HEALTH AND WELLBEING BOARD

Date and Time:- **Wednesday 28 January 2026 at 9.00 a.m.**

Venue:- **Rotherham Town Hall, The Crofts, Moorgate Street, Rotherham. S60 2TH**

The items which will be discussed are described on the agenda below and there are reports attached which give more details**.**

Rotherham Council advocates openness and transparency as part of its democratic processes. Anyone wishing to record (film or audio) the public parts of the meeting should inform the Chair or Governance Advisor of their intentions prior to the meeting.

AGENDA

1. **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. **Communications**

7. **Minutes of the previous meeting (Pages 3 - 21)**

8. **Family Hubs (Pages 23 - 40)**
   Alex Hawley, Consultant in Public Health, to present an update on Family Hubs.

9. **Health and Wellbeing Strategy Priorities (Pages 41 - 50)**
   Oscar Holden, Corporate Improvement Officer and Emily Parry-Harries, Director of Public Health, to present an update on the Board's Strategy priorities

10. Carers Strategy 2026-2031 (Pages 51 - 84)

Katy Lewis, Carers Strategy Manager, RMBC, to present the Carers Strategy 2026-31.

11. Public Mental Health Action Plan (Pages 85 - 107)

Ruth Fletcher-Brown, Public Health Specialist, Adult Care, Housing and Public Health, to present updates from the Public Mental Health Action Plan (formally known as the Better Mental Health for All).

For Information

12. Items escalated from Place Board

13. Foetal Alcohol Spectrum Disorder Project (Pages 109 - 140)

To receive the report from Chris Clark- Project Lead, City of Doncaster Council, on the Foetal Alcohol Spectrum Disorder project, to raise the Board's awareness.

14. Better Care Fund (Pages 141 - 151)

15. Rotherham Place Board (ICB Business) (Pages 153 - 166)

Minutes of meeting held on 17th September, 15th October and 19th November, 2025

The next meeting of the Health and Wellbeing Board will be held on Wednesday 1 April 2026 commencing at 9.00 a.m. in Rotherham Town Hall.

JOHN EDWARDS,
Chief Executive.

HEALTH AND WELLBEING BOARD
26th November, 2025

Present:-

Jason Page	Medical Director, Rotherham Place NHS SYICB **In the Chair**
Chief Inspector K. Bradley	South Yorkshire Police (representing Chief Supt. Andy Wright)
Andrew Bramidge	Strategic Director, Regeneration and Environment
Councillor Cusworth	Cabinet Member, Children and Young People's Services
John Edwards	Chief Executive, RMBC
Kym Gleeson	Healthwatch Rotherham
Tina Hohn	Virtual School Leader for Children in Care (representing Nicola Curley)
Shafiq Hussain	Chief Executive, Voluntary Action Rotherham
Bob Kirton	Managing Director, The Rotherham Foundation Trust
Emily Parry-Harris	Director of Public Health
Claire Smith	Director of Partnerships, Rotherham Place, NHS SYICB
Ian Spicer	Strategic Director, Adults, Housing and Social Care

Report Presenters:-

Alexandra Hart	Public Health Practitioner, RMBC
Denise Littlewood	Health Protection Principal, RMBC
Joanne Martin	Transformation and Delivery, NHS SY
Lorna Quinn	Public Health Intelligence, RMBC
Hannah Thornton	Director of Services (Projects), Voluntary Action Rotherham
Steph Watt	Urgent and Community Care, NHS SYICB

Also Present:-

Councillor Brent	
Gilly Brenner	Public Health Consultant, RMBC
Millie Dales	Public Health Intelligence Practitioner, RMBC
Alex Hawley	Public Health Consultant, Public Health
Oscar Holden	Corporate Improvement Officer, RMBC
Dawn Mitchell	Governance Advisor, RMBC

Apologies for absence were received from The Mayor (Councillor Ismail), Councillor Baker-Rogers, Nicola Curley (RMBC), Chris Edwards (NHS SYICB) , Nicola Ellis, Toby Lewis (RDaSH) and Joanne McDonough (RDaSH).

26. DECLARATIONS OF INTEREST

There were no Declarations of Interest to report.

27. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

No questions had been received in advance of the meeting and there were no members of the public or press in attendance at the meeting.

28. COMMUNICATIONS

There were no communications to report.

29. MINUTES OF THE PREVIOUS MEETING

Consideration was given to the minutes of the previous meeting held on 24th September, 2025.

Resolved:- That the minutes of the previous meeting held on 24th September, 2025, be approved as a true record.

30. 2025/26 WINTER PLAN

Steph Watt, Portfolio Lead Urgent and Community Care, presented a report on the 2025/26 Rotherham Winter Plan together with the following powerpoint:-

Winter 2024/25

- Urgent and Emergency Care Programme focussed on increasing out of hospital pathways as alternatives to avoidable conveyances and admissions and reducing discharge delays
- Additional monies were invested across Place to support system flow over winter utilising Section 75 Better Care monies and the national Discharge Fund together with organisational investment by The Rotherham Foundation Trust (TRFT) and Council

Winter Schedules 2024/25

- Comprehensive vaccination programme co-ordinated across Primary Care, TRFT and the Council supporting vulnerable citizens, care homes and health and care staff
- Increased GP appointments including acute respiratory hub
- 'PUSH' Community Health and Social Care Teams responding to non-critical 999 calls to reduce ambulance conveyances, including new respiratory and mental health pathways
- Increased capacity on the virtual ward
- Additional staffing resource including Consultant and resident doctor medical cover, therapy, Social Worker, enablement and portering resource
- Extended opening hours for Community Ready Unit with support to ensure timely medicines
- Extension of patient transport
- Home from Hospital Pathway to reduce waiting times
- Priority services identified for children with plans for temporary reductions elsewhere to support peak pressures
- Reduce in out of area mental health placement
- Robust mental health digital offer

- Rotherham safe space provided additional out-of-hours support for individuals in crisis
- Voluntary sector support through Age UK Hospital Aftercare Service, Urgent and Emergency Social Prescribers and NHS Responders providing post-discharge medicine delivery service

Going into Winter 2025/26
Post Winter/Summer Period

- Successful winter schemes embedded into business as usual
- £7M investment in new medical SDEC and ways of working
- Transfer of Care Hub co-located in the community setting
- High impact work/pro-active care
- Increased capacity virtual ward including remote tech
- Enablement waiting lists reduced from high of 66 to record low of 9 as of 13th August 2025
- Impact of system flow roles
- 4 hour performance improving – 70%+
- NCTR metric improved, metrics for 7, 14 and 21 day delays and discharges pre-5.00 p.m. all compared favourably with the region and those with lower NCTR
- Understanding ED demand work to target and promote alternative pathways

Challenges

- Demand still high in community and ED
- High levels of acuity and complexity reflecting Rotherham's ageing population and demographic
- New ED attendance normal 300+ compared to c270s previously
- Playing out through system flow and pressure on discharge care co-ordination and community pathways
- Record high of 391 attendances as at 20th October 2025
- Escalation beds remained open over the summer
- 30 surge beds open in October
- High levels of scrutiny

National Performance Metrics 2025/26

- Reduce ambulance wait times for Cat 2 (stroke, heart attacks, sepsis and major trauma) from 35 minutes to 30
- Eradicate ambulance handover delays – maximum 45 minutes
- Ensure 78% of people who attend ED were admitted, transferred or discharged within 4 hours
- Reduce number of patients waiting over 12 hours for admission or discharge
- Reduce the number of people waiting over 24 hours in ED for mental health care
- Tackle discharge delays initially focussing on those over 21 days (14 and 7 days). Aim for complex discharge within 48 hours
- Increase the number of children seen within 4 hours

National Learning re Vaccinations 2024/25

- Importance of vaccination uptake to reduce attendances/staff sickness
- Plan for peaks based on southern hemisphere and monitor actual impact with flexibility to adapt plans
- Need to build annual leave/staff sickness into plans
- Review IPC what has and has not worked and how connects with overarching plan
- Consider how staff vaccination programme can be incentivised

National Priorities for 2025/26/Rotherham Plans

- Improve vaccination uptake and reduce sickness
  Targeted plans to increase citizen/staff vaccination rates in Primary Care, Public Health and TRFT. TRFT aiming for 5% increase
  Joint working to target areas of high foot fall for over 75s/immunosuppressed
  Staffing/resources based on southern hemisphere – peak from New Year/February and national data
  Staff wellbeing support and targeted rotas to cover annual leave/sickness
- Improve access to Primary Care
  High impact respiratory, diabetes and proactive care pathways including highly complex frail patients
  Community-based multi-disciplinary co-located Transfer of Care Hub to reduce avoidable conveyances, admissions and discharge delays through referral, triage and allocation to community pathways
  Investment in enablement to embed D2A pathway and release capacity for UCR and virtual ward
  Expansion of the virtual ward including remote tech to support 'amber' acuity including SDEC hypertension
  Community X-ray pilot for care homes
  Enhanced mental health offer – safe space, crisis support, on-line/text support
- Increase the number of people receiving urgent care in Primary, Community and Mental Health settings including UCR and virtual ward
- Meet the 45 minute ambulance handover standard - W45 live from September
- Improve flow through hospitals including meeting 4 hour performance and ambulance standards, reduce 12 hour and discharge waits
  ACT/RMBC service re-design service improvements – releasing capacity
  Additional medical, clinical staff and porters to support periods of high demand
  Increased capacity for care co-ordination/timely decision making via TOCH
  New single referral form to streamline processes and reduce delays
  Improved process for out-of-area discharges

Extended transport hours
Reduced TTOs and Age UK TTO delivery service

- Set local target to improve discharge times
  Discharge trajectory across pathways. Review of system flow in community bed base. New dashboard and system escalation process
- Reduce lengths of stay for those requiring overnight emergency admissions
  Understanding demand in ED targeted action plan
  Medical SDEC opened July 2025 reducing need for overnight admission, new paperless processing
  Extended/consistent SDEC opening

Organisation Development, Communications and Engagement

- Whole system working together to support right care, time, place and reduce pressure on individuals/teams
- Targeted organisational development work
- Champion roles
- Communications and engagement plan with national, SY ICB and local plans aligned
- Local communications informed by understanding ED demand analysis

Discussion ensued with the following issues raised/clarified:-

- The virtual ward was currently focussed on those patients with hypertension and allowed them to be monitored at home and not brought into hospital for monitoring
- Section 25 monies had been used to “grow” enablement
- Ongoing high demand seen particularly as move into the winter with a lot of poorly patients in hospital. Delayed discharges were checked on a daily basis. The Out of Hospital Pathways were working but these were people who needed to be in hospital
- There were additional appointments in practices and also through the Respiratory Infection Hub
- The Yorkshire Ambulance Service had worked hard with the Trust to introduce a new pathway around mobile x-rays which was being piloted in care homes. Good feedback was being received from the homes
- W45 was a national initiative where if an ambulance had been waiting for more than 45 minutes the crew handed over the patient regardless of what the position was in ED. A whole new process had been put in place in the acute hospital to manage that situation and had been used as a national exemplar
- A number of schemes were in place to support the health and wellbeing of staff together with organisational development support and training around the changes being implemented
- The Emergency Department Care Hub provided an alternative to ED. Some patients were directed straight there from Primary Care

- A key part of the Winter Plan was the communication plan. Members of the public complained that they could not get an appointment; they could but may not be at the time and place they wanted. Work was being undertaken around understanding ED demand and why people attended when they did

Resolved:- That the information provided be noted.

31. WORKING WITH THE VOLUNTARY AND COMMUNITY SECTOR TO PROVIDE A MORE INTEGRATED APPROACH TO CARE

Hannah Thornton, Director of Services, Voluntary Action Rotherham, presented a report on the work being undertaken to further understand the role of the Voluntary Community and Social Enterprise Sector (VCSE) in contributing to the health, wellbeing and care across the Borough.

The following powerpoint presentation was given:-

Rotherham VCSE – State of the sector 2024

- 1,399 organisations – the majority of which were small (£10,000-£100,000) or micro (under £10,000 income)
- 3,388 employees worked in charities in Rotherham
- £120M estimated contribution of employees to the economy per annum
- 6,017 people volunteered in charities in Rotherham
- £17M estimated contribution of volunteers to the economy per annum
- 1,774 people were trustees in charities in Rotherham
- Overall income of charities in Rotherham - £97M
- Many organisations had a focus on diversity, equity and inclusion. Some were specifically dedicated to serving particular groups including:-
  Older people (26%)
  Disabled people (21%)
  People who were educationally or economically disadvantaged (14%)
  Communities experiencing racial inequity (13%)
  Young people (13%)

Connecting with People's Health

- Specialist and condition-specific
  Condition-specific peer support, Domiciliary Care, Specialist Carers support, Palliative Care, Counselling and Therapy
- Health creation and maintenance
  Physical and mental wellbeing, family support, creative health, faith and spirituality, support for older people, nature connection, local community hubs, social connection
- Addressing wider determinants
  Learning skills and digital inclusion, information, advocacy and benefits advice

Connection with people where they are
- Social-economic groups and deprivation
- Inclusion health and vulnerable groups
- Protected characteristics in the Equality Duty
- Geography

Funding
- Grants from Trust and foundations (31%)
- Fees and earned income (22%)
- Grants from the public sector (18%)
- Contracts of service agreements (11%)

Primary Care – Proactive Care
- Risk stratification of patients
  Moderate to severe frailty patients with 2+ hospital admissions in the last 12 months
  Diabetes and high risk of admission
  Respiratory and high risk of admission
- Rotherham Social Prescribing Service
- Dementia Carers Resilience Service
- Micro-Commissioned Support

Urgent and Emergency Care Centre
- Identification of patients on/awaiting discharge
  Integrated Discharge Team
  Urgent Therapy Team
  Reablement Team
  Healthy Hospitals Programme
  Community Hospital Admission Avoidance Team

Social Prescribing Community Hub Network
- Cortonwood Comeback Centre
- High Street Centre, Rawmarsh
- Unity Centre, Town Centre
- Kimberworth Park Community Partnership
- Dinnington Area Regeneration Trust
- The Learning Community, Dinnington
- Treeton Village Community and Resource Centre
- Kiveton Community Hub
- Rawmarsh Social Prescribing Hub

Primary Care – Integrated Mental Health Hubs
- Care Provision for people living with SMI
- In the context of the CMHT this included psychosis, bipolar disorder, personality disorder diagnosis, eating disorders, severe depression and mental health rehabilitation needs
- May be co-existing with other conditions such as frailty, cognitive impairment, neurodevelopmental conditions or substance use

Social Prescribing – Return on Investment

- Sheffield Hallam University's 4 year evaluation of the Service (published August 2024) identified
  - Reduced in-patient admissions for all patients who had been admitted to hospital more than twice in the 12 months prior to RESPS support
  - Reduced attendances at A&E for patients below the age of 80 during the 12 months following RSPS support

Discussion ensued with the following issues raised/clarified:-

- It had helped individuals secure £1.3M in additional benefits
- Somehow in the label "health and wellbeing" there was a need to fit in Primary Care
- The need to include LGBTQ+
- Need to reflect the increasing male suicide rate
- Important to engage with the public in a non-medicalised way and in a language they would understand
- The emphasis on the person and their journey/pathway made a big difference to service-led response
- Collaboration was vitally important to strengthen available resources

Resolved:- That the examples of partnership, integration and voluntary, community and social enterprise infrastructure be noted.

32. SCHOOL SURVEY ANALYSIS

Lorna Quinn, Public Health Intelligence Specialist, presented an analysis of the health and wellbeing related questions of the Rotherham School Survey and trend analysis.

