concept testing across a variety of services and education of staff. This will be achieved during quarter 3. Phase 4: Implementation of new services and measures for capturing success. This will be achieved during quarter 4. Performance against this priority will be measured as part of the Clinical Governance Framework and reporting will be through the Quality and Clinical Effective Group on a quarterly basis.</td>
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Priority Three – Enhancing “Day Therapy Services” through the introduction of a “Hearts and Minds Café”, Art Therapy and Increased Family Support for Pre Bereavement Care Planning.

(Addressing clinical effectiveness and patient experience)

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<th>Standard</th>
<th>How was this priority identified?</th>
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<tr>
<td>Day Therapy Services complement traditional Day Hospice attendance to enhance quality of life, health and well-being for patients diagnosed with cancer or other life limiting illness for which there is no curative treatment.</td>
<td>Hearts and Minds Café: Although there are already numerous support networks in Rotherham for people with mental illness and Dementia (memory and dementia cafes, singing for the brain etc.). It appears that there is a deficit in provision for patients with glioma’s and other long term conditions where cognitive decline is or will become evident.</td>
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<td>Hearts and Minds Café: To provide a therapeutic service for patients who have cognitive decline. This service will encompass support for the care giver with practical and emotional support in managing this memory loss and looking for ways to improve relationships/understanding of the illness.</td>
<td>Art Therapy: The Adults and Children’s Bereavement Support has identified several families and individuals who require more than talking to gain understanding of their grief and family situations.</td>
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<tr>
<td>Art Therapy: To extend and complement our counselling for adults and pre and post bereavement support for adults and children where a significant loved one has died from a palliative condition.</td>
<td>Family support for Pre Bereavement Care Planning. We have facilitated a Carer Support Group but attendance numbers have declined and local research has identified lots of other carer support groups throughout Rotherham. Also past attendees have stated that they don’t see themselves a ‘carer’ as this ‘labels’ them and suggests that just one person can be THE carer.</td>
</tr>
<tr>
<td>To extend and rename our Carer Support Group to “Family and Friends Support” (for pre bereavement care planning). This will encompass the whole family and friends.</td>
<td>Monitoring and reporting methods</td>
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</table>

How will this priority be achieved?

1. Scoping exercise across the organisation and with partner agencies to look at the numbers of patients and their families who would benefit from these services and what activities should take place at each session, for example the patient to attend with their care giver/family member so skills and coping mechanisms can be shared. This will include consideration of Diversional Therapy.
2. To develop a project plan by visiting other mental health café’s in Rotherham to learn what makes their group a success.
3. Training of current health care assistants in Day Therapies and the introduction of a counsellor with art therapy qualification.
4. We will look to advertise this with our partner agencies and internally to encourage attendance and identify families who would benefit from a family support session.

We will review the service activity data, referral and attendance numbers and utilise service user feedback.

We will measure patient, family and staff experience and patient/family and organisation outcome measures.

This data will be collected and presented on a monthly basis to the Quality and Clinical Governance Group to allow the service to be further developed in a way that continues to meet the needs of its users.

It must be noted that with any psychological interventions qualitative data is generally more useful than quantitative and hence it may take some time to formulate robust evidence of success or need for change.
Creating Emotional Resilience

Promoting emotional resilience is a key issue in Hospice Care to maintain wellbeing in a rewarding but delicate and challenging environment.

Providing support for Patients, Families, Carers, Staff and Volunteers is therefore vital.

Background
Histoinically Rotherham Hospice provided support for counselling and psychology through the provision of clinical psychologist providing one to one support to all counselling and psychology patients at all levels.

Bereavement Services were delivered only through a volunteer befriending service which did not historically have a robust or consistent method of providing supervision and support to volunteers.

In 2012 the Hospice began to provide Children’s Bereavement Support in the form of a group session running once a month.

In 2014 the Hospice looked at a whole service redesign and suggested recommendations to change the way that Counselling and Psychology Services were delivered whilst maintaining core Hospice values and integrating ‘compassionate caring’ principles into all service provision.

It was also seen as essential to provide appropriate supervision and reflection for all staff and volunteers involved in delivering these services.

Aim and implementation
This service redesign saw the formal introduction of a tiered Psychology and Counselling Service, providing appropriate support to patients and their families across levels 1 - 4. These 4 levels provide tiered support ensuring patients are seen at the right time by the most appropriate person.

Outcomes
These changes provided a skilled and dedicated workforce with increased ability to engage in complex communication with patients and families. They also allowed for whole system governance in this area, providing supervision and reflection in line with Best Practice.

By introducing allocated counselling and carer support time, improved outcomes for carers and families was also achieved.

The new service structure has seen increased access to bereavement and counselling services in general with a demand that still continues to outgrow capacity in certain areas.

Likert scaling tools are used in some areas to allow outcomes to be measured.

It is often the case that children withdraw or experience behavioural issues when they are dealing with difficult emotions. We have found that teachers report improvements in children’s general wellbeing, interaction with others, and performance when they have been attending Sunbeams. Children and young people also say that attending Sunbeams has a positive effect.

Staff and volunteers report positive feedback from Schwartz round attendees and measures in relation to sickness and absence will also be monitored in the future.

Further information
Throughout the last 2 years Rotherham Hospice has driven forward emotional support for patients, their families, care’s staff and volunteers. Some areas of support we offer are:

Child Bereavement Support Service (Sunbeams), Counselling and Psychology Service, Adult Pre and Post Bereavement Service and Schwartz Rounds.
Part 3 Statements of Assurance from the Board of Trustees

3.1 Statements of Assurance from the Board

The following are a series of statements that all providers must include in their Quality Account. It is important to note that many of these statements are not directly applicable to Specialist Palliative Care or End of Life Care providers, especially Hospices.

3.2 Review of Services

During 2017/18 Rotherham Hospice provided the following services:

- Inpatient Unit - consisting of 14 single inpatient bedrooms all with en-suite facilities including capacity for bariatric care
- Day Services - providing a minimum of 15 places a day, 4 days a week (excluding bank holidays) for traditional “Holistic Day Care” and 2 days a week providing Day Therapies, including Lymphoedema, Transfusion services, Medical Outpatients, Nursing Assessment and Triage, and Health and Well-Being Groups
- Transport for patients to and from the Hospice is also provided
- Hospice Community Team including Clinical Nurse Specialist Services and Hospice at Home (Rapid Response) services.
- End of Life Care, Domiciliary Services.
- Bereavement services, Carers Support and Chaplaincy Services
- Therapy Services, including, Complementary, Physiotherapy and Occupational therapy and Psychological Support Services

Rotherham Hospice has reviewed all the data available to them on the quality of care and efficiency across all of these services and used this information to facilitate service improvements and or demonstrate commissioner and regulatory compliance.

3.3 Income Generation

Rotherham Hospice is commissioned via the NHS Standard Contract, to deliver NHS End of Life Care and Specialist Palliative Care Services on behalf of Rotherham Clinical Commissioning Group. The income generated by the NHS services reviewed in 2016/17 represents 100% of the total income generated from the provision of NHS services by Rotherham Hospice for 2017/18. The overall income generated from the NHS contract represents 53% income for the Hospice for the same year.

3.4 Participation in Clinical Audits

National Clinical Audits and National Confidential Enquiries

For the first time during 2017/18 Rotherham Hospice was eligible to participate in two formal national clinical audits. However, although the Hospice participated in these national clinical audits and national confidential enquiries there is no list or number of cases submitted to either audit or enquiry due to the methodology of the studies used.

These included the National Evaluation of Schwartz Rounds 2017 and the National Comparative Audit of Blood Transfusions 2018.

The findings of these audits have been used to influence local practice and form a wider alliance of “Resilience” and support for staff. This work has been shared nationally at the Hospice UK conference 2017 and is planned again for the Hospice @ Home conference (The true cost of caring) in 2018.
In addition to formal audits the Hospice also conducted 16 internal clinical audits. These included participation in national audit programs such as “Safety Thermometer”; Patient Led Assessment of the Care Environment (PLACE) and the Hospice UK National Benchmarking Audits for IPU Bed occupancy and outcomes, (Falls and Medication Incidents). Locally agreed audits included evaluation of Nutrition and Hydration, Record keeping, CD audits, External Environment audits and Essential Steps (Infection Control).

These audits have then informed local action or service improvements plans and assisted in identifying key priority areas for the coming year.

Additional Audit from external parties also demonstrates the Hospice’s effectiveness as part of the wider Palliative Care and End of Life Care agenda. This is evident from the annual Deaths at Home Audit conducted by Public Health England.

**Focus on:**

**Audit of deaths outside hospital and % of H@H patients who remain to die at home:**

Annual data from Public Health England shows that the Rotherham percentage of deaths outside hospital increased markedly between the 12 months to Oct/Dec 2011 (47.3%) and to Oct/Dec 2012 (51.6%). Data fluctuated over the next 4 periods to Oct/Dec 2013 (51.0%). The percentage then increased again to Oct/Dec 2014 (52.7%) reaching its highest point so far and better than England average (52.4%). Between Oct/Dec 2014 (52.7%) and Oct/Dec 2016 (52.3%) data fluctuated again and ended virtually unchanged. However, between Oct/Dec 2016 and Oct/Dec 2017 (54.7%) the percentage increased significantly again and went above England average (54.0%).

This is in line with the 1662 saved avoidable admissions for 2016/17.

**Statement from External IPC Lead**

I can confirm that Rotherham Hospice had zero cases of MRSA bacteraemia or Clostridium difficile in 2017/18. There have been no reported outbreaks at the Hospice in 2017/18, even though this year saw both Regionally and Nationally high levels of Influenza and numerous cases of Norovirus or Rotavirus gastroenteritis. Mandatory training and hand hygiene updates are provided on a monthly basis by the Foundation Trust Infection Prevention and Control Nurses (IPCNs) (2017/18 saw 75% of staff attend this training). The Inpatient, Day Unit and Hospice @ Home teams complete “Essential Steps” audits on a monthly basis which includes observational audits of hand hygiene, compliance with bare below the elbows, Urinary Catheter Care and Enteral Feeding. Environmental audits are carried out by the IPCNs with the Unit Manager for Inpatients and the Day Unit on a quarterly basis with consistently excellent findings.
**Hygiene Code: Statement of Compliance for 2017/18**

Section 21 of the Health and Social Care Act 2008, places a statutory requirement on organisations to comply with the regulatory requirements for Cleanliness and Infection Control (Regulation 12 HSCA – Revised 2010). The regulatory requirements cover 10 specific areas and form the Code of Practice to which Health and Social Care Organisations should adhere. The following is Rotherham Hospices, statement of compliance against the 10 criteria listed in the code:

<table>
<thead>
<tr>
<th>Compliance Criteria</th>
<th>Performance against criteria</th>
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<tr>
<td><strong>1.</strong></td>
<td>The Hospice routinely screens all patients admitted to the Inpatient Unit for MRSA and uses an Inter-Trust Transfer Form to allow identification of any patients moving within the local healthcare system. We have full electronic access to receive laboratory reports from other trusts and have 24 hour access to laboratory services for screening and assessment.</td>
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<tr>
<td><strong>2.</strong></td>
<td>The Hospice has a number of processes in place for assessing cleanliness and infection control processes including the annual PLACE assessment, monthly self-assessments and quarterly external cleanliness audits. All of these have been positive across the year. This has seen 0% infections acquired at the Hospice during 2017/18. The Hospice uses cleaning materials in line with ISO 13485 that is effective in killing 99.9% of pathogens present. These materials also provide a secondary barrier for resistance to re-infection between cleaning episodes.</td>
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<tr>
<td><strong>3.</strong></td>
<td>Information on hand hygiene and the need for good infection control processes is visible in all areas, particularly the Inpatient and Day Units. Information on Barrier Nursing or other appropriate information is given to families as required. Ensuring appropriate antibiotic use for patients as required ensures optimal outcomes for Hospice patients and also reduces the risk of adverse events and anti-microbial resistance.</td>
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<td><strong>4.</strong></td>
<td>Appropriate signage is used to identify where infected patients are being Barrier Nursed (in line with local identification policies). Staff discuss any IPC requirements for individual patients at both the daily nursing and broader MDT meetings. Suitable patient and family level information is provided to service users and visitors on the prevention of and control of infections.</td>
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<td><strong>5.</strong></td>
<td>MRSA screening is performed on all patients on admission (unless they are too unwell – EOLC). 83% of patients were routinely screened during 2017/18. The Hospice has access to electronic laboratory reports and medical cover so all patients can have timely review and any treatment can be made as required. Any patients with the potential for developing infections have their individual IPC requirements discussed at both the daily nursing and broader MDT meetings. All patients who have an infection are barrier nursed (in line with local policies) and protective barrier nursing equipment is provided to match the requirements of the infection.</td>
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<td><strong>6.</strong></td>
<td>All staff and volunteers are aware of the importance of Infection Control and this is emphasised through training and development processes. These include audit and compliance processes, annual staff training and staff workbooks. Infection Control is also highlighted as an integral part of staff contracts.</td>
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<td><strong>7.</strong></td>
<td>All patients on the Inpatient Unit are nursed in single rooms. Therapies on the Day Unit are provided in clinical rooms as required. A separate “Transfusion room” is provided in Day Therapies and Treatment rooms and Complementary Therapy suites are kept separate at all times. However day patients who are infectious should not be brought into the Hospice for treatment if barrier nursing was required.</td>
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<td><strong>8.</strong></td>
<td>The Hospice has a contractual agreement with the local Foundation Trust for the supply of Laboratory Services. This includes the collection and transportation of samples from the Hospice, twice daily.</td>
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<td><strong>9.</strong></td>
<td>The Hospice works to policies and procedures developed and agreed in line with national and local guidance. It also has a contractual agreement with the local Foundation Trust for the supply of services related to infection prevention and control. The Hospice conducts individual patient risk assessments and formulates personal care plans to support patients and their families as required.</td>
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<tr>
<td><strong>10.</strong></td>
<td>All staff at the Hospice receive appropriate Occupational Health Screening prior to employment. For clinical staff this includes antibody screening and inoculations as required. Ongoing staff requirements are managed through a service level agreement with the local Foundation trust for Staff Health and Wellbeing Services. The Hospice also offers staff flu jabs annually and 77 staff received these in 2017. The Hospice Sickness and Absence policy requires 48 hours infection free before return to work.</td>
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3.5 Research

No patients receiving NHS services provided or sub-contracted by Rotherham Hospice in 2017/18 were recruited during that period to participate in formal research approved by a Research Ethics Committee.

3.6 Quality Improvement and Innovation Goals agreed with our Commissioners/ CQUIN Payment Framework

Rotherham Hospice NHS income in 2017/18 was conditional on achieving Quality Improvement and Innovation Goals through the Commissioning for Quality and Innovation Payment Framework.

National CQUINS
CQUIN 1 (National CQUIN 4)
Staff Health and Wellbeing

This CQUIN requires the Hospice to demonstrate how it supports staff overall health and wellbeing as well as specific measures in relation to the provision of support to maintain a healthy work environment.

2017/18 achievements:
All staff have access to healthy foods and have the ability to make healthy choices in relation to improved health and wellbeing. Work places have been assessed and provided safely in line with HSE requirements and reasonable adjustments have been made for individual staff where required.

Schwartz Rounds to improve emotional and psychological wellbeing were provided in 2017/18 however these were not been delivered for a few months due to the change of trained staff. As these evaluated extremely well by all staff attending, they will commence again in April 2018. Throughout the gap in delivery, individual staff support has been provided through Best Practice Sessions and 1-2-1 supervision.

All staff have access to an organisational program for counselling support as required. This has seen 2 staff accessing support from a variety of settings across the Hospice.

All staff have supportive access to Occupational Health as required. This has seen 12 staff referred for assessment as follows:

In addition 71 staff received the Influenza Vaccination via Hospice clinics.

The annual Hospice staff survey does not directly address the NHS CQUIN questions, therefore these have been asked separately in 2017/18 via Survey Monkey. The responses were as follows:
Q1. Does your organisation take positive action on health and well-being?

Q2. In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities?

Q3. During the last 12 months have you felt unwell as a result of work related stress?
3.7 What others say about us

As a learning organisation, Rotherham Hospice is keen to engage all Service Users and Key Stakeholders in feedback to support service improvement and increase quality and experience. With this in mind the organisation has robust networking systems in place with local strategic partners to ensure we receive feedback which can facilitate service improvement by strengthening what we do well and learning from situations where we did not meet expectation.

The Hospice also has a number of working groups which include representation from external organisations these include our Patient and Public Engagement Group, MND Working Group, Out Of Hours Rapid Response Steering Group and Care Home Engagement Group.

Feedback is also sought in the form of service user satisfaction surveys helping us to gain information from patients, family members and carers about the care that they received and their experience overall. These surveys have helped us to understand how our services are perceived by those people who use them. Learning from the comments made has enabled us to acknowledge where shortfalls in service provision exist and make positive service changes for the future. The Hospice also participates in the national “Friends and Family Test” feedback program.

Throughout 2017/18 feedback has been received and responded to as follows:

Bereavement Services 97.8% average positive feedback Inpatient Unit 99% average positive feedback (100% Friends and Family Test) Day Unit 98% average positive feedback (100% Friends and Family Test) Hospice @ Home 96.5% average positive feedback (100% Friends and Family Test)

Overall the Hospice has received an average of 98.4% positive experience feedback throughout 2017/18. This is alongside a tremendous 99.75% Friends and Family Test result.
Selections of the supporting comments are listed below:

From Hospice @ Home and Community CNS Team;

We would like to thank you all so much for your support during Mums illness it meant so much to us all the kindness you showed to myself and the family whilst making Mum so comfortable we cannot thank you enough. With much appreciation Family X

To all the girls who looked after husband X and got me through the days he was ill me and my family would like to thank you very much and just to say you all are a credit to the hospice team – Family X

Thank you for helping X and I through all the last few months. You were all a very special team which I would have loved to work with. You will be always special to me. Thank you once again X.

From Inpatient Unit;

Thank you all so much. You do an amazing job.
Thank you for giving my mum a peaceful end.

With our heartfelt thanks to you all for getting our ‘Man Mountain’ back on his feet. We are truly humbled and touched by the care and attention.

Thanks for caring for our mum with dignity and compassion.

A huge thank you for caring for our dad. We will never forget.

My Step-Father recently passed away after a few days in the hospice. What a fantastic place - the staff are, without exception, absolutely brilliant. Thank you for the care you gave to my Step-Father and the support and care you gave to my Mother whilst at his bedside.

It gave us peace of mind to know that X spent the last few weeks of her life amongst such special people.

We just wanted to say thank you for taking care of X. You made a difficult time more bearable.

From Day Hospice/Day Therapies;

Thank you on behalf of our mum for all the care and support in her final days, love from the family.

To the staff and helpers for being there and being helpful and making my 12 weeks go too fast, love from X.

To all the fantastic staff on the Day Ward, you are all kind, considerate and fabulous, nothing is too much trouble. Think the world of you all and thank you for everything you do for me and everyone else. Will really miss you all love from X.
From Bereavement Support Service;

An incredibly supportive process. Structured and efficient and delivered in an incredibly professional manner. This has been productive in sign posting myself to additional services via the Psychologist to further address my needs. My profound and heartfelt thanks to Rotherham Hospice and X. An exceptional service.

I found it soothing and comfortable when I saw X, she listened to me and I felt at ease with her. After 2 sessions I felt most confident to carry on. Before I saw her I was very low. Thank you for your help. The Hospice is the most calming place I have ever visited.

The counselling with X has been extremely helpful and I am benefiting from her guidance. X got to understand me quickly and made me seek other help, which I would not have done without her help, she is amazing and an asset to the Rotherham Hospice.

Thank you for your support and motivation in helping me reach this day, you gave me your time – the most thoughtful gift of all. Many thanks X.

Dear X, my counselling is coming to an end and I would like to give a huge thank you to the Rotherham Hospice and yourself for all your support, kindness and thoughts that you have got me through the most difficult time of my life losing my husband of 50 years. I have found the counselling sessions very helpful. Thank you, you have given me the strength to get on with my life.
With best wishes X.

From Sunbeams – the children’s feedback;

Coming to Sunbeams has helped me remember all the happy memories about my mum.

The group is a fantastic service for the kids and has helped them a little along the way to coming to terms with what has happened. I am extremely grateful the group exists.

From Sunbeams – the adults feedback;

The group has helped him realise he can think about Mum a little and he doesn’t have to occupy himself constantly to ‘forget’ or ‘ignore’ what has happened.

Yes. She has definitely come out of her shell and occasionally says something about her mum. X has enjoyed the group – it has given her time to think about mum while doing other activities.

I can’t thank you enough for all the help you gave X and X with the bereavement of their Grandad. We hope this helps other children as much as your kindness helped them.

From other professional at Bluebell Wood Children’s Hospice;

Thank you so much for letting me come along to your group, I found it so beneficial to see how your group runs and the structure of your plans. I came away with so many exciting ideas and ways to develop our own groups.
Denise Holyhead – Day Hospice Patient

Denise loves life – she is a fun loving wife and mother and is looking forward to her youngest son’s wedding in January 2018.

As Denise was putting away her Christmas tree back in January 2016 she needed to do some work on the computer. She tapped out some words and thought they looked strange, she didn’t give it much more thought and went back to putting her tree away. Later that day she was back at the computer and all seemed fine. Over the next couple of weeks she was struggling to remember words so she decided a visit to the doctors was needed. On January 27th she visited her GP who referred her for a brain scan. Within the week she was in hospital being operated on after being found to have 3 brain tumours. The larger one was removed but the other 2 are still there. She has had an aggressive course of radiotherapy and is constantly undergoing chemotherapy.

Towards the end of 2016 Denise came to Rotherham Hospice as a day patient. She has made so many friends and renewed her love of painting and knitting. Julie one of the HCSW gave her a bag of wool and said “here you go, why don’t you make a blanket” and then showed Denise how to knit the perfect square. The result is the fabulous blanket in the picture along with HCSW Karen Done. Denise’s sister put the backing on the blanket for her and Ella Bella at Bramley embroidered the Hospice logo in the middle.

Denise says “the Day Hospice is marvellous and saved me. It also gives my husband a break for the day as he is my full time carer”. All throughout her treatments she has remained positive and says she has some wonderful people in her life and wants to do as much as she can and have as much fun as possible.

From Cake and Coffee Bereavement Networking Group;

The first time I’ve been and everyone was very welcoming. A very good experience.

Thank you so much. Wonderful cakes, nice surroundings. A positive time to reminisce about X and talk over the fun times, the good times and think about a wonderful person. Thanks for the amazing care she was given and for assisting her to stay at home. Without your support we could not have kept her at home.

Enjoyed sharing my time with people at the Hospice who have lost loved ones same as me, had a lot in common. Look forward to the next one.

It was nice to see the people who were in our bereavement group and see how they were getting along and meet new faces and just to eat that lovely cake. Thank you.

Meeting everyone who has lost someone was a great help.

Finally, Rotherham Hospice receives excellent feedback from robust engagement with all our community partners ensuring we demonstrate a high level of social responsibility in line with organisational Best Practice and the requirements of the NHS Equality Delivery System (2).
3.8 Care Quality Commission (CQC)

Rotherham Hospice is registered with and regulated by the Care Quality Commission and its current registration status is approved and unconditional. Rotherham Hospice has no conditions on registration and registration is approved as follows:

Rotherham Hospice Trust is registered in respect of 4 Regulated Activities:
- Accommodation for persons who require nursing or personal care
- Diagnostic and screening procedures
- Transport services, triage and medical advice provided remotely
- Treatment of disease, disorder or injury

Regulation also states that:
- Services can only be provided to people 18 years of age and over (with exception for children’s bereavement support only)
- A maximum number of 14 patients can reside in the Inpatient Unit at any one time

Rotherham Hospice has not received a re-inspection by the Care Quality Commission in 2017/18 but has carried out many pieces of work including self-assessment of our current compliance and audits relating to our previous areas of requires improvement aiming to improve its rating to one of Good or Outstanding overall.