The following powerpoint presentation was given:-

Participation Overview

- All 16 Rotherham secondary schools responded
- Feedback was also received from the Pupil Referral Unit in Rotherham and students who were elective home educated
- A total of 4,602 students participated in the 2025 survey
- 2025 participation rate – 62.4% of eligible students took part. Total survey participants – combined = 4,602 Year 7 = 2,519 and Year 10 = 2,083

Overall Positive Trend

- Decrease in alcohol consumption, decrease in regular smoking (below 2% regular), decrease in 'poor' physical health (-20% fair and poor) and a decrease in students who do not eat breakfast (1 in 6)

Overall Negative Trend

- Increase of Year 10's regularly vaping, increase in poor mental health and an increase in bullying

Health and Wellbeing

- 4 in 5 young people reported their physical health as excellent or good
- 4 in 5 young people exercised at least twice a week
- 90% of young people had been to a dentist in the last 12 months
- 63% of young people reported their mental health as good or excellent
- 40% of young people had been bullied in the last 6 months but this was higher in younger years and girls

Factors to consider

- Those who did regular physical activity were less likely to have poor mental health
- Young people who engaged in culture were less likely to experience poor mental health and there were positive associations with physical activity

Next Steps

- To promote and refer to the results when considering the needs of our children and young people
- Opportunities to support the physical activity and culture element
- Document to be published alongside the Joint Strategic Needs Assessment
- Further work with CYPS
- Colleagues could request bespoke analysis

Discussion ensued with the following issues raised/clarified:-

- The survey was circulated in July/August. Pupils were given dedicated time to complete it
- The outcome of the survey was sent to all school leaders for them to consider the results for their particular school
- The survey included Year 7 and 10 pupils in alternative provision and special schools. There was likely to be a difference in the responses but that would be within the indepth analysis
- Work was to take place shortly with children and young people working with the School Games Organisation in schools to facilitate inschool engagement
- A real emphasis of the Sport England work was to give children and young people an opportunity to try different activities and have fun
- Elected Members each had small funding pots and may wish to use it to fund activities in their area – Ward specific data would be helpful

Resolved:- That the findings of the 2025 School Survey be noted.

33. HEALTH AND WELLBEING PRIORITIES UPDATE

Oscar Holden, Corporate Improvement Officer, presented an update on the Health and Wellbeing Priorities. The Health and Wellbeing Board Strategy 2025-30 was agreed at the Board's meeting in June and endorsed by Cabinet on 15th September, 2025 (Minute No. 40 refers). The priorities, agreed in principle, were:-

Priority 1: We will reduce the prevalence of smoking in Rotherham to 5% by 2030
Priority 2: We will increase the wellbeing of the people of Rotherham to above national average by 2030
Priority 3: We will increase the proportion of people who feel they have the support and resources they need to manage their own health
Priority 4: We will promote environments which support and enhance wellbeing

The finalised wording and metrics for the priorities had been further discussed at a meeting on 24th November, 2025:-

Priority 1 "We will reduce the prevalence of smoking in Rotherham by 5% by 2030"
Metrics
- Smoking rate (from existing Public Health metrics)
- Another metric that potentially measured smoking prevalence by areas of deprivation

Priority 2 "We will increase the good mental health of the people of Rotherham towards the national average by 2030"
Metrics
- Happiness measure for adults and a similar source for children and young people (from the Joint Strategic Needs Assessment)
- Life satisfaction question (Office of National Statistics)

Priority 3 "We will increase the proportion of people who feel they have the care and resources they need to support their own health"
Metrics
- Measure for soft services access
- Measure for families and wider support

Priority 4 "People in Rotherham have access to environments that promote their health and wellbeing and they understand why this matters"
Metrics
- Community Safety measure (from existing Safer Rotherham Partnership metrics)
- One other metric that will include one of the following: access to healthy food, adults take recommended exercise, air quality, public transport

Action Plan

Meeting	**Priority focus at Board meeting**	**Report/Strategy focus at Board meeting**	**Other significant item**
2026			
June	Priority 1	Integrated Care Board Forward Plan	Integrated Care Strategy
September	Priority 2	Joint Health and Wellbeing Strategy	Other Special Interest Groups System Plans
November	Priority 3	Joint Strategic Needs Assessment	Better Care Fund
2027			
January	Priority 4	Pharmaceutical Needs Assessment	Review of system pressure for winter
March	Review of year	Director of Public Health report	Forward plan

Oscar also reported on the following feedback from the Children and Young People's Partnership Board as follows:-

- Consider the suggestions for smokefree zones, mental health support and family-friendly initiatives
- Explore ways to promote services and activities such as through social media and in community spaces
- Continue to involve children, young people and families in shaping and renewing the strategy priorities.

Councillor Baker-Rogers had been invited to the next Partnership Board meeting in January to continue to involve children and young people in the Health and Wellbeing Board. These would be considered further once the new action plan was in place.

Discussion ensued with the following issues raised/clarified:-

- Healthwatch UK had put together a detailed consultation and feedback on the 4 priorities. These would be discussed at the January Board meeting
- Some of the measures were easier to measure than others. Metrics were needed that would give sufficient confidence that they were improving
- Children and young people had been rarely mentioned in the past but were now feeding their views into the priorities/discussions taking place

Resolved:- (1) That the 4 Rotherham Health and Wellbeing Strategy 2025-30 Priorities be agreed.

(2) That a further discussion take place at the January meeting on the specific metrics for the corresponding Priorities.

(3) That the feedback on the suggested priorities provided by the Children and Young People's Partnership Board in October 2025 be noted.

(4) That the new approach to the Health and Wellbeing action plan be agreed.

34. HEALTH PROTECTION ANNUAL REPORT

Denise Littlewood, Health Protection Principal, presented a summary of the assurance functions of the Rotherham Metropolitan Borough Council Health Protection Committee.

Denise gave the following powerpoint presentation:-

Assurance Overview

- Collaborative Multi-Agency Efforts
  Multiple agencies in Rotherham worked together to safeguard Public Health through co-ordinated health protection arrangements
- Health Protection Domains
  The report covered infectious disease control, screening, immunisation, emergency preparedness and infection prevention
- Stakeholder Assurance and Reporting

Screening Programmes

- Improved Screening Uptake – screening programmes in Rotherham had increased participation especially in breast, bowel and cervical cancer screenings
- Accessibility for Learning Disabilities – collaborative efforts had improved screening accessibility for individuals with learning disabilities
- Diabetic Eye Screening Progress – Diabetic Eye Screening Programme addressed backlog and maintained compliance with national invite interval standards
- Bowel Screening Age Extension – bowel screening programme expanded age coverage supporting early detection and national policy compliance

Immunisation Programmes

- MMR Vaccination Coverage – MMR dose 1 coverage by age 2 remained above 90%, aiming for 95% for effective community protection

- Adolescent Immunisation Challenges – Post-pandemic decline in adolescent vaccinations led to targeted interventions to improve school-based uptake

- HPV Vaccination Focus - HPV vaccination aligned with national cervical cancer elimination strategies to reduce disease incidence

- RSV Vaccination Introduction - RSV vaccine launched in 2024 for pregnant women and older adults to protect vulnerable groups

- Pertussis Vaccination for Pregnant Women – vaccination update amongst pregnant women remained above the 60% optimal threshold amid rising national cases and infant deaths

- Targeted Seasonal Flu Vaccination - seasonal flu vaccination targeted high-risk groups including young children, pregnant women and immunocompromised individuals through focused initiatives

- Focus on Vulnerable Populations - efforts prioritised individuals with chronic respiratory conditions, learning disabilities or severe mental illness to reduce infectious disease impact

- Healthcare Associated Infections - pathogen Surveillance – Monitoring key pathogens like MRSA, MSSA, C.Difficile and E.Coli was essential to control infection spread in healthcare settings

- Effective MRSA Control - cases decreased significantly reflecting success of targeted infection control measures and protocols

- Antimicrobial Stewardship - increased cases of C.Difficle were addressed by improved antimicrobial stewardship and staff interventions

- Care Home Hydration Project - initiatives in care homes supported infection control by improving patient health and reducing complications

- Low TB Incident in Rotherham - Rotherham maintained a low TB incidence despite rising national rates through effective local health strategies

- Enhanced Case Management - complex TB cases required enhanced case management to ensure proper treatment and thorough follow-up

- Collaborative Health Protection - regional collaboration and cohort reviews promoted best practices in TB screening and management

- Support for Underserved Populations - proactive TB management included ensuring care and support for underserved and vulnerable populations

- Infection Prevention and Control (IPC) - leadership and Co-ordination – Senior Public Health Practitioner led IPC initiatives ensuring focused and organised infection control efforts across the community

- IPC Audits and Outbreak Management - regular audits and outbreak management support helped identify risks early and enabled rapid response to infection incidents

- Community Engagement Training - engaging care homes and co-ordinating the IPC Champions Network strengthened infection prevention practices and staff competencies

- Strategic Integration - embedding IPC within local authority structures ensued sustainable and cohesive infection control to protect public health

- Emergency Planning and Response - Rotherham managed 33 emergency incidents in 2024/25 showing strong operational readiness and resilience

- Training Exercises - participation in Exercise Solaris and preparations for Exercise Pegasus had improved emergency response capabilities

- Regional Co-ordination - the upcoming South Yorkshire-wide rest centre plan enhanced co-ordinated support during emergencies

- Preparedness and Improvement - continuous updates to planning and response frameworks emphasised public health safety during crises

Strategic Priorities for 2025/26

- Community IPC Strengthening – focus on enhancing infection prevention and control through community-based programs for greater health impact
- Vaccination and Screening Uptake – improve vaccination and screening rates specifically in deprived and underserved populations to reduce health disparities
- Preparedness and Surveillance – prepare for adverse weather and pandemics whilst enhancing surveillance systems to detect emerging health threats early
- Addressing Antimicrobial Resistance – tackle antimicrobial resistance with targeted health strategies to protect public health and ensure effective treatments

Discussion ensued with the following issues raised/clarified:-

- Indepth scrutiny required of the MMR vaccination take up as some areas of the Borough had low uptake
- The flu season had started earlier this year
- The country was very close to the threshold of no longer being a low incidence country for TB. However, Rotherham still had cases which were more complex and took more time to manage. Need to understand what the level of TB was in the underserved population
- The changes in the ICB and reorganisation were a high risk as a lot of Health Protection Services sat within it and would remain to do so
- Positive communication about vaccination and the benefits they could bring to an individual and the wider population
- There were to be huge changes to the vaccination programme next year which would have to be worked into the plans
- Strengthen links between Public Health and Neighbourhood working
- The voluntary and community sector knew which areas had low take-up of vaccinations and would be happy to support engagement with residents

Resolved:- (1) That the findings of the annual report be noted.

(2) That the 2025/26 strategic priorities be endorsed.

35. ROTHERHAM FOOD NETWORK

Alexandra Hart, Public Health Practitioner, presented an overview of the Rotherham Food Network including the vision and action plan.

Alexandra gave the following powerpoint presentation:-

Why food matters
- Relevance across policy areas
- 4 of 5 top risk factors related to diet
- ¾ of Rotherham adults were overweight/obese
- High rates of overweight/obesity in children and young people
- Inequality driven by poverty

Food insecurity and inequality
- Inequalities in disposable income made healthy options too expensive
- Less healthy food was cheaper per calorie
- Marketing and offers promoted unhealthy options

Update
- Refresh of the action plan to cover the next 5 years
- Interest in working groups for Youth Cabinet and food growing
- Continuation of Food in Crisis Partnership
- Food Works project created 10 Just Meals freezer locations across Rotherham

Food Works Project
- £60,000 over 2 years from March 2025
- Installing 10 freezers within local community spaces
- Provided healthy surplus food derived ready meals for minimum £1
- Evaluation to follow and inform year 2

Risks and issues
- Food governance and strategy
- Good Food movement
- Healthy food for all
- Sustainable food economy
- Catering and procurement
- Sustainable food environment

Shafiq Hussain offered to support the Public Health Team to implement their work further. It was noted that David from VAR had been very helpful to progress the work so far.

Resolved:- (1) That the update from the Rotherham Food Network be noted.

(2) That the impact of lack of access to healthy sustainable food in Rotherham on health outcomes be noted.

(3) That the challenges that arose from the tensions of poverty, regeneration, economic growth, climate change and the accessibility of healthy sustainable food be noted.

(4) That the Board consider how Board Members could commit to driving forward any elements of the action plan.

36. NEIGHBOURHOOD WORKING

Joanne Martin, Programme Lead, Transformation and Delivery, NHS South Yorkshire, presented an update on the Neighbourhood Working programme.

Rotherham had been accepted onto the National Neighbourhood Health Implementation Programme (NNHIP), a national initiative aimed at accelerating neighbourhood working and strengthening proactive care.

Addressing health inequalities through the Programme went beyond improving outcomes for individuals; it strengthened the entire health and care system. By focusing on proactive care and targeted prevision, the aim was to reduce the disproportionate burden of disease in deprived communities and among minority groups. This approach ensured that those most at risk received timely, co-ordinated support which not only improved quality of life but also prevented escalation to acute care.

The programme supported a cultural shift towards prevention and community-based care, building resilience and equity across the system.

The Programme's collective role was to create the conditions for NbH to flourish:-

The Project
- Building on existing mechanisms
- Focussing on a defined cohort
  Adults with long term conditions and rising risk
  Local prioritisation, existing pilot schemes
  Most likely to have highest impact
- Refine, adapt, generate new ideas
- Rapid cycle testing driven by data
- Shared learning

The People
- Working towards a shared purpose
- Building on relationships across the system
- Taking collective action and shared accountability
- Being curious and open-minded
- Not being afraid of 'failure'
- Being action and delivery focussed

Suggested Neighbourhood Programme
- National Neighbourhood Programme – Proactive Care – Enhance Current Model
  Meets national cohort request
  Rotherham Place approach based on PCN footprint
  Involves all stakeholder participation
  Baseline established
  Data drive via Eclipse and judgement

- Local Neighbourhood Programme – Place wide
  Focus on prevention of diabetes and heart health
  Suggest focus on key drivers on long term conditions i.e. smoking, obesity and hypertension
  Target focus – Eastwood Village

The presentation also set out the proposed governance structure.

Discussion ensued with the following issues raised/clarified:-

- 18 identified people who attended the sessions including patients
- It was a 12 month programme and insufficient time to re-look at structure and re-organise teams but focus on what the function was of all the teams and the outcome could follow

- Ensure providing consistent universal provision of services but sufficiently flexible to be able to target communities across the Borough. It would be data driven as to where the resources needed to be focussed
- The workshops had extended beyond the national ask i.e. adults with 2 or more LTC and wanted to tackle prevention, support children, getting people fitter, tackle frailty and end of life care and getting people back to work
- It was not a new model for Rotherham but about enhancing the existing model
- The Operational Group had been set up and met once. It was currently feeding into the Place Board which had agreed to sponsor this as a programme
- How could Elected Members and Neighbourhood Co-ordinators support the Programme?
- It was a national Programme that was already 3 months into the 12 months. Undertaking a massive restructure across Rotherham to shape the way Social Care worked and Community Teams were provided into bespoke neighbourhoods would detract from getting the positive patient outcomes

Resolved:- (1) That the programme of the National Neighbourhood Health Implementation Programme (NNHIP) and the alignment of national requirements with Rotherham's local priorities be noted.

(2) That the proposed governance structure, including the establishment of the Operational Group reporting to the Place Leadership Team, and onward reporting to the Health and Wellbeing Board as required, be approved.

37. ITEMS ESCALATED FROM THE PLACE BOARD

There were no issues to report.

38. BETTER CARE FUND

a) Better Care Fund (BCG) Quarter 1 Reporting Template and Call-Off Partnership/Work Order 2025/26
It was noted that the BCF Q1 Reporting Template, covering the period 1st April to 30th June, 2025, had been submitted to NHS England on 15th August, 2025.

At the end of Quarter 1, Rotherham was 40 over target resulting in a population rate of 227.74 (per 100,000) against a Quarter 1 target population rate of 153.07. Based on previous learning, it was anticipated that the figures would reduce following data validation and mitigation activity.

It was further noted that the BCF Call-Off Partnership/Work Order 2025/26 had been fully signed by both partner organisations and in place by 30th September, 2025.

(b) BCF Quarter 2 Template
It was noted that the BCF Q2 Reporting Template, covering the period 1st July to 30th September, 2025, had been submitted to NHS England on 11th November, 2025.

During Q2 there had been 116 new admissions against a target of 82 although this was expected to be revised downward in the coming months.