Focus on compliance:
In the absence of a CQC formal review or re-inspection, the Board and Executive Team have driven forward a program of internal self-assessments to demonstrate our compliance across all 11 fundamental standards and 5 Key Lines of enquiry. This is in addition to the proactive management of quality services including a robust program of audits and clinical risk management.

In conjunction with our internal audit program, these self-assessments have enabled us to evidence the quality of compliance that we achieve whilst also identifying any areas of learning that can be applied. In line with a culture of continuous learning and improvement, these findings have been built into priorities and wider work streams for 2018/19.

Increased staff engagement has allowed us to build the staff voice into our planned improvements moving to increasing staff confidence and understanding in relation to “Quality and Best Practice” in order to achieve compliance.

Wider reviews include
During 2017/18 The Board as conducted 4 unannounced visits to clinical areas including, Inpatient Unit, Day Unit, Hospice Community Services and Patient and Family Support Services. In addition a visit was also conducted to consider Medicines Management. Each of these visits explored both staff, volunteer and service user experience alongside service, activity, risk management processes and learning that could be applied. All visits were extremely positive and well received by staff.

Rotherham Clinical Commissioning Group conducted a Quality Visit early in 2017/18 which explored the quality of services provided with a specific focus on the findings of the previous CQC inspection. This inspection was very positive overall with many areas of Best Practice identified. It also assisted in informing our self-assessment process and audit program throughout the year, particularly in relation to the management of medicines.

The Board of Trustees commissioned an external peer review to consider compliance against the 11 fundamental standards of the Health and Social Care Act (2014) and the evidence of Best Practice against the 5 Key Lines of Enquiry. This is planned for April 2018.
3.9 Data Quality

Rotherham Hospice did not submit records during 2017/18 to the Secondary Users Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. This is due to ineligibility to take part in the scheme. However, in the absence of this we have a local system in place for monitoring the quality of data and the use of the electronic Patient Information System, SystmOne. This provides monthly information on data quality and ensures accuracy in recording and reporting mechanisms.

Monthly data quality performance for 2017/18 is as follows:

<table>
<thead>
<tr>
<th>Month</th>
<th>April-15</th>
<th>May-15</th>
<th>June-15</th>
<th>July-15</th>
<th>August-15</th>
<th>September-15</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>97.3%</td>
<td>97.5%</td>
<td>98.2%</td>
<td>98.2%</td>
<td>98.5%</td>
<td>98.0%</td>
</tr>
<tr>
<td>October-15</td>
<td>97.5%</td>
<td>96.7%</td>
<td>96.9%</td>
<td>97.2%</td>
<td>96.4%</td>
<td>96.6%</td>
</tr>
</tbody>
</table>

NHS commissioning data quality targets stand at 90%. Therefore an annual average of 97.4% means that compliance has been consistently achieved throughout the year.

3.10 Information Governance Toolkit Attainment Levels

Throughout 2017/18 the Hospice has maintained the relevant framework documentation, polices, training, and security infrastructure to be able to demonstrate an attainment of 69% (Satisfactory) level 2 compliance with NHS Connecting for Health’s Information Governance standards, ensuring we provide service users, key stakeholders, staff and others with an interest in the organisation with the confidence that their information is dealt with efficiently, safely and securely.

The Hospice has completed and submitted its annual Information Governance Statement of Compliance in accordance with National Information Standards and CQC requirements.

In addition the Hospice has revised its Information Governance Framework, undertaking a gap analysis and identifying an action plan of work for 2018/19. This incorporates further work to ensure that the requirements of the new General Data Protection Regulations and the revised NHS Information Governance Guidance, ensuring that revised ways of working are consistently embedded in all clinical and none clinical practices.

The outcome of this work will be further reported as part of next year’s Quality Account.

Work to date includes:
• Staff training
• Improving Consent across all areas, particularly for the introduction of a Joint Rotherham Health Record
• Data process mapping
• Privacy Notices and statements
• Revised information for patients, families partners and supporters.

3.11 Clinical Coding Error Rate

Rotherham Hospice was not subject to the Audit Commissions, Payment by Results Clinical Coding Audit during 2017/18.
Part 4 - NHS Framework Domains 1 - 5

The core indicators are listed in the table below. The numbering scheme used in the table corresponds with the numbering of the indicators in the Regulation 4 Schedule within the Quality Accounts Regulations. Some of the indicators are not relevant to the Hospice. Trusts are only required to report on indicators that are relevant to the services that they provide or sub-contract in the reporting period therefore some areas have been shaded as not relevant.

<table>
<thead>
<tr>
<th>Prescribed information</th>
<th>Achievement</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Regulations 12-18 (Domains 1-3) are not applicable to Rotherham Hospice for the reporting period 2017/18.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. The percentage of patients aged: (i) 0 to 14; and (ii) 15 or over, readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period.</td>
<td>9.52% (29) patients were readmitted to the IPU over 36 episodes, within 28 days of a previous discharge, in the 2017/18 year. This is an increase of 0.22% from 2016/17 where the figure was 9.3%.</td>
<td>Rotherham Hospice considers that this data is as described for the following reasons: Changes in patient conditions and the issues with procuring appropriate community provision for some patients on discharge. The Rotherham Hospice has taken the following actions to improve this and so the quality of its services, by: The continuation of 48 hour emergency discharge cover from the Hospice @ Home service to ensure all discharges are safe and effective in the patients home environment. This also includes patients who are leaving the NHS Foundation Trust to die at home.</td>
</tr>
<tr>
<td>20. The trust’s responsiveness to the personal needs of its patients during the reporting period.</td>
<td>The Hospice does not have actual % data on its responsiveness to patients and their families. However the Hospice can evidence its ability to assess, plan and coordinate care in a responsive manner. This is also evident from the organisations response to incidents and complaints, ensuring learning and service improvement occurs as a result of its findings.</td>
<td>Rotherham Hospice considers that this data is as described for the following reasons: The Hospice is not required to submit this data to the HSCIC as routine reporting.</td>
</tr>
<tr>
<td>21. The percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends.</td>
<td>2017 staff survey suggests 98% of staff would recommend the trust as a provider of care to their family or friends.</td>
<td>Rotherham Hospice considers that this data is as described for the following reasons: Staff are happy with the type and quality of services that the trust provides.</td>
</tr>
<tr>
<td>21.1 This indicator is not a statutory requirement.</td>
<td>IPU – annual average 100% Day Therapies – annual average 100% CNS Service – annual average 100% H@H – annual average 100% Reception Token Boxes – 98.8%</td>
<td>Rotherham Hospice considers that this data is as described for the following reasons: Patients and families are generally happy with the care and support that they receive. Where individual responses were received that highlight improvements to be made, Rotherham Hospice has taken the following actions to improve this and so the quality of its services.</td>
</tr>
<tr>
<td>Prescribed information</td>
<td>Achievement</td>
<td>Response</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>24. The rate per 100,000 bed days of cases of <em>C. difficile</em> infection reported within the trust amongst patients aged 2 or over during the reporting period.</td>
<td>1 patient was admitted to IPU with a known <em>C. Difficile</em> infection but no patients were reported to have acquired a <em>C. difficile</em> infection at the Hospice during 2017/18.</td>
<td>Rotherham Hospice considers that this data is as described for the following reasons: High value is placed on infection control principles and all patients are nursed in single rooms. Please see our statement re the Hygiene Code in section 3.4)</td>
</tr>
<tr>
<td>25. The number and, where available, rate of patient safety incidents reported within the trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.</td>
<td>The trust reported the following clinical incidents overall in 2017/18.</td>
<td>Rotherham Hospice considers that this data is as described for the following reasons: Although the numbers seem very high for clinical incidents it is important to acknowledge that these are not all Hospice incidents but incidents escalated by the Hospice in relation to concerns found whilst working in the community or through medicines being wrongly dispensed from pharmacy or the hospital. The Rotherham Hospice has taken the following actions to improve this and so the quality of its services, by: All of these are reported and recorded so we can ensure that robust joint working reduces these incidents for the future.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q1: 20</th>
<th>Q2: 25</th>
<th>Q3: 23</th>
<th>Q4: 24</th>
<th>1 incident required escalation under the serious incident framework.</th>
</tr>
</thead>
<tbody>
<tr>
<td>No incidents required Coroner’s involvement due to the nature of injury sustained and or the time of death following the incident.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Focus on Responsive (section 20):
Although Rotherham Hospice cannot demonstrate its responsiveness through HSCIC level data, it can evidence its ability to plan, assess, deliver and coordinate the highest standard of patient care in a responsive manner. The information below shows the bed occupancy, number of deaths, number of discharges and length of stay for the Hospices IPU during 2017/18. This combined with the 1072 patients and families supported in the community and a total of 1,662 saved avoidable admissions, shows our ability to work collaboratively across all services to responsively meet patient and family need.
Rotherham Hospice has recorded and reported 92 incidents throughout 2017/18. Of this 92 it is important to note that 14 were non-clinical incidents and 24 were clinical incidents outside the Hospice care delivery.

Of the remaining 54 incidents, 19 were not related to patient care, leaving a total of 35 patient related clinical incidents.

There were 21 “No harm” or “Low harm” falls and only one fall that resulted in moderate injury or harm.

There were 12 medication incidents at levels 0 or 2 and only one incident graded at level 3, requiring escalation under the NHS Serious Incident Framework.

To consider these numbers in context and to understand their impact on quality and safety overall, it is important to consider them against Hospice performances nationally for the same time period.

The charts/graphs below show the number of falls and medication incidents that occurred on Rotherham Hospice’s IPU during 2017/18 and the comparative numbers reported by Hospices nationally as part of Hospice UK national Benchmark Program.
“How people die remains in the memory of those who live on”

Dame Cicely Saunders
5.1 Rotherham Clinical Commissioning Group (Rotherham CCG)

Rotherham CCG (RCCG) continues to work closely with Rotherham Hospice, both through strategic development and routine commissioning of hospice provision. RCCG is therefore well placed to comment on the quality of service provided by the Rotherham Hospice.

The Rotherham Hospice has continued to evidence good quality improvements in 2017-18 related to the key identified quality priorities. There has been focus on Individualised Care Planning and also around Community Care with a focus on Care Home support. The CCG welcomes the three key quality improvement priorities that the Hospice has identified for 2018/19, which will continue to develop high quality provision for all patients accessing the Rotherham Hospice services.

The CCG looks forward to a continued positive relationship with the Hospice over the coming year.

Dr Avanthi Gunasekera  
GP EOLC Commissioning Lead  
Rotherham CCG

5.2 Rotherham Health and Wellbeing Board

As chair of the Rotherham Health and Wellbeing Board I appreciate the work The Rotherham Hospice carries out for local residents, and how this is contributing to our local Health and Wellbeing Strategy 2018-25. This long-term strategy, published in March 2018 includes a life-course approach ensuring effective interventions for people from the start to the end of their life, and the work of the Hospice plays an important part in this by providing a service to people and their families at a difficult time – and it is welcoming to see the positive feedback received from staff and service users about some of the improvements that have been made.

Councillor David Roche  
Chair of the Rotherham Health & Wellbeing Board
Rotherham Hospice, Broom Road
Rotherham, South Yorkshire S60 2SW

Tel: 01709 308900
www.rotherhamHospice.org.uk

A Registered Charity
A Company Limited by Guarantee.

Registered Address: Broom Road, Rotherham, S60 2SW
Company Registration No: 2234222
Registered Charity No: 700356

Our care places the patient at the centre of everything we do.
Rotherham Integrated Care Partnership

Performance Report: Quarter 1

The performance framework will report against the agreed Milestones and Key Performance Indicators on a quarterly basis as follows:

<table>
<thead>
<tr>
<th>Delivery Team</th>
<th>Place Board</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 22 August 2018</td>
<td>5 September 2018</td>
</tr>
<tr>
<td>Q2 28 November 2018</td>
<td>12 December 2018</td>
</tr>
<tr>
<td>Q3 20 February 2019</td>
<td>6 March 2019</td>
</tr>
<tr>
<td>Q4 15 May 2019</td>
<td>5 June 2019</td>
</tr>
</tbody>
</table>

Key to ratings:
- **Brown**
  - Milestone
  - Not due to start
- **Red**
  - KPI Milestones
  - Not achieving target ($Tolerance = more than 2\%$) Significant issues
- **Amber**
  - KPI Milestones
  - Almost achieving target ($Tolerance = within 2\%$) Started but not on track
- **Green**
  - KPI Milestones
  - Achieving Target On track
- **Blue**
  - Milestones
  - Complete

There are five transformational workstreams, led by three Transformational Groups. All workstreams have key priorities as shown below:

<table>
<thead>
<tr>
<th>Children and Young People</th>
<th>Mental Health and Learning Disability</th>
<th>Acute and Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>C&amp;YP 1 Implementation of Children and Young People Mental Health Services (CAMHS) Transformation Plan</td>
<td>LD&amp;MH 1 Deliver improved outcomes and performance in the Improving Access to Psychological Therapies service</td>
<td>UC&amp;C 1 Creation of an integrated point of contact for care needs in Rotherham</td>
</tr>
<tr>
<td>C&amp;YP 2 Maternity and Better Births</td>
<td>LD&amp;MH 2 Improve dementia diagnosis and support</td>
<td>UC&amp;C 2 Expansion of the Integrated Rapid Response Service</td>
</tr>
<tr>
<td>C&amp;YP 3 Oversee delivery of the 0-19 healthy child pathway services</td>
<td>LD&amp;MH 3 Deliver CORE 24 mental health liaison services</td>
<td>UC&amp;C 3 Development of an integrated health and social care team to support the discharge of people out of hospital</td>
</tr>
<tr>
<td>C&amp;YP 4 Children’s Acute and Community Integration</td>
<td>LD&amp;MH 4 Transform the Woodlands ‘Fern’ ward</td>
<td>UC&amp;C 4 Implementation of integrated locality model across Rotherham</td>
</tr>
<tr>
<td>C&amp;YP 5 Special Educational Needs and Disability (SEND) – Journey to Excellence</td>
<td>LD&amp;MH 5 Improve community crisis response and intervention for mental health.</td>
<td>UC&amp;C 5 Development of the re-ablement and intermediate care offer</td>
</tr>
<tr>
<td>C&amp;YP 6 Implement ‘Signs of Safety’ for Children and Young People across partner organisations.</td>
<td>LD&amp;MH 6 Implement Public Health ‘Better Mental Health for All’ Strategy</td>
<td>UC&amp;C 6 Development of a coordinated approach to care home support.</td>
</tr>
<tr>
<td>C&amp;YP 7 Transitions</td>
<td>LD&amp;MH 7 Oversee delivery of Learning Disability Transforming Care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>LD&amp;MH 8 Support the implementation of the ‘my front door’ Learning Disability Strategy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>LD&amp;MH 9 Support the development of the Autism Strategy</td>
<td></td>
</tr>
</tbody>
</table>
### Summary of Performance against Milestones and KPIs

#### Children and Young People

<table>
<thead>
<tr>
<th>Priority</th>
<th>Number of milestones</th>
<th>BR</th>
<th>Blue</th>
<th>Green</th>
<th>Amber</th>
<th>Red</th>
<th>TBC</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2</td>
<td>Still to be agreed</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>3</td>
<td>4</td>
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<td>1</td>
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<td>3</td>
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<td>0</td>
</tr>
<tr>
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<td>2</td>
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<th>14</th>
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<td>% against total</td>
<td>4%</td>
<td>0%</td>
<td>56%</td>
<td>20%</td>
<td>4%</td>
<td>16%</td>
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</table>

<table>
<thead>
<tr>
<th>No. of KPIs</th>
<th>17</th>
<th>0</th>
<th>0</th>
<th>9</th>
<th>3</th>
<th>0</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>% against total</td>
<td>0%</td>
<td>0%</td>
<td>53%</td>
<td>18%</td>
<td>0%</td>
<td>29%</td>
<td></td>
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</tbody>
</table>

56% of milestones are on track or complete and 53% of KPIs are on track
4% of milestones are red

#### Mental Health and Learning Disability

<table>
<thead>
<tr>
<th>Priority</th>
<th>Number of milestones</th>
<th>BR</th>
<th>Blue</th>
<th>Green</th>
<th>Amber</th>
<th>Red</th>
<th>TBC</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>4</td>
<td>0</td>
<td>1</td>
<td>1</td>
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<td>2</td>
<td>3</td>
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<table>
<thead>
<tr>
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<tbody>
<tr>
<td>% against total</td>
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<td>9%</td>
<td>52%</td>
<td>35%</td>
<td>0%</td>
<td>4%</td>
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</table>

<table>
<thead>
<tr>
<th>No. of KPIs</th>
<th>16</th>
<th>0</th>
<th>0</th>
<th>6</th>
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<tbody>
<tr>
<td>% against total</td>
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<td>0%</td>
<td>38%</td>
<td>19%</td>
<td>19%</td>
<td>24%</td>
<td></td>
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</tbody>
</table>

52% of milestones are on track or complete and 38% of KPIs are on track
19% of KPIs are red

#### Urgent and Community

<table>
<thead>
<tr>
<th>Priority</th>
<th>Number of milestones</th>
<th>BR</th>
<th>Blue</th>
<th>Green</th>
<th>Amber</th>
<th>Red</th>
<th>TBC</th>
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<tbody>
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<td>1</td>
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<table>
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<th>12</th>
<th>2</th>
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<th>0</th>
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</thead>
<tbody>
<tr>
<td>% against total</td>
<td>39%</td>
<td>11%</td>
<td>43%</td>
<td>7%</td>
<td>0%</td>
<td>0%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>No. of KPIs</th>
<th>17</th>
<th>0</th>
<th>0</th>
<th>7</th>
<th>1</th>
<th>0</th>
<th>9</th>
</tr>
</thead>
<tbody>
<tr>
<td>% against total</td>
<td>0%</td>
<td>0%</td>
<td>41%</td>
<td>6%</td>
<td>0%</td>
<td>53%</td>
<td></td>
</tr>
</tbody>
</table>

54% of milestones are on track or complete and 41% of KPIs are on track

0% of KPIs are red
## MILESTONES

**CHILDREN AND YOUNG PEOPLE TRANSFORMATION GROUP**

**Chairs:** Councillor Gordon Watson, RMBC/ Vice Chair, Dr Jason Page, CCG

### Priority 1 C&YP – CAMHS Transformation Plan

<table>
<thead>
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<th>No.</th>
<th>Description</th>
<th>Target</th>
<th>Progress</th>
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<tbody>
<tr>
<td>CH1.1</td>
<td>Work with all stakeholders to review the RDaSH CAMHS ASD/ADHD diagnosis pathway.</td>
<td>Q4 18/19</td>
<td>G</td>
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<tr>
<td>CH1.2</td>
<td>Integration of the CAMHS Single Point of Access (SPA) and RMBC Early Help access point.</td>
<td>Q4 18/19</td>
<td>G</td>
<td>A</td>
</tr>
<tr>
<td>CH1.3</td>
<td>Improved CAMHS Crisis service out of hours.</td>
<td>Q4 18/19</td>
<td>G</td>
<td>A</td>
</tr>
<tr>
<td>CH1.4</td>
<td>Clarification of the pathways between the CAMHS service and Youth Offending Team (YOT) and ‘Liaison &amp; Diversion’ service.</td>
<td>Q3 18/19</td>
<td>G</td>
<td>G</td>
</tr>
<tr>
<td>CH1.5</td>
<td>Scoping out of a Schools ‘CAMHS’ service in line with the government ‘Green Paper’ recommendations</td>
<td>Q4 18/19</td>
<td>G</td>
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### Priority 2 C&YP – Maternity and Better births

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<th>No.</th>
<th>Description</th>
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### Priority 3 C&YP – 0-19 Healthy Child Pathway

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<th>No.</th>
<th>Description</th>
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<td></td>
<td>Q4 17/18</td>
</tr>
<tr>
<td>CH2.1</td>
<td>To map the 0-19 / RMBC pathways to identify opportunities for efficiencies and highlight any gaps.</td>
<td>Q4 18/19</td>
<td>BR</td>
<td>G</td>
</tr>
<tr>
<td>CH2.2</td>
<td>To address the barriers to 0-19 IPHN EHAs and increase the numbers submitted by the service.</td>
<td>Q4 18/19</td>
<td>G</td>
<td>A</td>
</tr>
<tr>
<td>CH2.3</td>
<td>All 0-19 Practitioners will have completed Signs of Safety training by the end of 2018/19.</td>
<td>Q4 18/19</td>
<td>G</td>
<td>G</td>
</tr>
<tr>
<td>CH2.4</td>
<td>We will work with partners to develop a tool and resources in order to capture the voice of the child Q4 18/19</td>
<td>Q4 18/19</td>
<td>G</td>
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### Priority 4 C&YP – Acute and Community Integration

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<th>No.</th>
<th>Description</th>
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<th>Comments</th>
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<tbody>
<tr>
<td></td>
<td></td>
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<td>Q4 17/18</td>
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<tr>
<td>CH3.1</td>
<td>Embed the work of the rapid response team with referral routes established across the system</td>
<td>Q4 18/19</td>
<td>G</td>
<td>G</td>
</tr>
<tr>
<td>CH3.2</td>
<td>Establish links between Rapid Response Team and Early Help</td>
<td>Q3 18/19</td>
<td>G</td>
<td>G</td>
</tr>
<tr>
<td>CH3.3</td>
<td>Pilot a direct link between Children’s Ward and Children’s Service to support timely discharge plans</td>
<td>Q3 18/19</td>
<td>G</td>
<td>G</td>
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<tr>
<td>No.</td>
<td>Description</td>
<td>Target</td>
<td>Progress</td>
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<tr>
<td>CH4.1</td>
<td>Develop Voices Action Plan</td>
<td>Q2 18/19</td>
<td>G</td>
<td>Meets have taken place with young people to help in the development of the plan with further meetings scheduled during August.</td>
</tr>
<tr>
<td>CH4.2</td>
<td>Undertake the following in respect of Joint Commissioning:</td>
<td>Q4 18/19</td>
<td>G</td>
<td>In progress and on track</td>
</tr>
<tr>
<td></td>
<td>• Implement the joint financial protocol and service specifications</td>
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<td>• Implement the Special School Funding Model</td>
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<td></td>
<td>• Review of SEMH Support Centres (PRUs)</td>
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<td></td>
<td>• Review of Traded Models</td>
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<td></td>
<td>• Review of service provision within the High Needs Budget</td>
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<tr>
<td>CH4.3</td>
<td>Create a plan to reduce placements outside Rotherham (including residential provision offer, Reduce OOA provision arrangements)</td>
<td>Q2 18/19</td>
<td>G</td>
<td>In progress and on track</td>
</tr>
<tr>
<td>CH4.4</td>
<td>Implement Phase 1 of the SEND Sufficiency Plan Complete building work resulting in additional provision at the following locations:</td>
<td>Q3 18/19</td>
<td>G</td>
<td>The SEND Hub is open with services in place and co-located.</td>
</tr>
<tr>
<td></td>
<td>• SEND Hub (co-location of services) - Complete</td>
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<td></td>
<td>• Cherry Tree / Kelford Schools (Open as SLD provision)</td>
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<td></td>
<td>• Abbey School (20 additional places)</td>
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<td></td>
<td>• 19-25 Provision (15 new college places)</td>
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<td></td>
<td>• Rowan Centre (15 additional places)</td>
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<tr>
<td>CH4.5</td>
<td>Appoint a lead officer and implement the Joint Preparation for Adulthood Action Plan</td>
<td>Q1 18/19</td>
<td>G</td>
<td>Draft Joint Preparation for Adulthood Action Plan developed. There has been no progress made in respect of appointing a lead officer. This has been escalated to senior management.</td>
</tr>
<tr>
<td>No.</td>
<td>Description</td>
<td>Target</td>
<td>Progress</td>
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<tr>
<td>CH5.1</td>
<td>The RLSCB will be sighted on the roll out to partners and this will include training to all levels of practitioner</td>
<td>Q2 18/19</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>CH5.2</td>
<td>Phase 1 of roll out of training</td>
<td>Q3 18/19</td>
<td>G</td>
<td>G</td>
</tr>
<tr>
<td>CH5.3</td>
<td>Phase 2 of roll out of training</td>
<td>Q4 18/19</td>
<td>BR</td>
<td>A</td>
</tr>
<tr>
<td>CH5.4</td>
<td>Evaluation and next steps</td>
<td>Q4 18/19</td>
<td>BR</td>
<td>BR</td>
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</tbody>
</table>
## Priority 7 C&YP – Transitions