Resolved:- (1) That the submission of the BCF Quarter 1 and 2 documentation to NHS England by respective deadlines, be noted.

(2) That the submitted of the Better Care Fund Call-Off Partnership/Work Order for 2025/26 be approved.

39. ROTHERHAM PLACE BOARD ICB BUSINESS

The minutes of the Rotherham Place Board ICB Business meeting held on 16th July, 2025, were noted.

40. ROTHERHAM PLACE BOARD MINUTES - PARTNERSHIP BUSINESS

The minutes of the Rotherham Place Board Partnership Business meetings held on 16th July, 2025, were noted.

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Agenda Item 8

Rotherham Metropolitan Borough Council

BRIEFING	**TO:**	Health and Wellbeing Board
	DATE:	28th January 2026
	LEAD OFFICER:	Alex Hawley Consultant in Public Health (Best Start and Beyond) Adult Care, Housing and Public Health Kirsty Woodhead Head of Service Family Help Children & Young People's Services
	TITLE:	Family Hubs Progress Update and Extension

1. Background

1.1 This briefing provides an update on the successful delivery of the three-year transformation project, the embedding of the Family Hub model, extended for a fourth year, and the expectations and focus of the programme until under the end of the next funding period (2028).

1.2 The Family Hubs and Start for Life Programme has been in place for three and a half years, following the initial three years of funding and the 12-month extension from 1st April 2025 to 31st March 2026. Year four of the programme provided an opportunity to explore the "go furthers" outlined in the national guidance, enabling local authorities to continue to strengthen delivery, innovate, and deepen integration across services.

1.3 The Family Hub Programme in Rotherham operates through a strong partnership approach, bringing together Rotherham Metropolitan Borough Council (RMBC), local health services including the 0-19 Service, Midwifery and the Voluntary and Community Sector (VCS) to deliver integrated support for families.

1.4 **Family Hubs**

Rotherham has three main Family Hubs across the Borough:

- Brookfield Family Hub
- The Place Family Hub
- Maltby Stepping Stones Family Hub

These buildings are currently designated (with the DfE) Children's Centres (0- 5); however, delivery has been expanded through the Family Hubs Programme to offer services to families with children aged 0-19 (25 with SEND).

These buildings provide co-location of services such as Early Help, Children's Social Care, 0-19 Public Health Nursing, Midwifery and other agencies delivering Family Hub Services. A range of Family Hub services are typically delivered from these buildings, including but not limited to:

- Parenting support, such as parenting groups and discussion groups.
- Peep learning together groups.
- Midwife appointments.
- Health visitor and nursery nurse appointments.

- Infant feeding support.
- Breast pump loan scheme.
- Antenatal classes and sessions for expectant parents.
- Groups and activities for children under 5 and their families, for example stay and play, baby massage, sensory sessions.
- Groups for young people such as targeted youth groups.
- Groups for parents of children with Special Educational Needs and Disabilities.
- Employment support from DWP Family Community Work Coaches.
- Peer support for families affected by perinatal mental health.

Attendees to these buildings are greeted by someone on reception who has undertaken a Family Hubs induction and can support and advise families to access services they might need.

1.5 **RMBC Family Hub Building**

Rotherham has four buildings, three of which are currently designated (with the DfE) Children's Centres (0- 5) which form part of the Family Hubs system across the Borough:

- Dalton Family and Children's Centre
- Dinnington Early Help Centre
- Dinnington Family and Children's Centre
- Ferham Family and Children's Centre

These buildings may have some co-located services such as Early Help, Midwifery and other agencies delivering Family Hub services, however due to the building size, this is on a lesser basis than the main Family Hub sites detailed previously. The range of Family Hub services typically delivered from these buildings, include but is not limited to:

- Parenting support, such as parenting groups and discussion groups.
- Peep learning together groups.
- Midwife appointments.
- Infant feeding support.
- Connectivity to the breast pump loan scheme.
- Groups and activities for children under 5 and their families, for example stay and play, baby massage, sensory sessions.
- Groups for young people such as targeted youth groups.
- Peer support for families affected by perinatal mental health.

1.6 **Family Hub network within the Voluntary and Community Sector (VCS)**

To support families to access Family Hubs services within their communities, Rotherham commissions organisations from the VCS to be part of the Family Hub network within the overall system. The network is commissioned annually and therefore subject to change. Currently the following organisations are part of the Family Hub network:

- REMA
- Swinton Lock
- Rotherham Parent and Carer Forum
- Jade Youth and Community Centre
- YWCA Yorkshire
- Clifton Learning Partnership
- Activate

- Bright Stars
- The Fun Hub
- Grimm and Co
- Kiveton Park Community Trust

These buildings don't typically have co-location of services but are places where families can access or be connected to some of the Family Hubs services/activities. The services delivered in these buildings will vary, however services which are typically delivered might include:

- Parenting support, such as parenting groups and discussion groups.
- Peep learning together groups.
- Infant feeding support.
- Groups and activities for children under 5 and their families, for example stay and play sessions.
- Groups for young people such as targeted youth groups.
- Peer support for families affected by perinatal mental health.

1.7 **Outreach services**

The Family Hubs programme recognises that some families face barriers to accessing services, therefore we include flexible, community-led support that responds to local needs. This means some of the Family Hubs services are delivered on an outreach basis, meaning they are delivered in other community venues across the Borough. These buildings include, but are not exclusive to local community centres, libraries, faith organisations and schools. These services are shaped on the needs within communities therefore they vary however, some of the services currently delivered include:

- Community led infant feeding sessions such as Big Latch event, Picnic in the park.
- Parenting support, such as parenting groups and discussion groups.
- Peep learning together groups.
- Midwife appointments.
- Health visitor and nursery nurse appointments.
- Infant feeding support.
- Antenatal classes and sessions for expectant parents.
- Groups and activities for children under 5 and their families, for example stay and play, baby massage, sensory sessions.
- Groups for young people such as targeted youth groups.
- Groups for parents of children with Special Educational Needs and Disabilities.

1.8 The Family Hubs programme has a strong infrastructure in place:

- Clear programme management structure along with numerous workstream leads to oversee delivery.
- Regular communication and engagement are supported through the Best Start in Life Guide and the monthly Family Hub newsletter, which keeps partners and families informed of services and support available through the programme.
- Governance and performance are embedded through a monthly operational group. Separate quarterly performance and communication meetings are scheduled.
- Initiatives such as Baby Packs have had a positive impact on registrations, helping to connect families with services early, with 93% of families agreeing to register for a family hub.

- Regular reporting mechanisms established to Department of Health & Social Care and Department of Education.

2. Key Issues

2.1 **Family Hub Programme Outcomes**

The programme has captured case studies showcasing success stories from volunteers, fathers, and engagement with ethnic minority groups. These stories highlight the impact of Family Hubs in building confidence, improving access to support, and fostering inclusive community engagement.

2.2 **Transformation:**

The first four years of the programme were intended to be a largely transformational project and has led to improved digital connectivity by using online tools and platforms to link families with services, resources, and information in a more accessible and efficient way. The network has been developed to support families access to services and the partners involved in the programme have worked together to develop integrated support for children and families.

2.3 **Parenting Support:**

The programme has expanded support for parents and carers by offering evidence-based sessions, co-facilitated to help parents and soon-to-be parents with aspects of parenthood. The programme has introduced a peer support and volunteer offer to complement targeted outreach and interventions, with 29 active volunteers.

The programme has an improved universal and targeted evidence-based parenting support offer with face-to-face programmes delivered across the Borough, alongside access to online programmes for those who prefer this approach. Access to online programmes that can be completed at their own pace, and convenience offers greater flexibility for parents and carers who may not usually complete programmes. As of November 2025, the Togetherness (previously Solihull) online programmes had 681 registered learners.

One example of tailored support was delivered through a partnership with Rotherham Ethnic Minority Alliance (REMA), who engaged mothers that would not normally access services. All participants successfully completed the Triple P parenting programme, and they were positive about its impact and how it helped build confidence and engagement with wider Family Hub support.

2.4 **Infant Feeding:**

The programme has enabled an expansion of the infant feeding offer with a recruitment and training pathway for infant feeding peer support volunteers led by the NHS Infant Feeding Lead and a Volunteer Co-ordinator based in Voluntary Action Rotherham. This has seen an increase in the number of infant feeding peer supporters, with a focus on recruiting women from under-represented ethnic backgrounds. Since quarter 2 of 2023/2024, 51 infant feeding peer supporters have been trained.

Six Children's Centre sites (part of the Family Hubs network) have achieved UNICEF Baby Friendly accreditation Stage 1:

- Brookfield Family Hub
- The Place Family Hub
- Maltby Stepping Stones Family Hub
- Dalton Family and Children's Centre
- Dinnington Family and Children's Centre

- Ferham Family and Children's Centre

39 staff have completed UNICEF Baby Friendly Initiative Managers Training.

2.5 **Perinatal Mental Health:**
At the start of the Family Hub programme, perinatal mental health awareness was identified as a major gap and resulted in significant investment in training for the Family Hub and wider workforce. Over 300 practitioners from across the Family Hub multi-agency workforce have completed perinatal mental health training to ensure that the workforce are equipped to effectively identify and support perinatal mental health.

In addition to co-located multi-agency staff in the main Family Hubs, the programme also works jointly with local charity Light Peer Support to provide support to families affected by perinatal mental health, with groups delivered from the Family Hubs.

Completion rates of the Maternal Mood questionnaire within 8 weeks of baby's birth, have steadily risen from 70.4% to 86.9% in quarter 3 of 2023/2024, evidencing an improvement in early identification of perinatal mental health.

2.6 **Home Learning**
As part of the Family Hubs and Start for Life Programme, the Department for Education required investment in the Peep Learning Together Programme. This is a programme to help parents, carers and practitioners share ideas and simple low-cost activities to support a baby and/or child's learning in everyday life, through talking, singing, play, and reading. The sessions are also an opportunity for families to meet and gain peer support. The programme covers personal, social, and emotional development, communication and language, early literacy, early maths, health, and physical development.

The programme has been embedded as part of the Family Hubs offer for parents and carers and a referral pathway has been established to support easy access. As of November 2025, 219 families have attended sessions since January 2024. It anticipated that they take the learning from the programme into their family home, and their engagement with their children.

2.7 **Parent Carer Panels:**
A key aim of the programme is to have a Parent and Carer Panel with representation from pregnant women, parents and carers of children under the age of 2. A Parent Carer Panel was established which put the needs of local babies and families at the centre of service design and delivery. The panel has been a significant contributor to the development of the programme with examples of their involvement with the programme including co-producing the Start for Life Offer and shaping the Perinatal Mental Health Pathway. The panel meet monthly and representatives from the panel attend the monthly FamilyHubs Operational Group to ensure that engagement with the Parent Carer Panel ensures continuous improvement of the Family Hubs programme.

2.8 **Start for Life Offer:**
The programme required the publication of a Start for Life offer for parents, carers and their families which sets out the services and support available to families in the borough during the first 1,001 days of a baby's life. The Parent Carer Panel were invaluable in this piece of work, ensuring that Rotherham's Start for Life offer was clear, easy to use, family friendly in its production, with relevant content.

The Start for Life offer is available to all families both digitally and physically and includes essential support that any new family might need: midwifery, health visiting,

	mental health support, infant-feeding advice and specialist breastfeeding support, safeguarding and services relating to SEND. The Guide was originally distributed by midwives but is now provided within the Baby Packs and across the system.
2.9	**Extension of Family Hubs programme:** In July 2025, in the policy paper 'Giving every child the best start in life', the Government set out its intention to strengthen support services for families, and to build on the Family Hubs and Start for Life approach (as well as their previous Sure Start approach), to create 'Best Start Family Hubs' across all areas of the country. In December 2025, it was announced that there will be a further three years of funding (2026/27, 2027/28, and 2028/29), extending to every local authority in England. The extended funding will transform and scale up early-years and whole-family support by embedding the Family Hubs delivery model, building a network of up to 1,000 hubs nationwide, and continuing to invest in Start for Life services (now known as 'Healthy Babies Programme'), tackling inequalities, and aligning with the government's broader early-intervention and child development goals. On 6th November 2025, Rotherham received a provisional allocation of £5,052,800 for financial years 2026-29. At this stage there is insufficient detail about expectations of delivery to be able to specify the plans for Rotherham's approach beyond March 2026. However, it is clear there is a new expectation to deliver a national target for achieving Good Level of Development for reception age students, by the end of the academic year of 2028. Moreover, there is now a strong commitment from Government to retaining the Family Hubs identity, supported by the continued roll out of Best Start Family Hubs across the Country and ongoing funding for Rotherham.
3. Key Actions and Timelines	
3.1	A management information data report and delivery plan progress updates were submitted to the DfE in September 2025 and are required on a quarterly basis, with follow-up progress interviews taking place monthly with the DfE.
3.2	The remaining Management Information (MI) Data Returns for year 4 of the programme have submission deadlines of 6th March 2026 (Q3 2025/26) and 22nd May 2026 (Q4 2025/26).
3.3	Rotherham's Best Start Local plan to be published on Council website by 31st March 2026, setting out our approach to Good Level of Development. There will also be a separate delivery plan for the Best Start Family Hubs and Healthy Babies programme.
3.4	April 2026 onwards will see the continuation of the Family Hubs Programme through Best Start Family Hubs and Healthy Babies programme.
4. Recommendations	
4.1	To note the progress made in the last four years, and the continuation of the programme with Best Start Family Hubs 2026-2029.

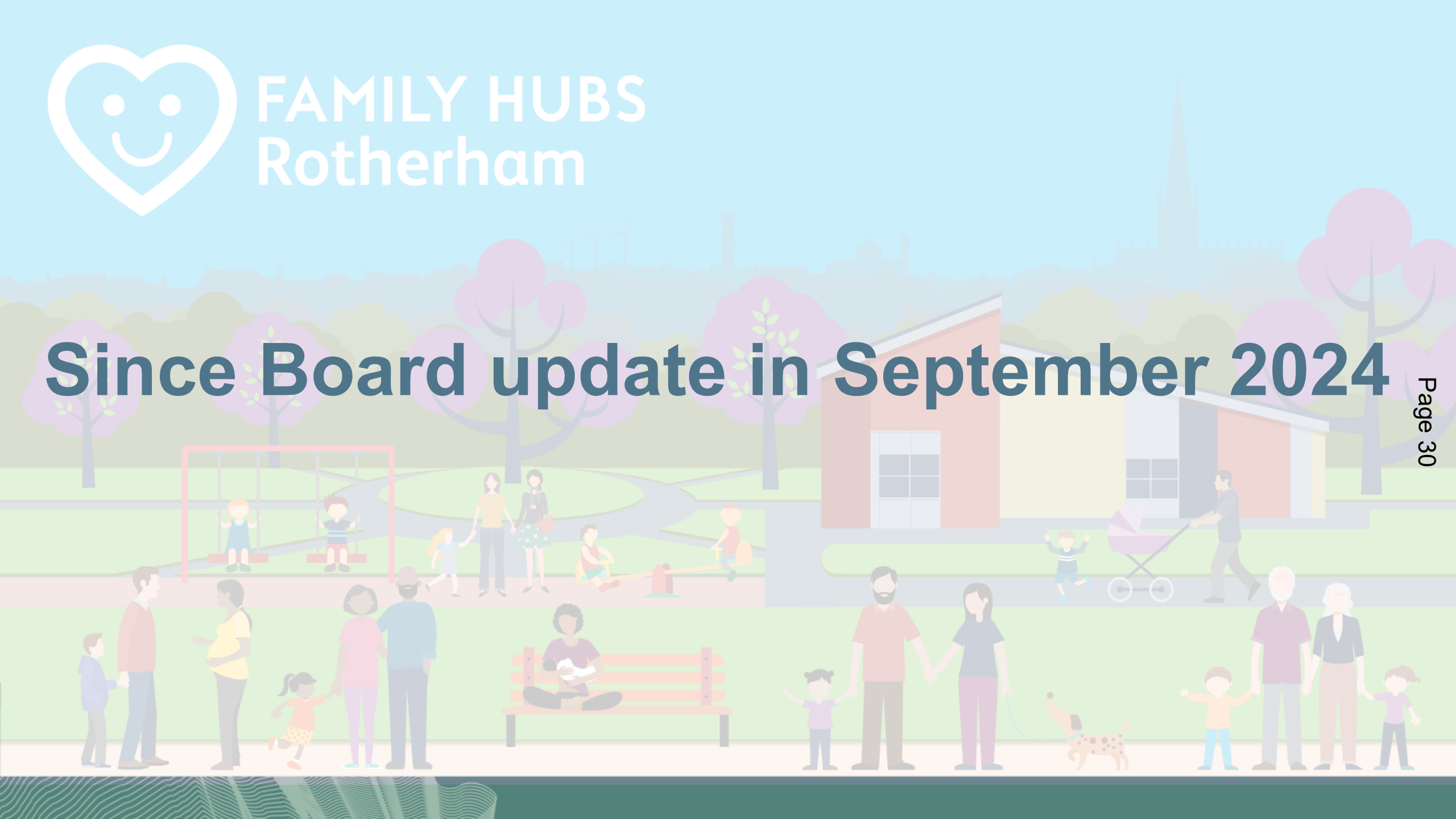
FAMILY HUBS Rotherham

Update to Health and Wellbeing Board

Alex Hawley, Kirsty Woodhead, January 2026

FAMILY HUBS
Rotherham

Since Board update in September 2024



Infrastructure

Over the first four years, the programme has transitioned to a system-wide offer for children and families. There is strong and sustainable infrastructure in place:

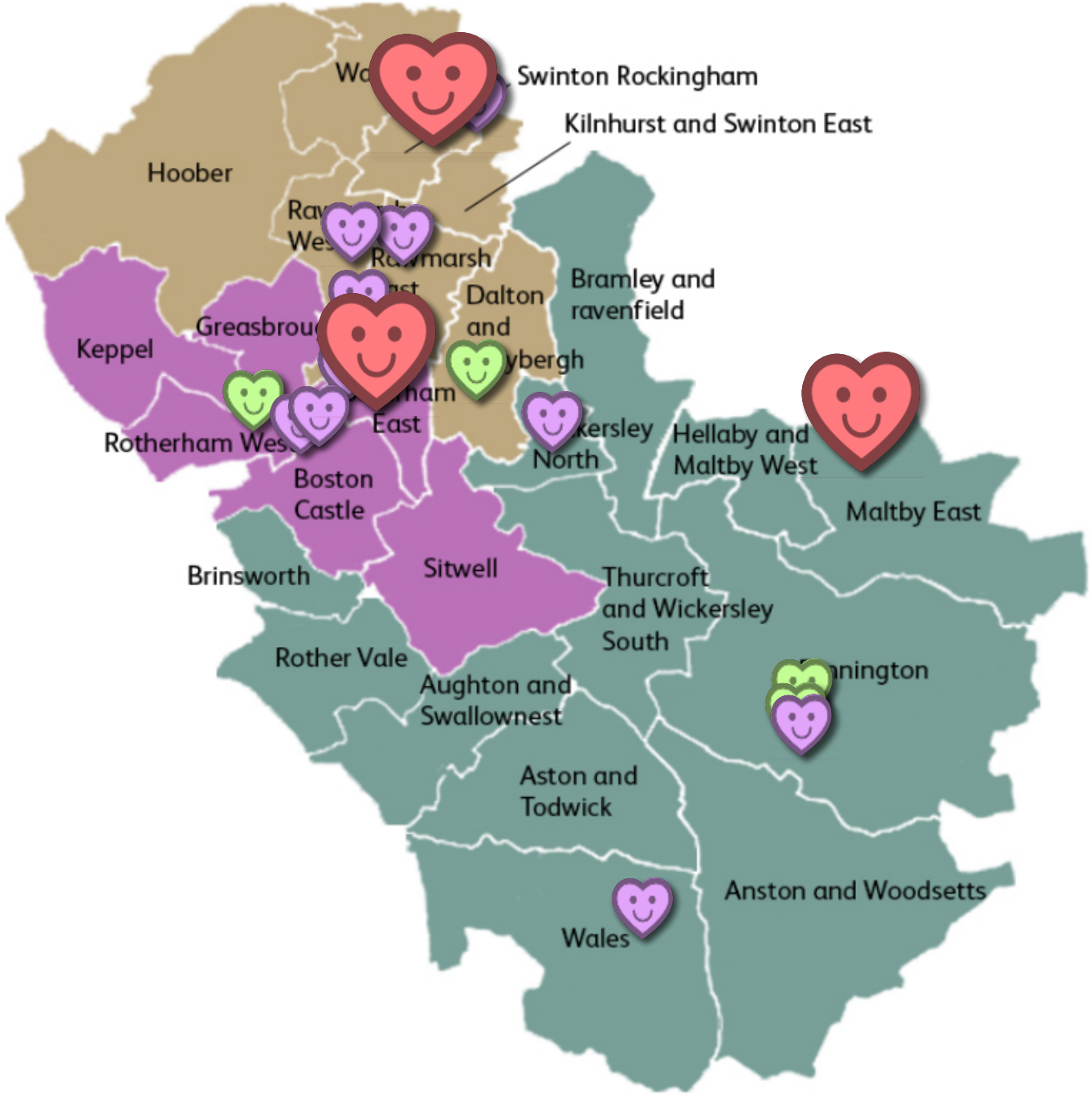
- A clear programme management structure supported by workstream leads.
- Regular communication and engagement are supported through the Best Start in Life Guide and the monthly Family Hub newsletter.
- Governance and performance are embedded through a monthly operational group, with separate quarterly performance and communication meetings.
- Early engagement initiatives - such as Baby Packs - continue to strengthen registration rates, with 93% of families choosing to register.
- Regular reporting mechanisms established to Department of Health & Social Care and Department of Education.

What's in a Family Hub?

The Family Hub Programme in Rotherham operates through a strong partnership approach with services delivered for children and families 0-19 (25 with SEND).

A range of Family Hub services are typically delivered from Family Hubs, including but not limited to:

- Parenting support, such as parenting groups and discussion groups.
- Peep learning together groups.
- Midwife appointments.
- Health visitor and nursery nurse appointments.
- Infant feeding support.
- Breast pump loan scheme.
- Antenatal classes and sessions for expectant parents.
- Groups and activities for children under 5 and their families, for example stay and play, baby massage, sensory sessions.
- Groups for young people such as targeted youth groups.
- Groups for parents of children with Special Educational Needs and Disabilities.
- Employment support from DWP Family Community Work Coaches.
- Peer support for families affected by perinatal mental health.



Rotherham Family Hubs
The Place Family Hub
Brookfield Family Hub
Maltby Stepping Stones Family Hub

Family Hub Network – RMBC sites
Dalton Family and Childrens Centre
Dinnington Early Help Centre
Dinnington Family and Childrens Centre
Ferham Family and Childrens Centre

Family Hub Network – Voluntary Community Sector
Activate
Bright Stars
CLP (Clifton Learning Partnership)
The Fun Hub
Grimm and Co
JADE
Kiveton Park and Wales Community Trust Development
REMA (Rotherham Ethnic Minority Alliance)
Rotherham Parent and Carer Forum (RPCF)
Swinton Lock
YWCA Yorkshire

Outreach Services

To reduce barriers, a range of services are delivered in community venues across the borough, including:

- Community led infant feeding sessions such as Big Latch event, Picnic in the park.
- Parenting support, such as parenting groups and discussion groups.
- Peep learning together groups.
- Midwife appointments.
- Health visitor and nursery nurse appointments.
- Infant feeding support.
- Antenatal classes and sessions for expectant parents.
- Groups and activities for children under 5 and their families, for example stay and play, baby massage, sensory sessions.
- Groups for young people such as targeted youth groups.
- Groups for parents of children with Special Educational Needs and Disabilities.

WHAT'S THE IMPACT?

HIGHLIGHTS FROM PARENTS ON OUR MOST POPULAR PATHWAYS

UNDERSTANDING YOUR CHILD

81% say this course is helpful

81% would recommend it

73% say it makes a difference

Reduced conflict in the relationship

Conflict Closeness

Child Parent Relationship Scale (CPRS)

entions that are offered and delivered
- face to face and online:

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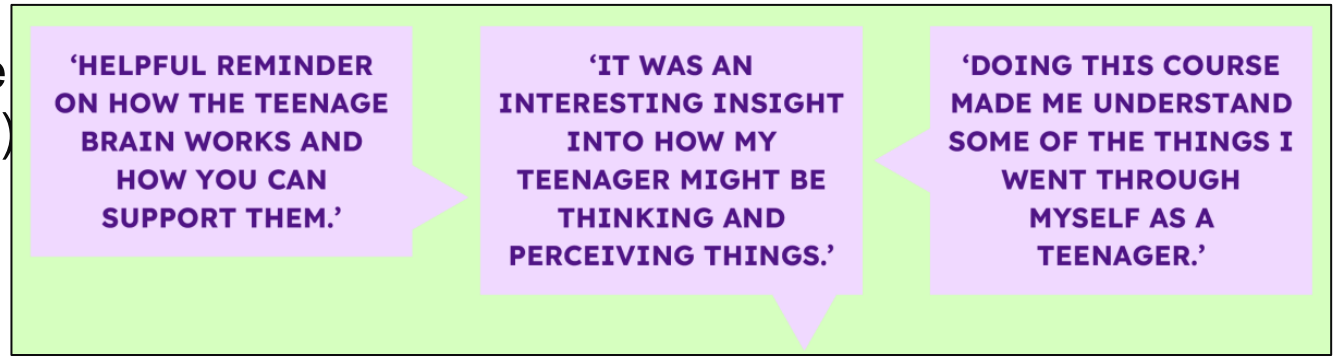
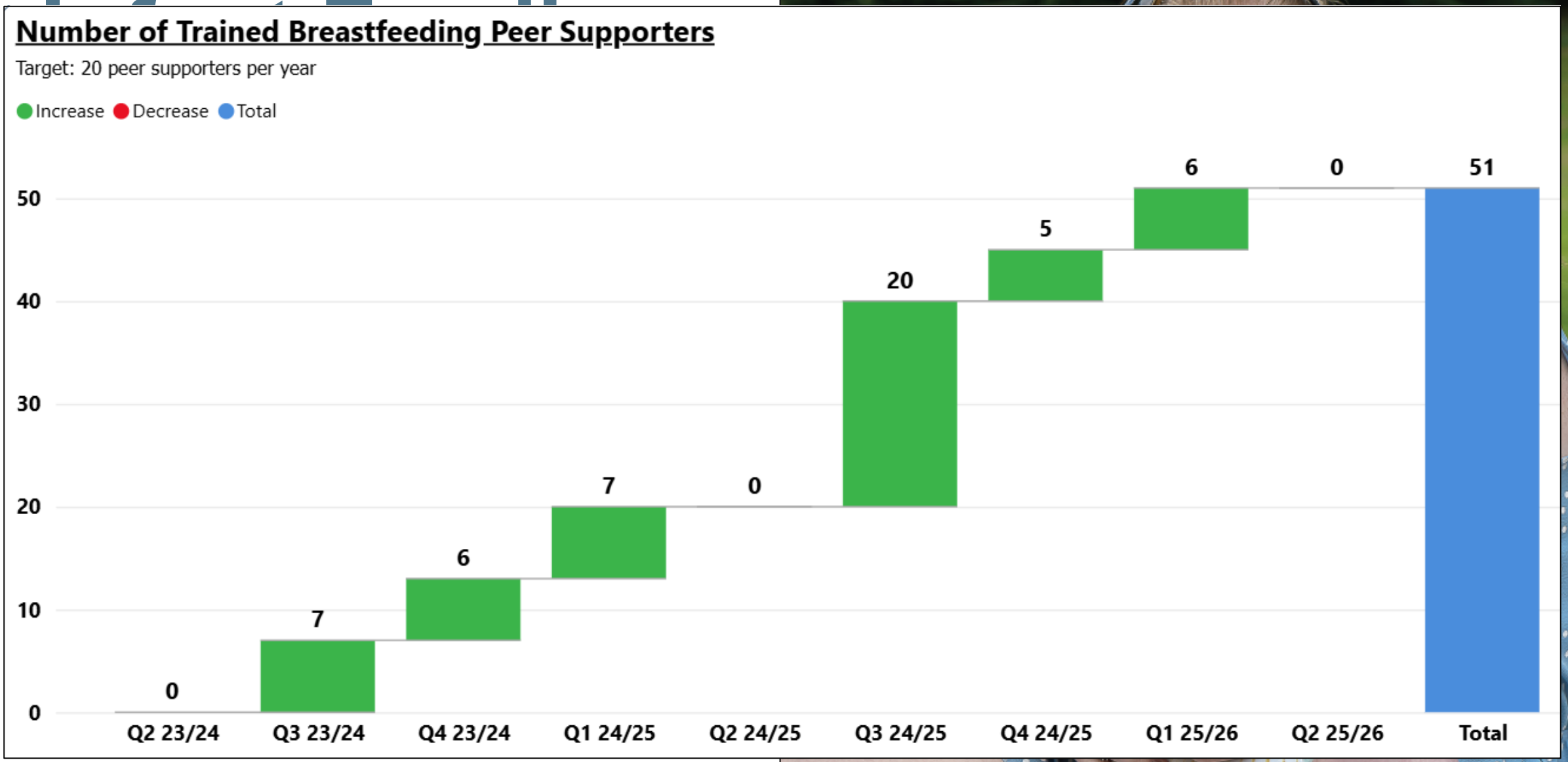
- The programme has introduced a peer support and volunteer offer with 29 active volunteers (as of end of September 2025)



Number of Trained Breastfeeding Peer Supporters

Target: 20 peer supporters per year



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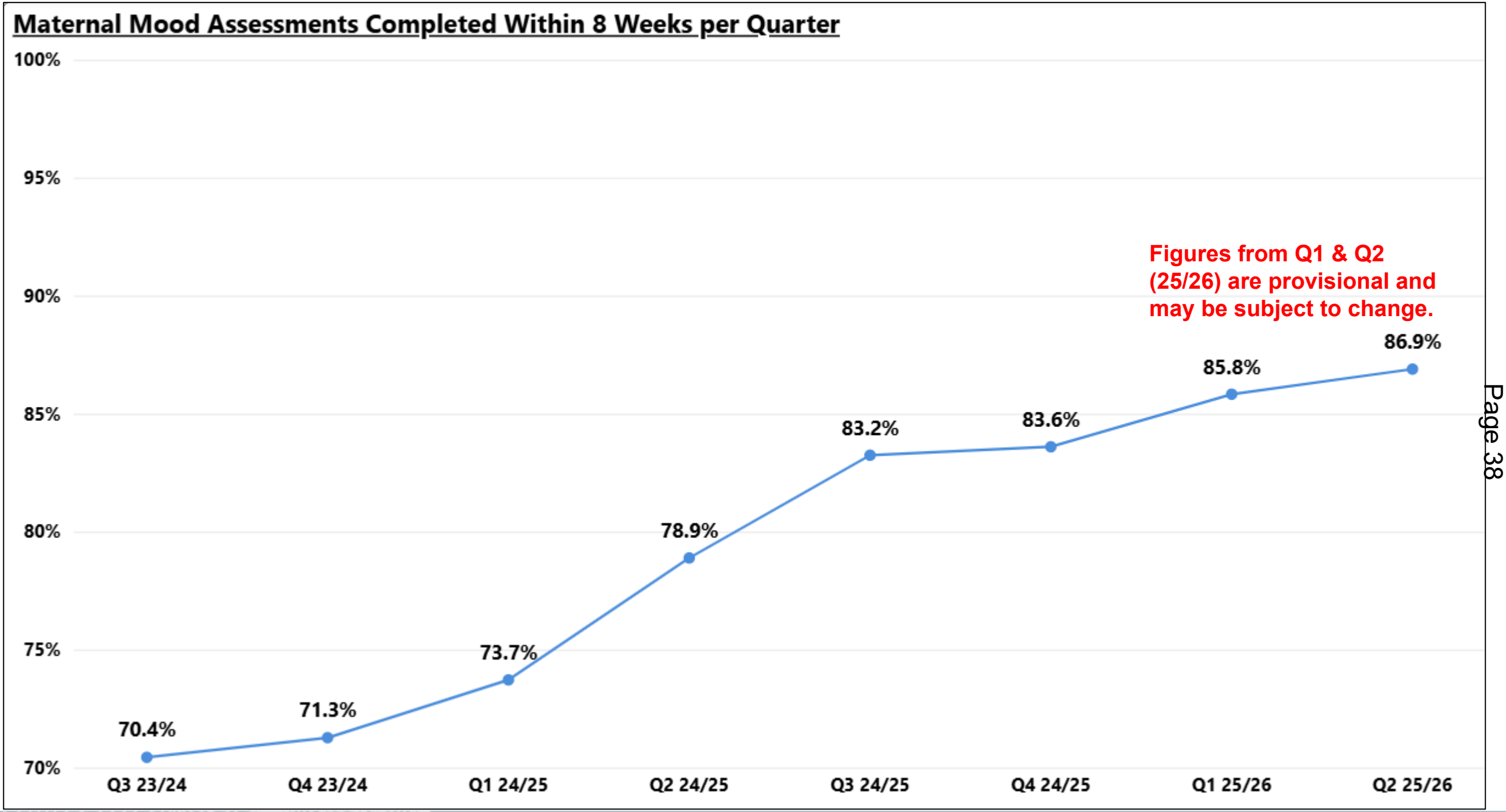
Maternal Mood Assessments Completed Within 8 Weeks per Quarter