<table>
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<tr>
<th>No.</th>
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<th>Comments</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>Q4 2017-18</td>
<td>Q1 2018</td>
<td>Q2 2018</td>
</tr>
<tr>
<td>CH6.1</td>
<td>The Transitions team to work jointly with Children Young People Services (CYPS), health and education for all new referrals for young people aged 14 to 18 with an Education, Health and Care Plan (EHCP) / Care Needs Assessment (CAN) who may be in need of a social care assessment using the Preparing for Adulthood model.</td>
<td>Q3 2018/19</td>
<td>BR 2019</td>
<td>TBC 2019</td>
</tr>
<tr>
<td>CH6.2</td>
<td>Develop a transition pathway based on Preparing for Adulthood model</td>
<td>Q3 2018/19</td>
<td>G 2019</td>
<td>TBC 2019</td>
</tr>
<tr>
<td>CH6.3</td>
<td>Create a data matrix of the full cohort and risk register</td>
<td>Q2 2018/19</td>
<td>TBC 2019</td>
<td>TBC 2019</td>
</tr>
<tr>
<td>CH6.4</td>
<td>Publish transition pathway on the Council website</td>
<td>Q3 2018/19</td>
<td>TBC 2019</td>
<td>TBC 2019</td>
</tr>
</tbody>
</table>

*Priority 2 is new and milestones will be included in Q2Milestones for Priority
*Milestones CH6.1 – 6.4 to be confirmed in Q2*
## Key Performance Indicators

### Children and Young People Transformation Group

**Chairs:** Councillor Gordon Watson, RMBC / Vice Chair, Dr Jason Page, CCG

<table>
<thead>
<tr>
<th>No.</th>
<th>Description</th>
<th>Trajectory</th>
<th>Target</th>
<th>Priority</th>
<th>Q1 1819</th>
<th>Q2 1819</th>
<th>Q3 1819</th>
<th>Q4 1819</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>CH/ KPI 1</td>
<td>Percentage of referrals assessed within 6 weeks</td>
<td>Increase</td>
<td>95%</td>
<td>CH1 - CAMHS</td>
<td>G-99%</td>
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<td></td>
<td>Target met in all 3 months. 99% average for the quarter.</td>
</tr>
<tr>
<td>CH/ KPI 2</td>
<td>Percentage of referrals receiving treatment within 18 weeks</td>
<td>Increase</td>
<td>95%</td>
<td>CH1 - CAMHS</td>
<td>G-98%</td>
<td></td>
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<td></td>
<td>98% average for the quarter. Slight dip in May, but performance recovered to 100% in June</td>
</tr>
<tr>
<td>CH/ KPI 3</td>
<td>Percentage of referrals triaged for urgency within 24 hours of receipt of referral</td>
<td>Increase</td>
<td>100%</td>
<td>CH1 - CAMHS</td>
<td>G-100%</td>
<td></td>
<td></td>
<td></td>
<td>Target met</td>
</tr>
<tr>
<td>CH/ KPI 4</td>
<td>Percentage of all appropriate urgent referrals assessed within 24 hours of receipt of referral</td>
<td>Increase</td>
<td>100%</td>
<td>CH1 - CAMHS</td>
<td>G-100%</td>
<td></td>
<td></td>
<td></td>
<td>Target met</td>
</tr>
<tr>
<td>CH/ KPI 5</td>
<td>Increased Early Help Assessments completed by 0-19 practitioners to a minimum of 10 per month</td>
<td>Increase</td>
<td>10 per month</td>
<td>CH 2 - 0-19</td>
<td>A-3</td>
<td></td>
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<td></td>
<td>Target agreed at 10 per month by Q4. Plan for Locality EHA managers to attend area team meeting for 0-19 teams to discuss EHA and process During Q1, there were 3 EHA’s completed by 0-19 practitioners. Only 14 were completed during all of 17/18 - it is anticipated that numbers will increase.</td>
</tr>
<tr>
<td>CH/ KPI 6</td>
<td>Evidence of voice of the child being considered in care planning through audit of individual records</td>
<td>Increase</td>
<td>25% sample</td>
<td>CH 2 - 0-19</td>
<td>To be reported in Q2</td>
<td></td>
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<td></td>
<td>Discussions have taken place between TRFT and the Head of Inclusion in CYPS to start planning. Once the tool is developed this will be part of the documentation audits that occur in TRFT</td>
</tr>
<tr>
<td>CH/ KPI 7</td>
<td>Increase the number of referrals to Early Help from Acute Clinical Services*</td>
<td>Increase</td>
<td>TBA – Need baseline data before we can set a realistic target</td>
<td>CH 3 - C&amp;A</td>
<td>To be reported in Q2</td>
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<td></td>
<td>CYPS will report the numbers of referrals from the Acute services. A validation process will need to be agreed. 29 referrals in Q1</td>
</tr>
<tr>
<td>CH/ KPI 8.1 to 8.3</td>
<td>8.1 Reduction in the number of young people 16/17 year old who have SEND who are NEET or Not Known</td>
<td>Reduce</td>
<td>Q4 – 17/18 was NEET 3.9% NK 0.4% (combined 4.3%)</td>
<td>CH 4 - SEND</td>
<td>G-8.5% Combined</td>
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<td>End June 2018: NEET 6.5% NK 2% (8.5%). Latest National (June): NEET 7% - NK 2.8% (9.8%). Indicator based on SEND Resident in Rotherham. Performance success is measured by NCCIS national comparison data. Performance is strong when compared with national comparators for the same period,</td>
</tr>
<tr>
<td>CH/ KPI</td>
<td>Indicator</td>
<td>Baseline</td>
<td>Target</td>
<td>Progress</td>
<td>Notes</td>
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<tr>
<td>CH/ KPI 9</td>
<td>Reduction in the number of exclusions</td>
<td>Reduce</td>
<td>Q4 – 17/18 was NEET 2.9% NK 4.1% (7%)</td>
<td>CH 4 - SEND</td>
<td>G 13.7% Combined</td>
<td>End June 2018: NEET 3.0% - NK 10.7% (13.7%). Indicator based on SEND Resident in Rotherham. Local measure and therefore doesn’t have any comparison data available.</td>
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<tr>
<td>CH/ KPI 10</td>
<td>Increased number of Children in Local Provision (reduced OOA)</td>
<td>Increase</td>
<td>Q4 – 17/18 was NEET 0.8% NK 11.2% (combined 12%)</td>
<td>CH 4 - SEND</td>
<td>G 13.6% Combined</td>
<td>End June 2018: NEET 1.6% - NK 12% (13.6). Latest National (June 18): NEET 14% - NK 66.3% (80.3%). Indicators based on SEND Resident in Rotherham. Performance success is measured by NCCIS national comparison data. Performance is strong when compared with national comparators for the same period.</td>
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<tr>
<td>CH/ KPI 11</td>
<td>Number of practitioners from across the Multi-agency partnership who have accessed the Rotherham Family Approach and Signs of safety Training (½ days and extended 2 day for safeguarding leads)</td>
<td>Increase</td>
<td>TBA 17/18 baseline = 0</td>
<td>CH 5 - ‘Signs of Safety’</td>
<td>G 345</td>
<td>As at the end of Quarter 1 (June 18) there were 190 CYP in an OOA provision out of 1939 CYP who have a EHCP in place (This is 57 Post -16 CYP and 133 other). 1749 CYP (from 1939) in a Local provision. A Sufficiency Plan has been developed and is currently being implemented which will increase the local authority special placements available, allowing those children currently placed OOA to be placed within authority provision where appropriate. The first of these placements will be available in September 2018 with the remaining placements on track to be available during 2018/19.</td>
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<tr>
<td>CH/ KPI 12</td>
<td>An increase in the conversion rate from contacts to referrals from Partnership agencies highlighting a better shared understanding &amp; assessment of risk and threshold - Evidence of embedding the change &amp; maximising impact.</td>
<td>Increase</td>
<td>50% by Q4</td>
<td>CH 5 - ‘Signs of Safety’</td>
<td>A 28.9%</td>
<td>To date 345 attended - breakdown: Children Centres 19 Schools 82 NHS/Health 67 Business Support 21 Adult services 71 YWCA 15 Difficult to put a target on this as we would need to know all workforce numbers involved.</td>
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<tr>
<td>CH/ KPI 13</td>
<td>Number of out of Borough residential placements</td>
<td>Reduce</td>
<td>TBA</td>
<td>CH 6 - Transitions</td>
<td>TBC</td>
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<tr>
<td>CH/ KPI 14</td>
<td>Ofsted CQC ratings for services used for transitions</td>
<td>Increase</td>
<td>TBA</td>
<td>CH 6 - Transitions</td>
<td>TBC</td>
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<tr>
<td>CH/ KPI 15</td>
<td>Numbers of SEND Tier 1 tribunal applications</td>
<td>Reduce</td>
<td>TBA</td>
<td>CH 6 - Transitions</td>
<td>TBC</td>
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* KPIs 13 – 15 to be updated for Q2
* KPIs for Maternity and Better Births to be included in Q2
# MENTAL HEALTH AND LEARNING DISABILITY TRANSFORMATION GROUP

## Chair: Ian Atkinson, RCCG

### Priority 1 MH - IAPT

<table>
<thead>
<tr>
<th>No.</th>
<th>Description</th>
<th>Target</th>
<th>Progress</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>MH1.1</td>
<td>Identify and agree workforce development and training requirements (LTC &amp; Core) - IAPT</td>
<td>Q1 18/19</td>
<td>G</td>
<td>On track – trainers graduated in June, 2 additional in August. Clinically operational in September.</td>
</tr>
<tr>
<td>MH1.2</td>
<td>Apply for NHS England LTC training (training commences October-18 &amp; March-19) – IAPT</td>
<td>Q1 18/19</td>
<td>G</td>
<td>NHS E funding received, staff scheduled for training as planned</td>
</tr>
<tr>
<td>MH1.3</td>
<td>All GP practice review support visits completed - IAPT</td>
<td>Q4 18/19</td>
<td>G</td>
<td>TBC</td>
</tr>
<tr>
<td>MH1.4</td>
<td>Delivery of 5 year forward IAPT 18/19 plan - IAPT</td>
<td>Q4 18/19</td>
<td>A</td>
<td>Links to M1.1 - not currently on track to deliver Q1 target, however, additional trainers will be operational in September.</td>
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</tbody>
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### Priority 2 MH - Dementia Diagnosis and Support

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<th>Progress</th>
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<tbody>
<tr>
<td>MH2.1</td>
<td>Review dementia diagnosis pathway</td>
<td>Q4 17/18</td>
<td>G</td>
<td>On track – performance above national target, increasing numbers of dementia diagnosis in primary care.</td>
</tr>
<tr>
<td>MH2.2</td>
<td>Develop new dementia pathway for post diagnostic care</td>
<td>Q4 18/19</td>
<td>BR</td>
<td>Clinically led review of Rotherham dementia care pathway commenced in Q1, with consideration of new NICE guidelines</td>
</tr>
</tbody>
</table>