Parent Carer Panel and Start for Life

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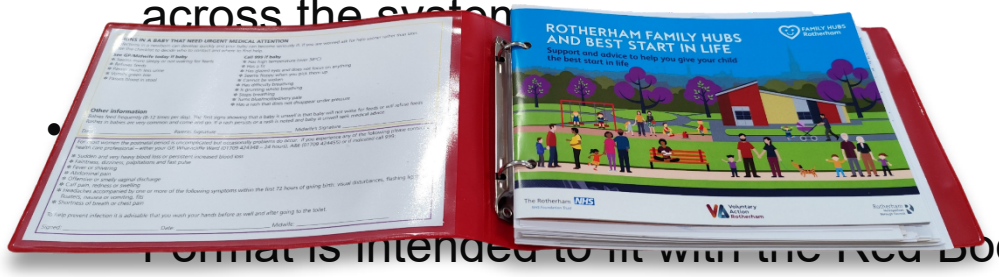
- Now provided within the baby packs and across the syste
- Format is intended to fit with the Red Book.



Update on the future of the Programme

Best Start Family Hubs & Healthy Babies Programme

- In December 2025, it was announced that there will be a further three years of funding, extending to every local authority in England.
- Continued investment in Start for Life services (now known as “Healthy Babies Programme”).
- Awaiting detailed programme guidance to inform Rotherham’s approach beyond March 2026.

Good Level of Development

- There is a new expectation to deliver a national target for achieving Good Level of Development for reception age students, by the end of the academic year of 2028.
- Rotherham’s Best Start Local plan to be published on Council website by 31st March 2026, setting out our approach to Good Level of Development.

BRIEFING	**TO:**	Health and Wellbeing Board
	DATE:	28/01/2025
	LEAD OFFICER	Oscar Holden, Corporate Improvement Officer, RMBC
	TITLE:	Health and Wellbeing Strategy Priorities Update

Background

1.1 The Rotherham Health and Wellbeing Board Strategy 2025-30 was agreed at the Health and Wellbeing Board meeting on 25th June 2025. The Strategy was the endorsed by Cabinet on 15th September 2025.

1.2 The Health and Wellbeing Board members then agreed its four priorities in principle by using nominal group technique to consider suggestions put forward by health and wellbeing system leaders at a workshop on 2nd October 2025 where the priorities were agreed in principle and the next steps were agreed.

1.3 A follow up session took place on 24th November where Health and Wellbeing Board members to agree the finalised wording and metrics for the priorities before coming to the Board meeting on 26th November for discussion

1.4 Further consultation has taken place with the RMBC Public Health Data Intelligence team and members of the Health and Wellbeing Board to refine the metrics to arrive at the suggestions below.

Key Issues

2.1 The agreed Health and Wellbeing Strategy 2025-30 priorities are:

- Priority 1: We will reduce the prevalence of smoking in Rotherham by 5% by 2030
- Priority 2: We will increase the wellbeing of the people of Rotherham towards the national average by 2030
- Priority 3: We will increase the proportion of people who feel they have the care and resources they need to support their own health
- Priority 4: People in Rotherham have access to environments that promote their health and wellbeing, and they understand why this matters.

2.2 The metrics for monitoring these for measuring these priorities are expected to be the following:

2.3 Life expectancy (taken from the Joint Strategic Needs Assessment) will be used as an overall measure across the four priorities.

2.4 Priority 1:

- Smoking prevalence rate (from existing Public Health metrics)
- Proportion of local smoking population who set a quit date (Department for Health and Social Care data recorded annually).

2.5 Priority 2:

- Happiness measure for adults and a similar source for children and young people (Office of National Statistics presented in the Joint Strategic Needs Assessment)

- Life satisfaction question (Office of National Statistics presented in the Joint Strategic Needs Assessment).

2.6 Priority 3:

- Social prescribing services referrals (VAR data)
- Access rates to Rotherhive and other online service (RMBC/ICB data).

2.7 Priority 4:

- Community safety measure (from existing Safer Rotherham Partnership metrics)
- Physical activity is measured at least annually (Sport England measure but opportunities to include local information as part of work programme).

2.8 The Rotherham Health and Wellbeing Board Strategy 2025-30 will be finalised upon the agreement of its priorities and will therefore require a new Action Plan.

2.9 At the November Health and Wellbeing Board meeting a streamlined version of the current Action Plan that represents the actions of the Board as a 12-month rolling programme was agreed, the Board is noted that a final version of this is intended to be brought to the March Health and Wellbeing Board meeting following consultation with the Exec Group. See below:

2.10

Meeting	Priority focus at Board meeting	Report/Strategy focus at Board meeting	Other significant item
June 2026	Priority 1	Integrated Care Board Forward Plan	Integrated Care Strategy
September 2026	Priority 2	Joint Health and Wellbeing Strategy	Other Special Interest Groups System Plans
November 2026	Priority 3	Joint Strategic Needs Assessment	Better Care Fund
January 2026	Priority 4	Public Needs Assessment (one in every three years)	Review of system pressure for winter
March 2026	Review of year	Director of Public Health Report	Forward Plan

Key Actions and Relevant Timelines

3.1 The Board formally agrees the new priorities metrics at the 28th January 2025 meeting after which these will be added to the Rotherham Health and Wellbeing Strategy as an appendix.

3.2 The Board will then start using the new format of the Action Plan that is outlined above from the following meeting in March 2026.

3.3 The Rotherham Health and Wellbeing Strategy 2025-30 will then be finalised entirely and due to run until the end of March 2030.

Implications for Health Inequalities

4.1 An Initial Equality Screening (Part A) and Equality Analysis (Part B) were completed to accompany the Rotherham Health and Wellbeing Strategy 2025-30 when this document was presented to Cabinet for endorsement in September 2025.

4.2 The Part B notes that the Strategy impacts upon all protected characteristics and does so in a positive and supportive manner as much of the work endorsed by the Board supports groups suffering from inequalities relating to health and wellbeing.

4.3	As the priorities for the Strategy will be added to the existing Strategy as an appendix these will align with the equality implications of the existing Part B.
Recommendations	
5.1	For the Board formally agree the priority metrics for the Health and Wellbeing Strategy 2025-30.

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Rotherham Health and Wellbeing Strategy 2025-30 Priorities

Oscar Holden, Business Support Partner for
the Health and Wellbeing Board

Priority One

“We will reduce the prevalence of smoking in Rotherham by 5% by 2030”

Metrics:

- Smoking rate (from existing Public Health metrics)
- Proportion of local smoking population who set a quit date (Department for Health and Social Care data).

Priority Two

“We will increase the mental health of the people of Rotherham towards the national average by 2030”

Metrics:

- Happiness measure for adults and a similar source for children and young people (from the Joint Strategic Needs Assessment)
- Life satisfaction question (Office of National Statistics).

Priority Three

“We will increase the proportion of people who feel they have the care and resources they need to support their own health”

Metrics:

- Measure for soft services access
- Measure for families and wider support.

Priority Four

“People in Rotherham have access to environments that promote their health and wellbeing, and they understand why this matters”

Metrics:

- Community safety measure (from existing Safer Rotherham Partnership metrics)
- Physical activity is measured at least annually (Sport England measure but opportunities to include local information as part of work programme).

Action Plan

Meeting	Priority focus at Board meeting	Report/Strategy focus at Board meeting	Other significant item
June 2026	Priority 1	Integrated Care Board Forward Plan	Integrated Care Strategy
September 2026	Priority 2	Joint Health and Wellbeing Strategy	Other Special Interest Groups System Plans
November 2026	Priority 3	Joint Strategic Needs Assessment	Better Care Fund
January 2026	Priority 4	Public Needs Assessment	Review of system pressure for winter
March 2026	Review of year	Director of Public Health Report	Forward Plan

BRIEFING	TO:	Health and Wellbeing Board
	DATE:	28 January 2026
	LEAD OFFICER	Katy Lewis Carers Strategy Manager, Strategic Commissioning, ACH&PH Katy.lewis@rotherham.gov.uk
	TITLE:	The Borough That Cares All-Age Carers Strategy 2026-2031

1. Background	
1.1	In July 2022, the Rotherham Health and Wellbeing Board approved the Borough That Cares Strategic Framework 2022-2025. This framework created a foundation of support, established a carers network, and introduced a co-production platform to build a carer friendly borough.
1.2	The co-production platform was utilised to develop a new strategy; carers and other key stakeholders were fully engaged to ensure the voice and experience of carers remains at the centre of service design and delivery across Rotherham.
1.3	Cabinet approved the Borough That Cares All-Age Carers Strategy 2026–2031 on 15 December 2025. The strategy provides clarity on the future vision, priorities and commitments to unpaid carers. It also enables continued engagement and ensures a voice for the carers of the borough**.** To be launched in April 2026, it builds on the foundations achieved in the previous strategic framework and sets the strategic direction for the five-year period to 2031.
1.4	The Rotherham Health and Wellbeing Board have requested a presentation to provide an overview of the strategy, its development and next steps.
2. Key Issues	
2.1	During April to August 2025, a programme of engagement was undertaken with carers, social care, health, the voluntary and community sector (VCS) and service providers to gather feedback on the achievements between 2022-2025, and to co-produce the vision, priorities and commitments for the next five years to 2031.
2.2	Twenty engagement sessions took place involving 399 participants. The feedback from these engagement sessions shaped the detail of the strategy for the next five years. Through listening to the voice of carers (including young carers), their views and experiences, and what matters most to them and their cared for loved ones, five key areas of focus were identified to form the commitments of the renewed strategy.
2.3	This presentation provides an update on how the Borough That Cares All-Age Carers Strategy 2026 – 2031 was co-produced. It will summarise: • The achievements of The Borough That Cares Strategic Framework 2022-2025 • The engagement activity in Spring/Summer 2025

	• The commitments for the next five years • Next steps.
3. Key Actions and Relevant Timelines	
3.1	Following approval of the strategy at Cabinet in December 2025, there are a number of next steps, as set out below: • January 2026 – Communication Plan developed • January to February 2026 – engagement with Carers and other stakeholders to develop the first-year delivery plan • March 2026 – Communication Plan implemented • April 2026 – Strategy launched and delivery plan commences.
4. Implications for Health Inequalities	
4.1	Carers are not currently recognised as having a protected characteristic under the Equality Act 2010 however the Council considers Carers to hold this protection when undertaking Equality Assessments. The commitments in the Strategy will address the health inequalities that impact carers in Rotherham.
5. Recommendations	
5.1	That the Health and Wellbeing Board receives the report and presentation as an update on the development of the Carers Strategy for 2026-2031 and agrees to receive annual reports on delivery of the strategy and associated delivery plan.

THE BOROUGH THAT CARES

ALL-AGE CARERS STRATEGY

2026-2031

Rotherham Metropolitan Borough Council

Health & Wellbeing Board
28 January 2026

Katy Lewis
Carers Strategy Manager
katy.lewis@rotherham.gov.uk

What will be covered

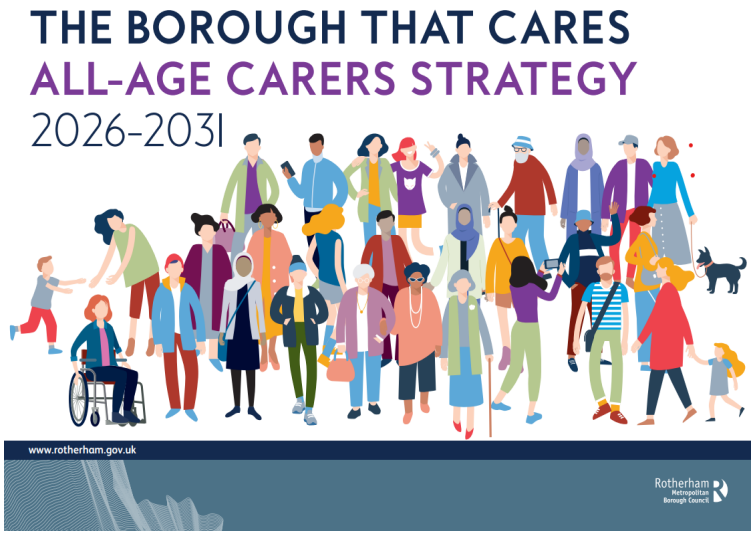
- Summary of achievements of The Borough That Cares Strategic Framework 2022-2025
- Engagement activity in Spring/Summer 2025
- Commitments for the next five years
- Next steps.

Looking back

The Borough That Cares Strategic Framework 2022 – 2025

Achievements:

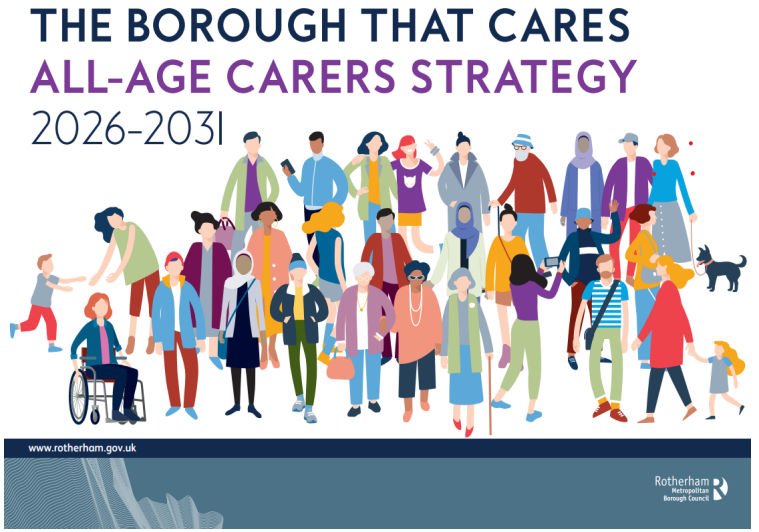
- Improved access to information – created the Council Carers Information Hub, Carers Directory and Carers Newsletter
- Information Navigators integrated to support carers who are digitally excluded
- Expanded community support through a small grant programme
- Strengthened carer voice and influence - establishing The Borough That Cares Strategic Network as a voice, influence and engagement group.



The Borough That Cares Strategic Framework 2022 – 2025

Achievements cont.:

- Established a Multi-Agency Strategic Group to drive change within organisations
- Increased Carers Assessment capacity through the employment of Carers Link Officers
- Celebrated carers - Carers Week and Carers Rights Day are now recognised community events in the Borough.



Looking forward

Engagement – to inform the Strategy

- A programme of engagement took place between March and August 2025 to gather the views of carers and a range of other stakeholders
- 23 engagement events took place
- 399 participants engaged
- Participants included carers and young carers, the people they care for, social care and health professionals, care providers and the voluntary and community sector
- A facilitated engagement session was undertaken with young carers and their families in July 2025
- Researched best practice and utilised national and local data.

Our Five Commitments

Five themes emerged from the engagement which translated into commitments:

1. Identification and Early Intervention
2. Support Carers and Ensure Their Voice is Heard
3. Support Carers Through Times of Change
4. Work in Partnership
5. Co-Design a Responsive Support Offer for Carers.

1. Identification and Early Intervention

- Identify carers, including young carers, earlier in their journey and ensure timely access to advice, support, and preventative services, before needs escalate into crisis

- Provide clear, practical guidance on the carers' service offer and how to navigate it, ensuring carers are aware of available support through clear, multi-channel communication

- Explore flexible support options for carers in employment, including better workplace awareness, access to low-level interventions and improved links with employers

- Promote carer friendly health services that recognise the barriers carers face in accessing care for themselves, and ensure carers are supported to prioritise their own health.

2. Support Carers & Ensure Their Voice is Heard

- Ensure carers are routinely provided with clear, timely information during key health and social care service interactions
- Develop clearer pathways for carers, especially at the point of diagnosis, so they are easily connected to the right services and support
- Recognise the value of shared experiences and increase opportunities for carers to connect with and support each other
- Work with schools, youth services, and family support teams to identify and support young carers earlier, ensuring their emotional wellbeing and family stability are prioritised.

2. Support Carers & Ensure Their Voice is Heard cont.

- Provide training and resources to frontline staff across health and social care to improve recognition of carers and ensure they are treated as partners in care

- Continue to involve carers in shaping services and monitoring progress, ensuring their voices remain central to everything we do.

3. Support Carers Through Times of Change

- Support carers through key transitions and ensure that health and social care professionals provide carers with timely, updated information when the condition of the person they care for changes, not just at the point of diagnosis

- Empower carers to plan for the future, providing structured support to develop contingency plans and long-term care arrangements, when they are no longer able to provide care

- Support professionals to have sensitive, timely conversations with carers about deterioration and end-of-life care, helping carers feel more prepared and informed

- Raise awareness of the support available during end-of-life care and bereavement, and ensure this information is accessible, clear, and shared proactively with carers.

4. Work in Partnership

- Improve joint working across education, health and social care, particularly to identify carers at key contact points such as hospital discharge, ensuring carers are included in planning and decision making

- Develop clearer, more joined-up pathways, digital tools and Carer Champions to help carers navigate complex systems

- Develop a shared understanding of personalised care across all services, so that when multiple agencies are involved, the carer and the person they care for experience joined-up, person-centred support.

5. Co-Design a Responsive Support Offer for Carers

- Regularly analyse feedback and data to understand carers' experiences and outcomes and identify gaps between assessed needs and actual support received

- Provide a clear and easy-to-understand overview of available services, and create flexible ways for people to access support without always needing a Carers Assessment

- Increase practitioner confidence in supporting carers to access advice, information and support, utilising universal services, the VCSE sector and commissioned services to meet need and achieve identified outcomes.

5. Co-Design a Responsive Support Offer for Carers cont.

- Evaluate the success of existing services and co-design new services or information with carers
- Involve carers in shaping training to ensure it is relevant and include carers' voices through stories, videos or lived experience contributions
- Improve ways to track satisfaction, uptake and wellbeing outcomes to inform ongoing service development.

Next Steps

- January 2026 – Communication Plan developed
- January to February 2026 – engagement with carers and other stakeholders to develop the first-year delivery plan
- March 2026 – Communication Plan implemented
- April 2026 – Strategy launched and delivery plan commences, with ongoing monitoring.

Thank you

Any questions?

THE BOROUGH THAT CARES

ALL-AGE CARERS STRATEGY

2026-2031

www.rotherham.gov.uk

Rotherham Metropolitan Borough Council

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FOREWORD

We are proud to introduce Rotherham's All-Age Carers Strategy for 2026-31, a strategy shaped by the voices of young carers, adult, and parent carers who generously shared their experiences, insights, and aspirations with us. They have been central to identifying the priorities that matter most and ensuring this strategy reflects the reality of caring in Rotherham today.

We met and listened to carers of all ages and background, including children and young people, those caring for a few hours a week to those providing round-the-clock support. They told us about the challenges of navigating services, the emotional and financial pressures they face, and the importance of being recognised, respected, and supported.

This strategy is our shared commitment to act on what they told us.

Over the next five years, we will work together to:

- Identify carers earlier and provide timely support
- Improve access to information, guidance, and peer support
- Support carers through times of change, including planning for the future
- Strengthen co-ordination across services and embed co-production
- Ensure carers are recognised as partners in care and empowered to live fulfilling lives alongside their caring role.

We know that caring can be both rewarding and demanding. That's why this strategy sets out our commitment to build a system that works with and for carers, one that is inclusive, responsive, and rooted in lived experience.

To every carer, professional, and partner who contributed: Thank You.

Your voice is at the heart of this strategy, and your continued involvement will be vital in delivering real and lasting change.

Together, we are building a borough that cares.

Councillor Joanna Baker-Rogers
Cabinet Member for Adult Social Care and Health

Councillor Victoria Cusworth
Cabinet Member for Children and Young People's Service

Ian Spicer
Strategic Director of Adult Care, Housing and Public Health

Nicola Curley
Strategic Director of Children and Young People's Services

INTRODUCTION

This All-Age Carers Strategy has been developed to ensure carers, living in Rotherham, or supporting someone that lives in Rotherham are recognised, supported, and empowered.

Developed through a comprehensive programme of co-production and engagement, involving 23 focus groups and nearly 400 individuals, it outlines a commitment by the Council, Health Partners and the Voluntary, Community and Social Enterprise (VCSE) sector to work in partnership to improve the health and well-being of carers in the borough.

The views and experiences of carers of all ages and from all walks of life, adult social care staff, commissioned service providers, VCSE sector organisations, health professionals, and community groups and networks have contributed to its development.

With over 26,000 residents identifying as carers, and many more providing care without formal recognition, this strategy aims to reach carers at every stage of their journey.

What is caring?

A carer is anyone who cares for a friend or family member who can't cope without support. This might be because of aging, illness, disability, poor mental health, or an addiction.

It isn't someone who volunteers or is employed to provide support, a carer could be in education, in receipt of Carers Allowance or working whilst caring.

A caring role may develop over a period of time or happen suddenly without allowing time to prepare. It could be for a few hours each week, or 24 hours a day, 7 days a week and a carer may care for different people at different times in their lifetime.

A carer might be:

- an adult caring for other adults
- a parent caring for children who are ill or have a disability
- a young person caring for a parent, sibling, relative, or friend.

KEY LEGISLATION

THE CARE ACT 2014

Key provisions include:

- Legal right to a carer's assessment based on the appearance of need.
- Eligibility for support based on the impact of caring on wellbeing and personal outcomes.
- Requirement for support planning, personal budgets, and option for direct payments.
- Local authorities may charge for services, though most do not.
- Wellbeing principle places carers' wellbeing on equal footing with those they care for.
- Duties on local authorities include prevention, information and advice, transition support, and advocacy.

HEALTH AND CARE ACT 2022

Strengthens carer involvement in health services:

- NHS England and Integrated Care Boards must involve carers in planning and decision-making.
- Carers must be identified and involved early in hospital discharge planning.
- Emphasis on tailored support, recognition, and collaboration with local authorities and voluntary organisations.

This strategy aligns to these key pieces of legislation

WORK AND FAMILIES ACT 2006

- Flexible Working Rights: Extended to carers of adults, allowing them to request flexible working arrangements.
- Parental and Adoption Leave: Enhanced leave and pay entitlements for parents, which may benefit carers who are also parents.

CHILDREN AND FAMILIES ACT 2014

Focuses on young carers and parent carers:

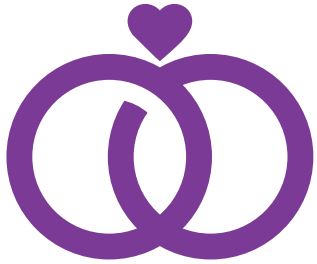
- Young carers (under 18) must be assessed if needs are apparent or on request.
- Assessment considers appropriateness of caring role, education, aspirations, and family needs.
- Parent carers of disabled children are entitled to assessment based on need.
- Encourages a whole-family approach and coordinated assessments.

CARER'S LEAVE ACT 2023

- Statutory Unpaid Leave: Up to one week per year for employees to provide or arrange care for a dependant with long-term care needs.
- Day-One Right: Available from the first day of employment.
- Flexible Use: Leave can be taken in half days, full days, or a full week.
- No Proof Required: Employers cannot demand evidence of caring responsibilities.
- Employment Protection: Employees are protected from dismissal or victimisation for taking carer's leave.

FACTS ABOUT CARERS

266,000
people live in Rotherham,
26,313 (10.48%) are carers

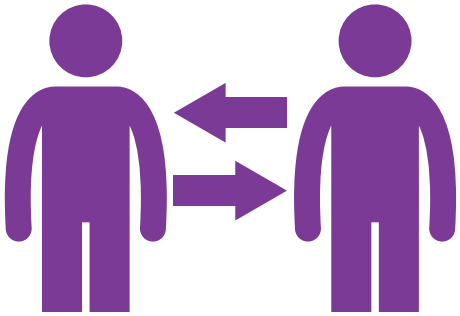


60%
of carers
are married

30.8%
of carers are
registered
disabled

45,627 school pupils
in Rotherham borough,
82 of these were identified
as young carers in the 2025
school census

44% of people
caring more than
50 hours per week
are not in good health



In 2025 34 young
carers received one to
one support to reduce
the impact of their
caring responsibilities

FACTS ABOUT CARERS

3.2% of residents are in receipt of Attendance Allowance

51% of carers are economically inactive

12% of residents are in receipt of the daily living component of PIP or the care component of DLA

46.6% of carers are employed, 40.4% of these are employed in the public sector

15.2% of Rotherham's population have care needs

3% of carers are in receipt of carers allowance

ACHIEVEMENTS OF THE BOROUGH THAT CARES STRATEGIC FRAMEWORK 2022–2025

Carers Strategy Manager appointed to oversee the implementation of the Strategy.

Improved Access to Information via the carers information page on our website, a carers directory in both digital and paper formats, and the carers newsletter. Six editions have been published, with a growing subscriber list of 132 to date. Webpage activity continues to grow, with an average of 890 views and 375 users per month.

Information Navigator Roles integrated into commissioned services to support carers who may face barriers in accessing information, ensuring personalised advice and guidance is available.

Expanded Community Support through a small grant programme, third sector organisations were supported to deliver tailored services that promote carers' health and wellbeing.

This included support for carers with additional needs such as dementia, head injuries, substance misuse, parent carers, and carers from minority communities (BAME, Chinese, LGBTQ+).

A total of 19 community organisations received funding, benefitting an estimated 830 individuals.

Carers reported improvements in physical, social, mental, and emotional wellbeing. The programme also strengthened engagement with community services and encouraged organisations to 'think carer' in their ongoing work.

Strengthened Carer Voice and Influence by growing the Borough That Cares Strategic Network as a platform for voice, influence, and engagement. 30 members now regularly attend the monthly meetings.

Celebrated Carers by recognising Carers Week (June) and Carers Rights Day (November) as major community events, with growing participation each year. Over the three years, 21 events were co-produced for Carers Week and three for Carers Rights Day, led by the Borough That Cares Network.

Established a Multi-Agency Strategic Group to drive change within member organisations which now includes 23 registered members, fostering collaboration and shared responsibility.

Increased Carer's Assessment capacity through the employment of Carers Link Officers resulting in reduced waiting times and improved access to timely support.

Began developing a digital app, utilising funding from the Accelerating Reform Fund, carers are working with a commissioned provider to design a bespoke app to enhance the ability to identify and support carers. This tool will extend the reach, particularly to those not currently engaging with services.

Embedded Co-Production and engagement as a core principle across local carer groups and organisations, with high levels of participation. This collaborative approach has directly informed the development of the strategy for 2026-2031.

WHAT CARERS TOLD US

Over the period of the Borough that Cares Strategic Framework 2022-25 carers have shared examples of positive changes that have helped them in their caring role, however carers have also told us that more needs to be done to drive further improvements.

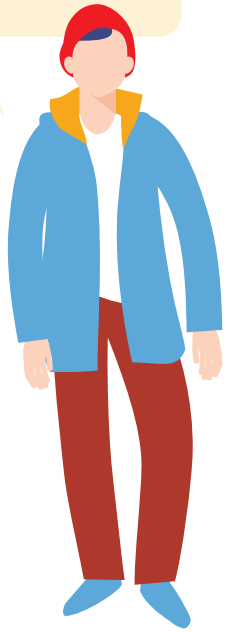
So to develop this new strategy, between March and August 2025, we undertook a comprehensive engagement process to gather the current views and experience of carers and cared for people in the borough.

We also gathered insight from a wide range of stakeholders, social care and health professionals, care providers, and representatives from the VCSE sector. In total, nearly 400 individuals participated in this engagement.

Themes began to emerge, reflecting the lived experiences and needs of carers in Rotherham. These local themes, such as accessible information, maintaining their own health and wellbeing and combining caring with paid employment, often aligned with broader trends in national sources of evidence, helping us to validate and strengthen our understanding of the issues that matter most.

A lack of early information and advice was a major cause of stress and burnout. Many carers only discovered the support available to maintain their own health and wellbeing after reaching a crisis point.

Carers raised concerns about health inequalities, sharing that they often delay seeking treatment for their own health issues due to caring responsibilities.



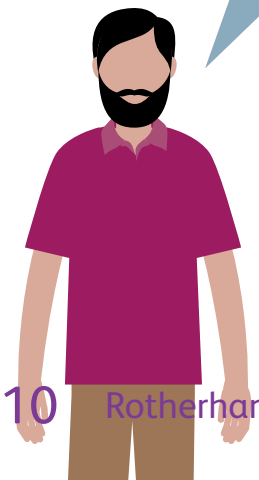
Carers in employment, said that low-level needs often go unrecognised and unsupported, yet these can quickly escalate, forcing a reduction in hours or leaving the workplace altogether.

Young carers shared that they often live with high levels of anxiety, especially when their family unit is under strain. They rely on the stability of their family, and when that falters, their sense of security is shaken, until someone recognises their situation and steps in with support.

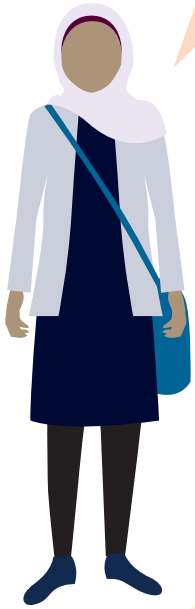
Carers told us that one of the hardest parts of being a carer is navigating the different systems across health and adult social care.

WHAT CARERS TOLD US

Many carers found valuable support online in relation to the health conditions of those they care for, when there was a clear diagnosis pathway they were signposted to support services. However, they expressed frustration that guidance wasn't automatically provided during health service interactions. Too often, the responsibility fell on carers to seek out information themselves, including speaking with other carers and they told us we must do better.



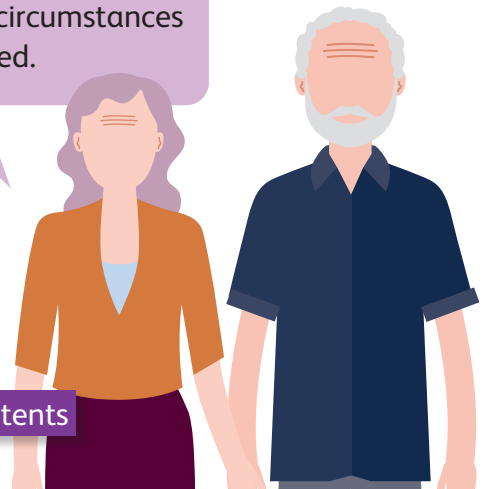
Carers expressed frustration at the lack of coordination between agencies, and that they were often excluded from important discussions, particularly during hospital discharge planning.