### Priority 3 MH - Delivery CORE 24 MH Liaison Services

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<tr>
<th>No.</th>
<th>Description</th>
<th>Target</th>
<th>Progress</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>MH3.1</td>
<td>Funding received to support expansion of service to CORE 24 compliance</td>
<td>Q2 18/19</td>
<td>G</td>
<td>Successful NHS E funding bid, to be received in Q2</td>
</tr>
<tr>
<td>MH3.2</td>
<td>CORE 24 standards delivered in Rotherham.</td>
<td>Q2 18/19</td>
<td>G</td>
<td>On track – a full implementation plan developed and agreed between CCG and RDASH on track for delivery in Q2</td>
</tr>
<tr>
<td>MH3.3</td>
<td>Core 24 Service self-sustaining. – 19/20 onwards</td>
<td>Q1 19/20</td>
<td>G</td>
<td>On track – initial dialogue undertaken between partners to identify opportunity for sustainability in 19/20</td>
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</table>
### Priority 4 MH - Transform Ferns Ward

<table>
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<tr>
<th>No.</th>
<th>Description</th>
<th>Target</th>
<th>Progress</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>MH4.1</td>
<td>Implementation of agreed model of provision at Ferns and continuous evaluation</td>
<td>Q3 18/19</td>
<td>G G G G</td>
<td>On track – clinically developed model in place, continuous review and refinement of model</td>
</tr>
<tr>
<td>MH4.2</td>
<td>Agree long-term model and funding source for Ferns.</td>
<td>Q3 18/19</td>
<td>G G G G</td>
<td>Funding for 18/19 agreed. Full evaluation being developed by system partners to determine long-term sustainability</td>
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</tbody>
</table>

### Priority 5 MH - Improve Community Crisis Response (including Core Fidelity, suicide-prevention)

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<tr>
<th>No.</th>
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<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>MH5.1</td>
<td>Complete CORE Fidelity review, recommendations and action plan for improvement (including investment requirements)</td>
<td>Q4 18/19</td>
<td>G G G G</td>
<td>Core Fidelity Review completed, Action Plan in development.</td>
</tr>
<tr>
<td>MH5.2</td>
<td>SY&amp;B ICS NHS England Suicide-prevention – delivery of Rotherham element of the plan</td>
<td>Q4 18/19</td>
<td>BR G G G</td>
<td>System wide discussion with the National Team to identify opportunities for SYB system wide suicide prevention schemes</td>
</tr>
<tr>
<td>MH5.3</td>
<td>Refresh of the Rotherham suicide prevention and self-harm action plan</td>
<td>Q3 18/19</td>
<td>A A A A</td>
<td>Milestone revised to deliver in Q3 in light of Suicide prevention ICS work and peer review in September</td>
</tr>
</tbody>
</table>

### Priority 6 MH – Public Health: Better Mental Health for All Strategy

<table>
<thead>
<tr>
<th>No.</th>
<th>Description</th>
<th>Target</th>
<th>Progress</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>MH6.1</td>
<td>Launch of Five Ways to Wellbeing campaign</td>
<td>Q1 18/19</td>
<td>G B B B</td>
<td>Launch complete</td>
</tr>
<tr>
<td>MH6.2</td>
<td>Five Ways communication and marketing plan for 2018/19 - agreed and delivered by partners</td>
<td>Q1 18/19</td>
<td>G G G G</td>
<td>On track. VAR and RMBC covered Give and Active respectively. In September the colleges are leading on Learning and the CCG is leading on Connect in October</td>
</tr>
<tr>
<td>MH6.3</td>
<td>Evidence of integration of Five Ways messages within provider and commissioned services</td>
<td>Q4 18/19</td>
<td>A G G G</td>
<td>Good progress being made. Discussions are taking place with adults services, children’s services to take place</td>
</tr>
</tbody>
</table>
### Priority 7 LD – Oversee Delivery of Transforming Care

<table>
<thead>
<tr>
<th>No.</th>
<th>Description</th>
<th>Target</th>
<th>Progress</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>LD7.1</td>
<td>RMBC and CCG to agree process for funding learning disability joint placements</td>
<td>Q2 18/19</td>
<td>NEW A</td>
<td>Drafted decision making framework shared across all partners for consideration</td>
</tr>
<tr>
<td>LD7.2</td>
<td>Identify Indicative costs for transforming care cohort (including those on the risk register)</td>
<td>Q2 18/19</td>
<td>NEW A</td>
<td>Implementation of joint review of Transforming Care caseload commenced</td>
</tr>
<tr>
<td>LD7.3</td>
<td>Commissioning solutions to be in place to meet national deadline</td>
<td>Q4 18/19</td>
<td>NEW A</td>
<td>Close partnership working across the system has taken place to identify possible placement opportunities for identified transforming care caseload</td>
</tr>
</tbody>
</table>

### Priority 8 LD – Support the Implementation of the My Front Door – Learning Disability Strategy

<table>
<thead>
<tr>
<th>No.</th>
<th>Description</th>
<th>Target</th>
<th>Progress</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>LD8.1</td>
<td>Delivery of joint Learning Disability transformation strategy</td>
<td>Q4 19/20</td>
<td>NEW A</td>
<td>Action Plan in response to strategy in development, system partners considering adoption of LD strategy</td>
</tr>
</tbody>
</table>

### Priority 9 LD – Support the development of an Autism Strategy

<table>
<thead>
<tr>
<th>No.</th>
<th>Description</th>
<th>Target</th>
<th>Progress</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>LD9.1</td>
<td>Complete the development of the Autism Strategy (including Action Plan)</td>
<td>Q3 18/19</td>
<td>NEW A</td>
<td>Draft Autism strategy in development through Autism Strategy Group</td>
</tr>
<tr>
<td>LD9.2</td>
<td>Development of Rotherham based Autism and ADHD diagnostic pathway</td>
<td>Q4 18/19</td>
<td>NEW A</td>
<td>Initial clinically led dialogue undertaken to scope opportunities for development of pathway</td>
</tr>
</tbody>
</table>
### Key Performance Indicators

**Learning Disability and Mental Health Transformation Group**

Chair: Ian Atkinson, RCCG

<table>
<thead>
<tr>
<th>No.</th>
<th>Description</th>
<th>Trajectory</th>
<th>Target</th>
<th>Priority</th>
<th>Q1 1819</th>
<th>Q2 1819</th>
<th>Q3 1819</th>
<th>Q4 1819</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>MH/KPI 1</td>
<td>Percentage of people referred to IAPT commencing treatment within 6 weeks of referral.</td>
<td>Maintain</td>
<td>75%</td>
<td>MH 1 - IAPT</td>
<td>G 78.3%</td>
<td></td>
<td></td>
<td></td>
<td>Q4 was 94.4%, performance has dipped in June, although still achieving above target. Additional trainers graduated – should see impact on performance.</td>
</tr>
<tr>
<td>MH/KPI 2</td>
<td>% Compliance of those who have entered (i.e. received) treatment as a proportion of people entering treatment with anxiety or depression&lt;br&gt;Qtrly target % Qtr1 = 4.34%; Qtr 2 = 4.48%; Qtr 3 = 4.61%; Qtr 4 = 4.75%</td>
<td>Increase</td>
<td>19%</td>
<td>MH 1 - IAPT</td>
<td>R 3.84%</td>
<td></td>
<td></td>
<td></td>
<td>Trainers recruited in Q1 (as per MH1.1 milestone), agency staff had been used in 2017/18. Performance dipped due to reduced caseload while in training. Expectation that performance will improve by Q2.</td>
</tr>
<tr>
<td>MH/KPI 3</td>
<td>% of people who have completed treatment having attended at least 2 treatment contacts and are moving to recovery</td>
<td>Increase</td>
<td>≥ 50%</td>
<td>MH 1 - IAPT</td>
<td>G 59.1%</td>
<td></td>
<td></td>
<td></td>
<td>May compliance is 59.1% against the 50% target. The service continues to achieve against the KPI.</td>
</tr>
<tr>
<td>MH/KPI 4</td>
<td>Dementia diagnosis rates (%)</td>
<td>Maintain</td>
<td>National = 67%&lt;br&gt;Local = ≥80%</td>
<td>MH 2 - Dementia</td>
<td>G 83.5%</td>
<td></td>
<td></td>
<td></td>
<td>National target is 67%. Local target set to maintain or improve on 80%. June performance was 83.5%.</td>
</tr>
<tr>
<td>MH/KPI 5</td>
<td>% of GP practices achieving 62% of Post diagnostic support plan recorded in last 12 months</td>
<td>Increase</td>
<td>TBC</td>
<td>MH 2 - Dementia</td>
<td>TBC in Q2</td>
<td></td>
<td></td>
<td></td>
<td>Baseline is 62% based on Rotherham GP practices current average / 39% currently equal to or above 62%. Performance to be reported on a 6 monthly basis.</td>
</tr>
<tr>
<td>MH/KPI 6</td>
<td>Urgent and emergency MH response within 1 hour of receiving an urgent referral (Core 24 liaison)</td>
<td>Increase</td>
<td>95%</td>
<td>MH 3 - Core 24</td>
<td>R 58%</td>
<td></td>
<td></td>
<td></td>
<td>Referrals Adults Q1 = 150 / OP = 13. Combined 163. Within 1 hour Adults Q1 87 / OP = 8. Combined 95. Q1 = 58%. Service not currently provided 24/7. 24/7 service is expected to commence end of Sept/beg of Oct. Performance is then expected to increase to 95%.</td>
</tr>
<tr>
<td>MH/KPI 7</td>
<td>Average length of stay (Ferns)</td>
<td>Decrease</td>
<td>28 days</td>
<td>MH 4 - Ferns</td>
<td>R 47</td>
<td></td>
<td></td>
<td></td>
<td>Q1 average LOS = 47 days. April 43, May 48.8, June 49.8. Issues allocating a Social Worker and gaining input causing delays. Ward procedures being amended so discharge planning begins earlier. Can be issues with expectations around discharge destinations changing.</td>
</tr>
<tr>
<td>MH/KPI 8</td>
<td>To reduce the suicide rate by 10% from the 2013-15 baseline (14.2 per 100,000)</td>
<td>Decrease</td>
<td>MH 5 - Crisis</td>
<td>TBC in Q3</td>
<td>We will report on this metric once per year. The metric is reported over a rolling 3 year period due to the small numbers involved. The next three year data (2015-2017) will be available in November 2018.</td>
<td></td>
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</tr>
<tr>
<td>MH/KPI 9</td>
<td>Referrals who require a Face to Face assessment who were seen within 4 Hours % Compliance (crisis)</td>
<td>Increase</td>
<td>≥95%</td>
<td>MH 5 - Crisis</td>
<td>G 100%</td>
<td>May compliance is 100% against the 95% target.</td>
<td></td>
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</tr>
<tr>
<td>LD/KPI 10</td>
<td>Ensure that patients receive a CETR prior to a planned admission to an Assessment and Treatment Unit or mental health inpatients: adults.</td>
<td>Increase</td>
<td>95%</td>
<td>LD 7 - Transforming Care</td>
<td>G</td>
<td>On track</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LD/KPI 11</td>
<td>Ensure that patients receive a CETR prior to a planned admission to an Assessment and Treatment Unit or mental health inpatients: children.</td>
<td>Increase</td>
<td>95%</td>
<td>LD 7 - Transforming Care</td>
<td>G</td>
<td>On track</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LD/KPI 12</td>
<td>Ensure that patients in an Assessment and Treatment Unit receive a Care and Treatment Review (CTR) every 6 months.</td>
<td>Increase</td>
<td>100%</td>
<td>LD 7 - Transforming Care</td>
<td>A</td>
<td>One individual CTR delayed by 1 month – this will be resolved in the next 6 weeks.</td>
<td></td>
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</tr>
<tr>
<td>LD/KPI 13</td>
<td>Reduce the number of people admitted in line with the South Yorkshire and North Lincolnshire LD TCP trajectory – Local Reporting</td>
<td>Reduce</td>
<td>Target = 3 – CCG funded LD beds / 5 – NHSE funded secure LD beds</td>
<td>LD 7 - Transforming Care</td>
<td>A</td>
<td>Local and TCP trajectories are off track with 4 patients in hospital beds.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LD/KPI 14</td>
<td>Proportion of eligible adults with a learning disability having a GP health check</td>
<td>Increase</td>
<td>1058</td>
<td>LD 8 - LD Strategy</td>
<td>A 124</td>
<td>CCG I&amp;AF, requirement to agree a trajectory as part of 1819 planning – reported quarterly. Trajectory is: Q1 159, Q2 159, Q3 318, Q4 423 Achieved 124 against target of 159 in Q1, however only 19 practices submitted their figures so we may have achieved the target.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>LD/KPI 15</td>
<td>Proportion of adults with a learning disability in paid employment</td>
<td>Increase</td>
<td>TBC</td>
<td>LD 8 - LD Strategy</td>
<td>TBC</td>
<td>ASCOF 1E</td>
<td></td>
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</tr>
<tr>
<td>LD/KPI 16</td>
<td>Proportion of adults with a learning disability who live in their own home or with their family</td>
<td>Increase</td>
<td>TBC</td>
<td>LD 8 - LD Strategy</td>
<td>TBC</td>
<td>ASCOF 1G</td>
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</tr>
</tbody>
</table>

* KPIs for Mental Health for All and Autism are being considered, this will be updated for Q2
* KPI 6 and 7 to be updated for Q2
## MILESTONES

### URGENT CARE AND COMMUNITY TRANSFORMATION GROUP

**Chairs:** Chris Holt, TRFT and Anne Marie Lubanski RMBC

#### Priority 1 UC&C - Integrated Point of Contract

<table>
<thead>
<tr>
<th>No.</th>
<th>Description</th>
<th>Target</th>
<th>Progress</th>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Q4 1718</td>
<td>Q1 1819</td>
</tr>
<tr>
<td>UC 1.1</td>
<td>Transfer mental health referrals to the Care Co-ordination Centre</td>
<td>Q2 18/19</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>UC 1.2</td>
<td>Agree joint working arrangements between Integrated Rapid Response/Care Co-ordination Centre /Single Point of Access to test the models.</td>
<td>Q2 18/19</td>
<td>G</td>
<td>G</td>
</tr>
<tr>
<td>UC 1.3</td>
<td>Co-locate Care Co-ordination Centre with Integrated Rapid Response</td>
<td>Q3 18/19</td>
<td>G</td>
<td>G</td>
</tr>
<tr>
<td>UC 1.4</td>
<td>Evaluate joint working arrangements between health and RMBC Single Point of Access</td>
<td>Q3 18/19</td>
<td>BR</td>
<td>BR</td>
</tr>
<tr>
<td>UC 1.5</td>
<td>Partners agree integrated service model for Single Point of Access and Care Co-ordination Centre</td>
<td>Q4 18/19</td>
<td>BR</td>
<td>BR</td>
</tr>
<tr>
<td>UC 1.6</td>
<td>New service model in place</td>
<td>Q2 19/20</td>
<td>BR</td>
<td>BR</td>
</tr>
</tbody>
</table>

#### Priority 2 UC&C - Integrated Rapid Response (Phase 1)

<table>
<thead>
<tr>
<th>No.</th>
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<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Q4 1718</td>
<td>Q1 1819</td>
</tr>
<tr>
<td>UC 2.1</td>
<td>Complete separation of planned/unplanned activity within District Nursing</td>
<td>Q2 18/19</td>
<td>G</td>
<td>G</td>
</tr>
<tr>
<td>UC 2.2</td>
<td>Co-locate the unplanned and Integrated Rapid Response teams</td>
<td>Q3 18/19</td>
<td>G</td>
<td>G</td>
</tr>
<tr>
<td>UC 2.3</td>
<td>Incorporate unplanned specialist community nursing work into the Integrated Rapid Response team</td>
<td>Q1 19/20</td>
<td>G</td>
<td>BR</td>
</tr>
</tbody>
</table>
## Priority 3 UC&C - Integrated Discharge (Phase 2)

<table>
<thead>
<tr>
<th>No.</th>
<th>Description</th>
<th>Target</th>
<th>Progress</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>UC 3.1</td>
<td>Appointment of Integrated Service Manager</td>
<td>Q2 18/19</td>
<td>G</td>
<td>B</td>
</tr>
<tr>
<td>UC 3.2</td>
<td>Appointment of Ward Co-ordinator Roles</td>
<td>Q2 18/19</td>
<td>G</td>
<td>B</td>
</tr>
<tr>
<td>UC 3.3</td>
<td>Partners approve Service Model (incl. team structure and 7/7 working and front door interface)</td>
<td>Q4 18/19</td>
<td>G</td>
<td>G</td>
</tr>
<tr>
<td>UC 3.4</td>
<td>Implement new model</td>
<td>Q2 19/20</td>
<td>BR</td>
<td>BR</td>
</tr>
</tbody>
</table>

## Priority 4 UC&C - Integrated Locality Pilot (Phase 2)

<table>
<thead>
<tr>
<th>No.</th>
<th>Description</th>
<th>Target</th>
<th>Progress</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>UC 4.1</td>
<td>Map of current resources in each Partnership area for all organisations complete</td>
<td>Q3 18/19</td>
<td>G</td>
<td>G</td>
</tr>
<tr>
<td>UC 4.2</td>
<td>Agree outcome framework with partners - identify joint outcomes, agree governance and identify accountable officers for delivery within provider organisations</td>
<td>Q3 18/19</td>
<td>G</td>
<td>G</td>
</tr>
<tr>
<td>UC 4.3</td>
<td>Hold launch workshops (to agree work plans and targets and working principles)</td>
<td>Q3 18/19</td>
<td>G</td>
<td>G</td>
</tr>
<tr>
<td>UC 4.4</td>
<td>Partnership leadership teams agreed by partners</td>
<td>Q3 18/19</td>
<td>BR</td>
<td>BR</td>
</tr>
<tr>
<td>UC 4.5</td>
<td>Team configuration agreed by partners</td>
<td>Q4 18/19</td>
<td>BR</td>
<td>BR</td>
</tr>
<tr>
<td>UC 4.6</td>
<td>Implementation plan for full roll out agreed by partners</td>
<td>Q4 18/19</td>
<td>BR</td>
<td>BR</td>
</tr>
<tr>
<td>UC 4.7</td>
<td>Agree Long Term Conditions LES to ensure that it links with the localities</td>
<td>Q1 19/20</td>
<td>BR</td>
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</tr>
</tbody>
</table>

## Priority 5 UC&C – Home First Model: Reablement and Intermediate Care

<table>
<thead>
<tr>
<th>No.</th>
<th>Description</th>
<th>Target</th>
<th>Progress</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>UC 5.1</td>
<td>Carry out financial modelling of current pathways</td>
<td>Q2 18/19</td>
<td>G</td>
<td>G</td>
</tr>
<tr>
<td>UC 5.2</td>
<td>Programme lead to develop a comprehensive milestone and action plan for delivery of this priority</td>
<td>Q2 18/19</td>
<td>New</td>
<td>A</td>
</tr>
<tr>
<td>UC 5.3</td>
<td>Develop draft service model and service specifications for reablement, intermediate Care and Home First</td>
<td>Q4 18/19</td>
<td>New</td>
<td>BR</td>
</tr>
<tr>
<td>UC 5.4</td>
<td>Phase 1 of new service model implemented</td>
<td>Q4 18/19</td>
<td>BR</td>
<td>BR</td>
</tr>
<tr>
<td>No.</td>
<td>Description</td>
<td>Target</td>
<td>Progress</td>
<td>Comments</td>
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<td></td>
<td></td>
<td>Q4 17/18</td>
<td>Q1 18/19</td>
<td>Q2 18/19</td>
</tr>
<tr>
<td>UC 6.1</td>
<td>Local implementation of Red Bag Scheme</td>
<td>Q1 18/19</td>
<td>G</td>
<td>B</td>
</tr>
<tr>
<td>UC 6.2</td>
<td>Implement and evaluate care home pilots: Trusted Assessor, Telehealth and End of Life</td>
<td>Q1-Q3 18/19</td>
<td>G</td>
<td>G</td>
</tr>
<tr>
<td>UC 6.3</td>
<td>Review training requirements for Care Home staff to enable effective delivery of service</td>
<td>Q4 18/19</td>
<td>G</td>
<td>G</td>
</tr>
<tr>
<td>UC 6.4</td>
<td>Continue to ensure the Care Home LES is fit for purpose</td>
<td>Q4 18/19</td>
<td>G</td>
<td>G</td>
</tr>
<tr>
<td>No.</td>
<td>Description</td>
<td>Trajectory</td>
<td>1819 Target</td>
<td>Priority(ies)</td>
</tr>
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</tr>
<tr>
<td>UC/KPI 1</td>
<td>SPA - Percentage of people provided with information and advice at first point of contact (to prevent service need) - ASCOF</td>
<td>Increase</td>
<td>2750</td>
<td>UC 1 - IPC</td>
</tr>
<tr>
<td>UC/KPI 2</td>
<td>CCC – Number of GP urgent admissions to AMU (including those referred through CCC) (TRFT KPI suite)</td>
<td>Increase</td>
<td>3150 threshold</td>
<td>UC 1 – IPC, UC 5 – IC /Reab</td>
</tr>
<tr>
<td>UC/KPI 3</td>
<td>Percentage of new clients who have had a formal social care assessment completed this year, that went on to receive long term social care support - ASCOF</td>
<td>Reduction</td>
<td>TBC</td>
<td>UC 1 – IPC, UC 2 – IRR, UC 4 – Int Locality</td>
</tr>
<tr>
<td>UC/KPI 4</td>
<td>Proportion of new clients who receive short term (enabement) service in year with an outcome of no further requests made for support - ASCOF 2d</td>
<td>Increase</td>
<td>83%</td>
<td>UC 1 – IPC, UC 2 – IRR, UC 4 – Int Locality</td>
</tr>
<tr>
<td>UC/KPI 5</td>
<td>New permanent admissions to residential nursing care for adults – 65+ BCF/ASCOF 2a (2)</td>
<td>Decrease</td>
<td>140.69</td>
<td>UC 1 – IPC, UC 2 – IRR, UC 4 – Int Locality</td>
</tr>
<tr>
<td>UC/KPI 6</td>
<td>Proportion of older people (65 and over) still at home 91 days after discharge from hospital into reablement / rehabilitation services – BCF/ASCOF 2B (1)</td>
<td>Increase</td>
<td>89%</td>
<td>UC 1 – IPC, UC 2 – IRR, UC 4 – Int Locality</td>
</tr>
<tr>
<td>UC/KPI 7</td>
<td>Reduce non elective admissions (BCF)</td>
<td>Reduction</td>
<td>2359</td>
<td>UC 1 – IPC, UC 2 – IRR, UC 4 – Int Locality</td>
</tr>
<tr>
<td>UC/KPI 8</td>
<td>Number of emergency re-admissions within 30 days of hospital discharge (all age) - BCF</td>
<td>Reduction</td>
<td>TBC</td>
<td>UC 1 – IPC, UC 2 – IRR, UC 4 – Int Locality</td>
</tr>
<tr>
<td>UC/KPI 9</td>
<td>Length of stay in hospital (over 64’s)</td>
<td>Reduction</td>
<td>TBC</td>
<td>UC 2 – IRR, UC 4 – Int Locality</td>
</tr>
<tr>
<td>UC/KPI 10</td>
<td>Reducing long lengths of stay (super stranded patients)</td>
<td>Reduction</td>
<td>39 = 10% reduction on 17/18</td>
<td>UC 2 – IRR, UC 4 – Int Locality</td>
</tr>
</tbody>
</table>
| UC/KPI 11 | Number of patients discharged to their usual place of residence (over 64’s) | Increase | TBC | UC 2 - IRR  
UC 3 - IDisc  
UC 5 – Int  
Locality | TBC | Current data shows 90+% of people are coded as going back to usual place of residence – further work to take place to analyse and establish a more appropriate data collection. To be confirmed in Q2 |
| UC/KPI 12 | Intermediate Care - Average length of stay (general rehabilitation) (beds only) | Reduce | TBC | UC 2 - IRR  
UC 3 - IDisc  
UC 5 – Int  
Locality | TBC | |
| UC/KPI 13 | Intermediate Care - Average length of stay (specialist rehabilitation) (beds only) | Reduce | TBC | UC 2 - IRR  
UC 3 - IDisc  
UC 5 – Int  
Locality | TBC | |
| UC/KPI 14 | Intermediate Care - Late discharge - LOS > 6 weeks (general rehabilitation) | Reduce | TBC | UC 2 - IRR  
UC 3 - IDisc  
UC 5 – Int  
Locality | TBC | |
| UC/ KPI 15 | Delayed transfer of care from hospital (I&AF 127e). | Reduction | 3.5% | UC 3 – IDis  
G 2.1% | G | Following the on-going implementation of an action plan across partners, performance has significantly improved. May 18 provisional performance is 2.1%. |
| UC/ KPI 16 | Number of A&E attendances from care home residents (local) | Reduction | 1500 | UC 6 – Care  
Homes  
A 400 | A 400 | RAG rate based on April 145, May 133, June 122 = 400. Qtr average = 375 – so slightly above expected |
| UC/ KPI 17 | Percentage of attendances that resulted in hospital admission | Reduction | 72% | UC 6 – Care  
Homes  
G 72.3% | G | On track |