Although having a difficult conversation about deterioration wasn't easy, and it was hard to know the right time, carers told us it was better to be informed than to be caught off guard by unexpected changes.

When the cared for person became terminally ill, carers didn't know what support was available, limiting their choices and support at a critical time.

Whilst carers often received information at the point of diagnosis, particularly for degenerative conditions, they were not given further guidance when circumstances changed.



Carers recognised the pressures facing health and social care services but felt that more could be done to work together effectively. Improved coordination would not only make life easier but would also reduce duplication and waste. Although services often take a personalised approach individually, this is lost when multiple services are involved, leaving carers to bridge the gaps.

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OUR COMMITMENTS

The commitments set out in this strategy require strong and sustained partnership working. We are committed to working collaboratively across social care, health, education, and the VCSE sector to deliver meaningful change for carers in Rotherham.

Identification and early intervention	Identify carers, including young carers, earlier in their journey and ensure timely access to advice, support, and preventative services before needs escalate into crisis.
	Provide clear, practical guidance on the carers' service offer and how to navigate it, ensuring carers are aware of available support through clear, multi-channel communication.
	Explore flexible support options for carers in employment, including better workplace awareness, access to low-level interventions, and improved links with employers.
	Promote carer friendly health services that recognise the barriers carers face in accessing care for themselves, and ensure carers are supported to prioritise their own health.
Support carers and ensure their voice is heard	Ensure carers are routinely provided with clear, timely information during key health and social care service interactions.
	Develop clearer pathways for carers, especially at the point of diagnosis, so they are easily connected to the right services and support.
	Recognise the value of shared experiences and increase opportunities for carers to connect with and support each other.
	Work with schools, youth services, and family support teams to identify and support young carers earlier, ensuring their emotional wellbeing and family stability are prioritised.
	Provide training and resources to frontline staff across health and social care to improve recognition of carers and ensure they are treated as partners in care.
	Continue to involve carers in shaping services and monitoring progress, ensuring their voices remain central to everything we do.

OUR COMMITMENTS

Support carers through times of change	Support carers during key transitions and ensure that health and social care professionals provide carers with timely, updated information when the condition of the person they care for changes, not just at the point of diagnosis.
	Empower carers to plan for the future, providing structured support to develop contingency plans and long-term care arrangements, when they are no longer able to provide care.
	Support professionals to have sensitive, timely conversations with carers about deterioration and end-of-life care, helping carers feel more prepared and informed.
	Raise awareness of the support available during end-of-life care and bereavement, and ensure this information is accessible, clear, and shared proactively with carers.
Work in partnership	Improve joint working across education, health and social care, particularly to identify carers at key contact points such as hospital discharge, ensuring carers are included in planning and decision-making.
	Develop clearer, more joined-up pathways, digital tools and carer champions to help carers navigate complex systems.
	Develop a shared understanding of personalised care across all services, so that when multiple agencies are involved, the carer and the person they care for experience joined-up, person-centred support.
Co-design a responsive support offer for carers	Regularly analyse feedback and data to understand carers' experiences and outcomes and identify gaps between assessed needs and actual support received.
	Provide a clear and easy-to-understand overview of available services, and create flexible ways for people to access support without always needing a Carers Assessment.
	Increase practitioner confidence in supporting carers to access advice, information and support, utilising universal services, the VCSE sector and commissioned services to meet need and achieve identified outcomes.
	Evaluate the success of existing services and co-design new services or information with carers.
	Involve carers in shaping training to ensure it is relevant and include carers' voices through stories, videos or lived experience contributions.
	Improve ways to track satisfaction, uptake and wellbeing outcomes to inform ongoing service development.

HOW WILL WE MAKE IT HAPPEN?

Each year, carers and partners will help shape a delivery plan. Progress will be shared through the carers' network and strategic group, with updates on achievements and outcomes reported to the Rotherham Health and Wellbeing Board.

Our commitment to carer involvement

We recognise that carers are experts by experience, and your ongoing involvement is essential to shaping, delivering, and monitoring our strategy. We are committed to working in partnership with you at every stage.

How you can get involved

- **Regular feedback:** We will provide opportunities for you to share your experiences and suggestions through surveys, focus groups and forums
- **Co-production:** We will invite you to help design and review services, ensuring your voice is central to decision-making
- **Monitoring progress:** We will involve you in reviewing our progress against the five commitments, using your insights to help us understand what is working and where we need to improve
- **Case studies and stories:** We will welcome your stories and examples to help us illustrate the real impact of our work and highlight areas for change
- **Carer reference groups:** We will support the development of carer-led groups to provide ongoing advice and challenge to our work.

We will make sure that all involvement opportunities are accessible, inclusive and flexible to fit around your caring responsibilities.

We want to work with you to make sure our strategy delivers real change for carers in Rotherham. If you would like to share your experiences, join a carers' group, take part in feedback sessions, or help shape future services, we would love to hear from you.

To get involved or find out more:

- Contact us by email at **commissioningenquiries@rotherham.gov.uk**
- Visit our website at **www.rotherham.gov.uk/carers**

Together, we can make a difference.

CONNECTING STRATEGIES

Rotherham Council Plan 2022-2025

Rotherham Adult Social Care Strategy 2024-2027

Rotherham Learning Disability Strategy 2024-2027

Rotherham's Housing Strategy 2022-2025

Rotherham Council's Digital Strategy

Rotherham Joint Health and Wellbeing Strategy

Rotherham Hospice Living Life's Wishes 2024-2030

Rotherham Loneliness Action Plan 2023-2025

Moving Rotherham Partnership Action Plan 2025-2026

USEFUL CONTACTS AND INFORMATION

Adult Contact Team
01709 822330

Children and Young People Services
01709 336080

Rotherham Carers Newsletter

Carers Information Hub

Your own important numbers

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Ref: 88736 / JANUARY 2026

BRIEFING	**TO:**	Health and Wellbeing Board
	DATE:	28th January 2026
	LEAD OFFICER	Ruth Fletcher-Brown Public Health Specialist, Adult Care, Housing and Public Health 01709 255867
	TITLE:	Better Mental Health for All- Report to Health and Wellbeing Board

Background

1.1 Rotherham Health and Wellbeing Board adopted the public mental health strategy, Better Mental Health for All, in 2017.

1.2 The Better Mental Health for All Strategy and Action Plan for Rotherham 2017-2025, outlined actions that partners of the Health and Wellbeing Board (HWB) were committed to take to improve the mental health for all people living and working in Rotherham. Delivery of this was overseen by the Better Mental Health for All Group which represented all partners of the HWB.

1.3 The strategy and action plan were about linking into community assets (strengths) and connecting people within their local community. The strategy recognised the skills, knowledge and expertise of individuals and the physical, cultural and economic assets that communities and organisations already have to build on to improve mental health and wellbeing.

1.4 As further commitment to early intervention and prevention, Rotherham Health and Wellbeing Board, submitted a detailed application form in 2023, to become a signatory of the Prevention Concordat for Mental Health. This Concordat was launched by Public Health England in 2017 (now Office of Health Improvement and Disparities, OHID) and refreshed in December 2020.

1.5 The Prevention Concordat for Better Mental Health focuses on upstream interventions and the wider determinants of health. It is a whole population approach and includes those at greater risk. It supports joint cross-sectoral action locally, including those with living experience and the wider community. It encourages collaborative working to address local needs and identify local assets and it is about building the capacity of the local workforce to prevent mental ill health.

1.6 The Benefits to the Rotherham Health and Wellbeing Board of being a signatory to the Prevention Concordat for Mental Health are:

- demonstrating a focus on prevention
- committing to an annual prevention and promotion action plan
- being part of a growing community of practice with other Boards and organisations.
- linking local stakeholders on the prevention agenda
- linking to national professional academic and voluntary sector expertise in mental health.

1.7	Rotherham Health and Wellbeing Board was approved to become a signatory by an OHID panel in September 2023, with the HWB committing to having an annual prevention and promotion action plan.
1.8	With the end of the Better Mental Health for All Strategy and two years on from the Prevention Concordat application, it was pertinent to review, with all partners of the HWB, Rotherham's approach to early invention and prevention in relation to mental health.
Key Issues	
2.1	Mental health in Rotherham continues to be a priority area for action. ➢ Rotherham depression rates for adults aged 18 plus who are registered with a GP for depression is 17.3% (2022/2023). This is above the national average and higher that similar local authorities, Barnsley and Doncaster. ➢ In 2022-2023 24.3% of Rotherham adults aged 16 plus self-reported high anxiety scores. ➢ In the 2024 School Survey, 40% of secondary school children reported their mental health as 'fair' or 'poor'.
2.2	In 2023-2024 a mental health needs assessment was conducted in Rotherham. The first recommendation from this report is: ➢ Promotion of awareness: to continue work to promote public and patient awareness of mental health issues and emotions, such as reinforcing that it is normal to feel low sometimes, anti-depressants are not a quick fix for all issues, and when and how people can access support, as well as emphasising the importance of community and social connections in protecting and improving mental health and wellbeing.
2.3	The Mental Health Needs Assessment also identified some inclusion groups where either mental illness rates were higher and or where the uptake to mental health services could be improved.
2.4	The Rotherham Better Mental Health Strategy, and the Prevention Concordat application detailed the Health and Wellbeing Boards' commitment to early intervention and prevention in relation to mental health.
2.5	With the information from the Mental Health Needs Assessment, the end of the current Better Mental Health for All Strategy (2017-2025), and two years on from the HWB's Prevention Concordat application, it was time to review with all partners of the HWB, Rotherham's approach to early invention and prevention.
2.6	A Stakeholder event was held in the summer of 2025. The aim of this half-day event was to bring together stakeholders across Rotherham to identify priorities and principles for a new public mental health vision for the borough. It was independently facilitated by the Centre for Mental Health, Chief Executive Officer, Andy Bell.
2.7	Prior to the workshop we asked community groups across Rotherham, what mental health meant to them and what would support their mental health.
2.8	The workshop: ➢ Heard from the lived experience of local communities in Rotherham ➢ Worked collaboratively on a vision of a mentally healthier place to live ➢ Looked at mental health in Rotherham today

	➢ Heard insights and ideas from national research and good practice from across the country on what works to promote good mental health. ➢ Identified priorities for promoting and protecting mental health in Rotherham.
2.9	Following the workshop, the Public Mental Health Lead pulled this information into the attached infographic, taking advice from Andy Bell, CEO Centre for Mental Health. This looks at a vision and delivery mechanisms for improving mental wellbeing across the Rotherham population.
2.10	This has been shared with Partners of the Better Mental Health for All Group.
2.11	The infographic looks at the building blocks of good mental health many of which outside of health services, good housing, good employment, feeling safe, connections with others, access to green spaces and tackling stigma and discrimination, highlighting the need for partnership working on this.
2.12	The infographic looks at where actions can be taken in priority places, where to support good mental health amongst inclusion groups, where to advocate and where to embed early intervention and prevention.
2.13	The infographic highlights where this work aligns to other council and HWB Partner plans and strategies.
2.14	The Better Mental Health for All Group will now work to identify key actions for delivery over a 2-year period.
2.15	The Public Mental Health Lead will work with Partners to develop opportunities for early intervention and prevention, where this can be embedded into existing plans and how this can be measured.
Key Actions and Relevant Timelines	
3.1	A stakeholder event was held in the summer to look at the vision and delivery mechanisms for mental wellbeing across the Rotherham population. The resulting infographic has been shared with the Better Mental Health for All Group (July 2025)
3.2	The infographic is proposing the way forwards for early intervention and prevention work. This will be presented to the Health and Wellbeing Board for sign off in Spring 2026.
3.3	The Better Mental Health for All Group will work to identify key actions for delivery over a 2-year period (Spring 2026).
3.4	The infographic and identified key actions will demonstrate the HWB's ongoing commitment to early intervention and prevention and will support the ongoing commitment to OHID's Prevention Concordat for Mental Health (Spring 2026 onwards).
3.5	The Better Mental Health for All Group will agree on outcome measures (Spring meeting 2026).
3.6	Annual updates will be reported to the HWB.

Implications for Health Inequalities	
4.1	The workshop drew upon the living experience of some of the inclusion groups in Rotherham and this helped shaped the vision. This living experience will be a focus in shaping the actions proposed to address early intervention and prevention. Further opportunities will be explored to look at including the voice of other inclusion groups.
4.2	The Mental Health Needs Assessment focused on the health inequalities in relation to mental heath and wellbeing and access to services. This Better Mental Health for All vision will utilise this information to shape future actions.
4.3	A standing item on the Better Mental Health for All Group agenda is Voice and Influence, giving all Partners an opportunity to share and shape future work.
Recommendations	
5.1	HWB to support the vision and delivery mechanisms for mental wellbeing across the Rotherham population.
5.2	HWB Partners to attend and contribute to the Better Mental Health for All Group which will oversee the delivery of actions for early intervention and prevention in relation to mental health.
5.3	HWB to receive annual updates on progress.

Better Mental Health for All

A Rotherham where everyone can thrive mentally, emotionally, and socially, in safe, inclusive, and supportive environments

Ruth Fletcher-Brown, Public Health Specialist, RMBC

Current Picture

- Rotherham Health and Wellbeing Board adopted the public mental health strategy, Better Mental Health for All, in 2017.
- The Better Mental Health for All Strategy and Action Plan for Rotherham 2017-2025, outlined actions that partners of the Health and Wellbeing Board (HWB) were committed to take to improve the mental health for all people living and working in Rotherham.
- Delivery of this was overseen by the Better Mental Health for All Group which represented all partners of the HWB.
- Rotherham Health and Wellbeing Board, submitted a detailed application form in 2023, to become a signatory of the Prevention Concordat for Mental Health. This was approved in September 2023.

Stakeholder Event

Partners of the Health and Wellbeing Board attended a workshop in July facilitated by Andy Bell, Centre for Mental Health. Stakeholders at the workshop:

- Heard from the lived experience of local communities in Rotherham
- Worked collaboratively on a vision of a mentally healthier place to live
- Looked at mental health in Rotherham today
- Heard insights and ideas from national research and good practice from across the country on what works to promote good mental health.
- Identified priorities for promoting and protecting mental health in Rotherham.

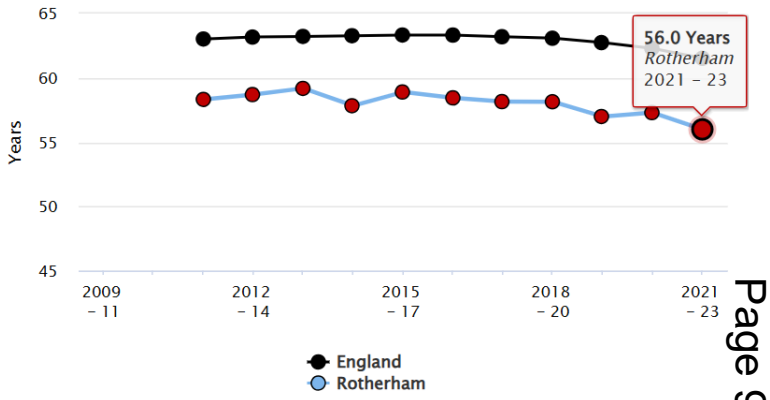
Healthy life expectancy and mental health

Healthy Life Expectancy (HLE) is closely linked to mental health, and mental ill-health and poor wellbeing are associated with reduced HLE:

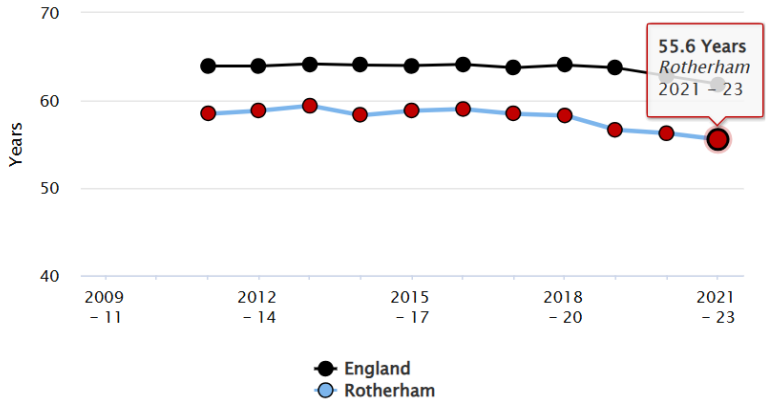
- Reduced quality of life
- Increased mortality risk
- Physical health connection

In Rotherham HLE has been decreasing from 59 in 2015-17 to 56 years in 2021-23 for both males and females.