*KPI’s 3, 8, 9, 10 and 11 to be updated for Q2 – some further analysis required  
*KPI 6 is collected annually and will be available Q3/4  
*KPI’s 12, 13 and 14 further work is to take place to establish an appropriate set of metrics for LOS (general and complex) that will promote independence
Rotherham Integrated Care Partnership

Minutes

Title of Meeting: PUBLIC Rotherham ICP Place Board
Time of Meeting: 9:00am – 10:00am
Date of Meeting: Wednesday 3rd October 2018
Venue: Elm Room (G.04), Oak House
Chair: Chris Edwards
Contact for Meeting: Lydia George 01709 302116 or Lydia.george@nhs.net

Apologies: Louise Barnett, The Rotherham NHS Foundation Trust
Dr Gok Muthoo, Connect Healthcare Rotherham Ltd

Conflicts of Interest: General declarations were acknowledged for Members as providers/commissioners of services. However, no specific direct conflicts/declarations were made relating to any items on today’s agenda.

Members Present:
- Chris Edwards (CE), Chair, Chief Officer, Rotherham CCG (Chair)
- Sharon Kemp, (SK), Chief Executive, Rotherham MBC
- Kathryn Singh, (KS), Chief Executive, Rotherham, Doncaster & Sth Humber Foundation Trust (RDaSH)
- Janet Wheatley (JW), Chief Executive, Voluntary Action Rotherham (VAR)
- Chris Holt, Director of Transformation, TRFT (for Louise Barnett)

Participating Observers
- Dr Richard Cullen (RCu), Joint Chair, Health & Wellbeing Board, Rotherham CCG
- Cllr David Roche (DR), Joint Chair, Heath & Wellbeing Board, RMBC

In Attendance:
- Lydia George (LG), Strategy & Development Lead, Rotherham CCG
- Gordon Laidlaw (GL), Head of Communications, Rotherham CCG
- Ian Atkinson, Chair, Rotherham ICP Delivery Team
- Dermot Pearson (DP), Director of Legal Services, RMBC
- Jon Stonehouse, Director of Children’s Services, RMBC
- Jenny Lingrell, Joint Assistant Director Commissioning, Performance & Inclusion, RMBC

Wendy Commons, Minute Taker

There were two members of the public present.

Ken Dolan
Ian Roddison
<table>
<thead>
<tr>
<th>Item Number</th>
<th>Discussion Items</th>
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<tbody>
<tr>
<td><strong>1</strong></td>
<td>Public &amp; Patient Questions</td>
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<td></td>
<td>Ken Dolan asked a question, directed at RMBC, about how the council was engaged at South Yorkshire and Bassetlaw system level. Sharon Kemp clarified the position of the Council in relation the Rotherham Integrated Care Partnership and the South Yorkshire and Bassetlaw Integrated Care System.</td>
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2 | Transformation Group Updates: |

Place Board received progress updates on the transformation areas below:

**Children & Young People’s Transformation Group**

**Subject – Special Educational Needs & Disability (SEND)**

*Presented by Jenny Lingrell*

Jenny highlighted what’s going well with as:

- An action plan has been compiled with input from young people and their parents to develop the ‘voices’ of young people.
- All seven projects of the Year 1 SEND sufficiency plan are in delivery
- Rotherham’s first 19-25 provision for SEND has opened
- Health sufficiency plan is in draft and approved for consultation
- SEND health focus group has a clear action plan to have clear pathways in place and co-produce and deliver SEND training across the workforce
- The all age autism strategy is now in consultation phase

Jenny will liaise with Gordon Laidlaw to provide detail on the new ‘SEND college’ that has opened in Broom for 19-25s to determine how and where this development can be positively communicated.

*Action: JL/GL*

Jenny explained that there has been a slight increase in exclusions and requests for education health and care plans. Work is being undertaken to understand and address these.

Preparations are continuing for the unannounced local area SEND inspection which is thought to be imminent. This will be a joint inspection by the CQC and OFSTED.

Following an enquiry, from David Roche, for the next SEND update Jenny will include a diagram showing the structure between organisations to demonstrate the working links for co-production of action plans etc.

*Action: JL*

**Urgent & Community Care Transformation Group**

**Subject – Integrated Locality Model implementation**

*Presented by Chris Holt*

Chris Holt updated Place Board on the progress made with the implementation of the integrated locality model including:

A workshop had been held with physical and mental health practitioners, GPs, Social Care, Commissioner and Voluntary Sector colleagues attending to take stock, determine what to focus on and the actions that need to be taken.

Analysis of the health and social care annual review dataset had taken place resulting in over 3000 adults records being matched. Teams will now be able to make targeted interventions that will make a real difference and make MDT working more effective.

In relation to what the group is ‘worried about’, additional support for the locality initiative work has been brought in to address competing priorities and ease individual’s workloads. Addressing the flexibility of workforce to adapt better and mature into locality/partnership working ways is still ongoing and a visit to Wallsall had recently taken place to look at how the approach they had adopted.

Next steps for the transformation group will include looking at the top ten high intensity users, reviewing the long term conditions case management multi-disciplinary team and making adjustments to the packages of care to determine whether small adjustments can be made so that the some referrals (that can often cause delays) can be avoided.
The Place Board was assured that the milestones for implementation are currently on track for achievement.

Sharon Kemp asked Janet Wheatley if she could bring feedback from voluntary sector colleagues on the impact as these changes are implemented.  

*Action: JW*

Richard Cullen reported that digital technology is now in place to assist but staff need to adapt from using paper to inputting into a system. An app has also been developed to make consent to share records much easier. As the Lead on IT Digital, RC offered the IT workstream's help with any issues around the implementation and engaging with staff.

**Mental Health & Learning Disability Transformation Group**  
**Dementia (inc Ferns)**  
**Presented by Ian Atkinson**

Ian Atkinson reminded Place Board members of the MH & LD Transformation Group’s strategy which included looking to increase diagnostic rates and then to increase the amount of care for those in the community setting. He was pleased to report the current dementia diagnostic rate of 83.4% against a national target of 67% resulting in Rotherham dementia diagnosis being ranked top in Yorkshire and Humber. Good progress is also being made in referrals to dementia carer resilience where there has been a significant increase in referrals.

Work is still taking place to ensure support after diagnosis with a pathway expected to be in place by April 2019, however it was acknowledged that despite endorsing Rotherham’s direction of travel the new NICE guidance has caused delay, particularly around the interpretation of ‘Specialist’.

Ferns has proved a successful development in supporting step-down out of hospital for patients with dementia. It has been a pilot basis so far and is awaiting timely evaluation to be able to make decision to go forward. This evaluation is expected in November and will come to public Place Board in January 2019 for formal feedback.  

*Action: IA/LG for agenda*

Ian advised that the commitment to deliver the revised pathway will cause pressure in order to achieve the challenging timeline of April 2019.

Following a query, Ian assured Members that diagnosing dementia quicker is not increasing waiting times as GPs are able to prescribe as a result of the early diagnosis.

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### 3  
**Response to the Department of Health (DoH) consultation on prescribing gluten free foods**

Chris Edwards advised that the DoH had recently concluded their consultation on gluten free prescribing recommending that a limited range of bread and mix products is retained on prescription in future and all other gluten free products ie biscuits, cereals, cooking aids, grains/flours and pasta will no longer be available.

Rotherham CCG has taken the decision to follow the national approach and will continue to prescribe bread and mixes. Over 500 letters have been sent out to Rotherham coeliac patients informing them of these changes. The CCG has not received any complaints but did receive one response complementing them on its pathway and service which includes access to dietary advice and providing gluten free cookery lessons and supermarket tours.

Place Board noted the action taken by the CCG and agreed that it will be useful to be informed of any such similar decisions made in future which affect the Rotherham population.  

*Action: CE*

### 4  
**Government Response to H&SC Committee’s Inquiry**

Chris Edwards referred to the recently published Government response to the recommendations of the Health & Social Care Committee’s inquiry into ‘Integrated care: organisations, partnerships and systems, received for information. Place Board acknowledged that it was helpful to receive relative national documents for information but recognised that Rotherham will continue to do its best for its local population.
The minutes from the July meeting were accepted as a true and accurate record.

**Rotherham ICP Place Plan & Agreement** - Following the approval of the Rotherham Place Plan at September’s Place Board, Lydia George advised that it is now progressing through Partner’s governance arrangements. Similarly, the approved version of the Rotherham Integrated Care Partnership Agreement is now being signed by Partner organisations after which a hard copy of the fully signed version will be disseminated to Partners.

**NHS England Consultation on the Integrated Provider Contract** – It was agreed that each partner organisation will respond individually to this consultation.

*Action: LG*

6 **Communications to Partners**

Gordon Laidlaw had no specific issues for Partners to note. However, Gordon will consider and liaise on communicating gluten free products prescribing and the new SEND college at Broom

*Action: GL*

David Roche updated Members that interviews for the post of Policy and Partnership Officer post were due to take place and he will confirm once a candidate has been appointed. This post will support the Health & Wellbeing Board and will be in attendance at this meeting working closely with Lydia George.

9 **Risk/Items for Escalation**

None.

10 **Future Agenda Items**

Future Agenda Items
- Communications & Engagement Strategy (Nov)
- Social Prescribing Strategy Update
- Ferns Evaluation (Jan 2019)

Standard Agenda Items
- Delivery Dashboard/performance framework
- Transformation Groups Update (as per rolling schedule)
  - C&YP - Child & Adolescent Mental Health
  - U&CC - Integrated Single Point of Contact
  - MH & LD - Core 24

11 **Date of Next Meeting**

Wednesday 7th November 2018, at 9am at Elm Room, Oak House

**Membership**

NHS Rotherham CCG (RCCG) - Chief Officer - Chris Edwards (Joint Chair)
Rotherham Metropolitan Borough Council (RMBC) - Chief Executive – Sharon Kemp (Joint Chair)
The Rotherham Foundation Trust (TRFT) - Chief Executive – Louise Barnett
Voluntary Action Rotherham (VAR) - Chief Executive – Janet Wheatley
Rotherham Doncaster and South Humber NHS Trust (RDaSH) - Chief Executive – Kathryn Singh
Connect Healthcare Rotherham Ltd (Rotherham GP Federation) – Dr Gok Muthoo

**Participating Observers:**

Joint Chair, Health and Wellbeing Board, RMBC - Cllr David Roche
Joint Chair, Health and Wellbeing Board, RCCG - Dr Richard Cullen

**In Attendance:**

Director of Legal Services, RMBC – Dermot Pearson
Head of Communications, RCCG – Gordon Laidlaw
Strategy & Development Lead, RCCG – Lydia George
Policy and Partnership Officer, RMBC – Vacancy
Deputy Chief Officer, RCCG – Ian Atkinson (as Delivery Team Place Joint Chair)