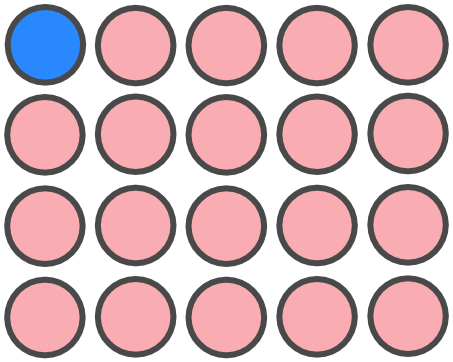
Healthy life expectancy at birth (Male)



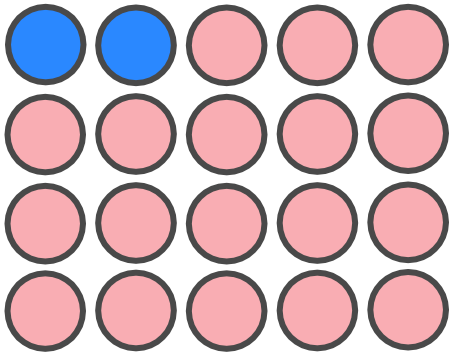
Healthy life expectancy at birth (Female)



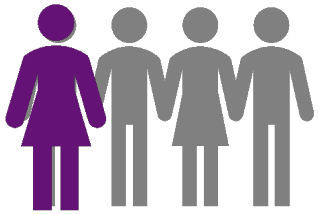
Wellbeing



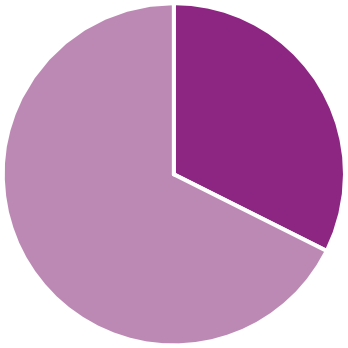
1 in 20 people in Rotherham are reporting low life satisfaction.



1 in 10 people in Rotherham are reporting low happiness.



1 in 4 people in Rotherham report high anxiety.

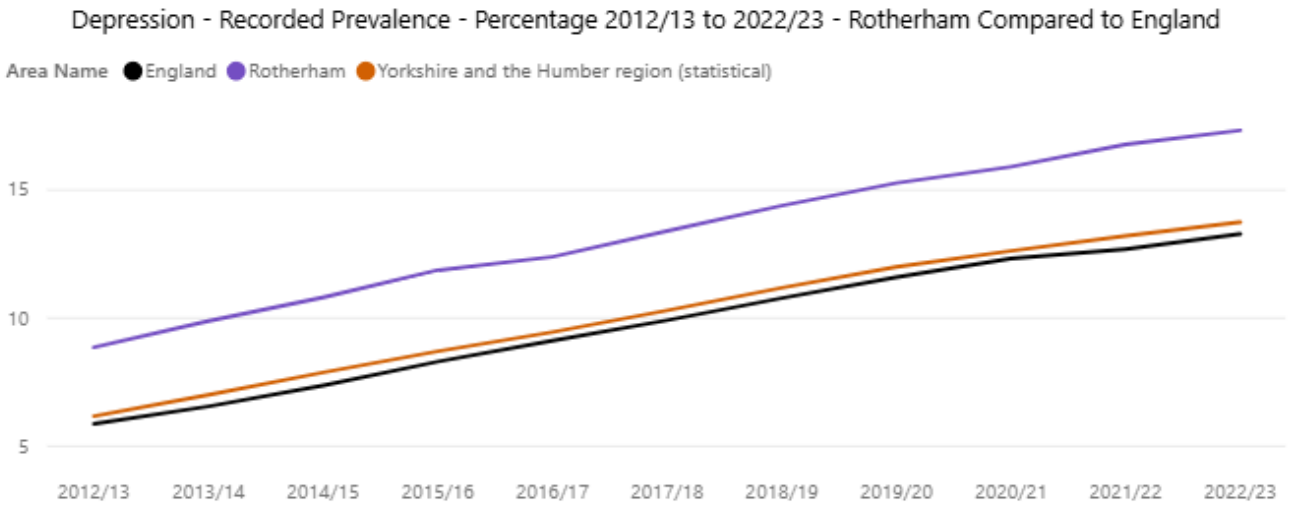


32.4% of respondents have always, or often, experienced poor mental health or poor emotional wellbeing lately.

2022/23 - The available data on wellbeing is from the Annual Population Survey (APS) conducted by the Office for National Statistics. Survey undertaken with Rotherham residents.

Mental health conditions

- It is estimated that 19% of the population aged 16 and over, and 12% of the population aged 65 and older have a common mental health condition.
- The prevalence of depression in Rotherham has increased between 2013 and 2022, from 9.9% to 17.3%, remaining above the England average of 13.2%.
- 1.5 out of every 100 individuals were newly diagnosed with depression in 2023/24.



Children and young people

- 40% of secondary school children report their mental health as ‘fair’ or ‘poor’.
- Girls were twice as likely to report persistent loneliness (22.4%) compared to boys (10.6%).
- 1 in 2 children in care had emotional wellbeing that was a cause for concern in 2023/24.

Engagement around mental health

Groups and individuals told us.....

- Increased stress and pressure was identified as a major cause of poor mental health
- Bereavement can cause loneliness and poor mental health.
- COVID, brought challenges and opportunities. Some people said that others are still anxious about going out.
- They didn't want to be a burden to their families. Some families live a long distance away and even if they lived nearer, families have their own lives.
- Caring for someone can lead to the carer feeling lonely and having poor mental health.
- Feeling lonely can lead to thoughts of suicide.
- Having poor mental health and feeling lonely can lead to unhelpful ways of coping and negative effects on health and wellbeing; increased substance abuse (alcohol, drugs, tobacco), increased gambling, frequent sickness, new pains and hallucinations.
- Lack of societal inclusion causes poor mental health (physically and digitally)

Engagement around mental health

- Having people to talk to is a key to prevention
- The natural environment, particularly for walking was a huge positive
- Creativity, the arts at an individual, community and large scale helps with people's mental health
- Safe spaces in town to meet

Quotes around mental health

'The hardest part is telling people how you feel'

'Once I opened up and spoke to people, it did really help'

'your job can affect your health'

'It's a very big picture, mental health, it's not just one thing, there can be many things.. involves that constitutes to a person's mental health.'

'Planning - thinking even about architecture and building and how you develop housing. We've sort of created housing that's sort of all isolated'.

'it is just about community and volunteers and people who are willing to go in and chat to people.'

What is important for improving wellbeing?

- Children and young people:
  - Safe spaces to chat with others
  - Resources for accessing support
  - Online support
- Adult health survey:
  - Family and friends
  - Exercising
  - Patient groups

What Mental Health Means to Us (11-24 year olds)

to be happy	prioritising the mindset you in	leading a healthiest life possible	prioritising our mental space like you would if you had hurt your knee	ensuring you can live your life to the fullest
feeling good	to not feel sad	thinking well	how we feel	to feel happy around others
something we should learn about from a young age	been able to cope	my mental health determines how much I enjoy my day	to not feel stressed	feeling content
a feeling of fulfilment	something my parents struggle with so I feel like I may do too	with good mental health I can be productive	to feel like I am contributing to my area in a positive way	something we talk about more than we used to at home
having a mind that gives me resilience	how we feel when we get up			

What Does a Mentally Heathy Rotherham Look Like?

- feeling proud of where we live
- feeling safe
- news and media focussing on the good things happening
- celebrating mental health more
- when we are physical well it impacts us mentally
- having a sense of belonging to where we live
- a positive label of the town makes us feel happy to life here
- things to look forward to
- celebrating achievements
- celebrating who I am and feeling safe to do so - example Pride
- reducing/ending loneliness
- more discipline in schools to respond to bullying
- celebrating community differences
- accepting one another for our likes and dislikes
- better healthier food that mum tells me impacts our wellness
- more access to therapists and councillors?
- no money worries

What Does a Mentally Heathy Rotherham Look Like? (2)

- not as much access to alcohol?
- keeping fit
- moving for mental health like we do at SYPA!
- I do CBT and that helps
- opportunities to meet people in a safe place
- not having too much takeaway food
- learning at school from been little things to do to make me happy
- more places for those with sensory/neurodiverse health
- I feel places like this help us be mentally healthy
- helping my parents as well as me
- where people feel a sense of purpose
- been proud to live here
- breaking the stigma of asking for help
- being myself
- feeling accepted
- embracing diversity

Better Mental Health for All

Vision: A Rotherham where everyone can thrive mentally, emotionally, and socially, in safe, inclusive, and supportive environments.

Council Plan
• Places are thriving, safe, and clean • An economy that works for everyone • Children and young people achieve their potential • Residents live well • One Council that listens and learns.

Health and Wellbeing Board Strategy
Support the people of Rotherham to live in good and improving mental health throughout their lives, accessing and shaping the services and resources they need.

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

Key Data – Rotherham JSNA

Building blocks for good mental health

- Good Housing
- Good Employment
- Good Transport
- Feeling Safe
- Tackling Poverty
- Tackling Stigma
- Tackling Discrimination
- Social Connectedness

Key Values

• Prevention First • Equity and Inclusion
• Co-production • Whole-System Approach
• Address Commercial Determinants

Links to other plans and strategies

- Adult Social Care Mental Health Strategy
- All Age Autism Strategy
- Best Start and Beyond
- Carers Strategy
- Dementia 100 framework tool
- Employment and Skills Strategy
- Financial Inclusion Plan
- Healthy Homes Plan
- Leaning Disability Strategy
- Loneliness Action Plan
- No Families Left Behind
- Prevention and Health Inequalities Plan
- Prevention Concordat
- Rotherham Housing Strategy
- Rotherham Mental Health Needs Assessment
- Suicide Prevention and Self Harm Action Plan

Support priority groups

- Children and young people (up to age 25)
- Later life (55+)
- Communities who experience inequalities
- Perinatal / early years
- Working Age Adults

Take action in priority places

- Care environments
- Family Hubs
- People's homes
- Rural and urban environments
- Schools
- Workplaces

Advocate for opportunities

- Creative health
- Drug and alcohol projects
- Moving Rotherham
- Neighbourhood health
- Safe, inclusive and supportive communities
- Sustainable transport
- Ward plans

Embed public health influence

- Five Ways to Wellbeing
- Making every contact count
- Measuring the impact
- Mental health in all policies
- Understanding and using data

Next steps

- The Better Mental Health for All Group will work to identify key actions for delivery over a 2-year period
- The infographic and identified key actions will demonstrate the HWB's ongoing commitment to early intervention and prevention and will support the ongoing commitment to OHID's Prevention Concordat for Mental Health onwards.
- The Better Mental Health for All Group will agree on outcome measures
- Annual updates will be reported to the HWB.

Thank you

Any Questions

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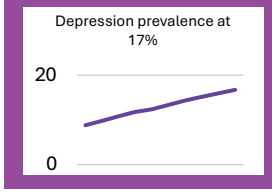

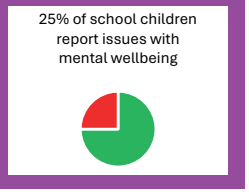

Building blocks for good mental health

Key Values

• Prevention First • Equity and Inclusion
• Co-production • Whole-System Approach
• Address Commercial Determinants

Links to other plans and strategies

- Adult Social Care Mental Health Strategy
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BRIEFING	**TO:**	Health and Wellbeing Board
	DATE:	28 January 2026
	LEAD OFFICER	Chris Clark
	TITLE:	Project Officer, Doncaster Metropolitan Borough Council

Background

1.1	The proposal for the Foetal Alcohol Spectrum Disorder (FASD) Project was to engage a specialist educational psychologist to contribute to the initial assessment of children who may be affected by foetal alcohol spectrum disorder and produce effective education plans to meet the specific needs of affected children.
1.2	A presentation on the FASD Project came to the Rotherham Health and Wellbeing Board meeting in January 2025.
1.3	The presentation included detail on the key project deliverables such as the FASD Pathway development and implementation, the formation of a Steering Group, a Prevention and Awareness working group, and the setting up of an Educational Psychology Service.
1.4	One of the actions associated with this presentation was for an update to be addressed to the Board in January 2026.

Key Issues

2.1	The central purpose of this proposal is to get agencies working together in a multi-disciplinary way around the specific issue of FASD. South Yorkshire Integrated Care Board (ICB) were involved with the project throughout and have worked closely to support the development of Prevention & Awareness services across South Yorkshire (SY). We have worked closely to start developing a FASD pathway to diagnosis and support across SY, utilising developments from other agencies. One Adoption West and One Adoption North & Humber have supported where appropriate to develop a Yorkshire approach to bringing FASD to the fore across a range of services.
2.2	Three distinct working groups were established throughout the project, these were: Prevention & Awareness: Working across SY to develop and deliver strategies, Working to identify current support services around FASD, where there are gaps and who we need to work with to fill these gaps, Looking at the development of services to support FASD diagnosis. The achievements of each respective group are outlined in the main report.
2.3	The scheme saw have the set up of three multidisciplinary FASD working groups in 3 of the four Local Authorities (LA), with discussions continuing to take place with the 4th, although they include FASD in their 0–24-month programme. The Educational Psychology team have trained over 650 members of staff across SY schools, adoptive parents, post adoption Social workers and educational psychologists and virtual school staff amongst other outcomes.

2.4	There is a raised awareness of FASD across SY and more trained staff thanks to the project. More staff across SY have received FASD training and the feedback from this training has been excellent. Adopters, both new and existing now have a better understanding of FASD and where to gain support with their adoptees. The educational Psychologists are creating an FASD toolkit that will be available across SY with tools for parents, schools and educational psychologists. We are working with authorities across SY to develop and FASD eLearning package that is available to all staff across SY.
2.5	The recommendations were to provide a longer lead time from the grant agreement to starting the project to allow for recruitment to positions across the project. There were opportunities noted to share best practice, issues and risks at the various meetings throughout the duration of the projects. Overall, the process was well received except for engagement with NHS colleagues throughout the project.
Key Actions and Relevant Timelines	
3.1	The FASD Project ran from April 2023 until March 2025, due to the duration of the grant.
Implications for Health Inequalities	
4.1	FASD is the most common yet unrecognised neurodevelopmental condition in the world. It is the most commonly known cause of neurodevelopmental disability and birth defect in the western world. 1 in 20 in the UK could have FASD compared to 1 in 94 with Autism Spectrum Disorder.
4.2	The condition is therefore a largely hidden disability and is closely associated with entrenching disadvantage across the life course and placing additional demand on health, social care and wider public services.
4.3	The SY FASD Project is aiming to create a system for recognising and implementing support systems and appropriate care for those with the condition with the opportunities left open for further work across the region to support those affected.
Recommendations	
5.1	That the Rotherham Health and Wellbeing Board note the information provided about the conclusion of the FASD Project for South Yorkshire.

Children's Services
Sheffield Educational Psychology Service
Principal Educational Psychologist:
Natalie Askham
Building 7, Manor Lane Depot, Manor Way, Sheffield, S2 1TR
Tel: 0114 250 6800

Sheffield Educational Psychology Service and One Adoption South Yorkshire Foetal Alcohol Spectrum Disorder Project – Evaluation

August 2025

What is Foetal Alcohol Spectrum Disorder (FASD)?

FASD is a lifelong neurodevelopmental condition that is caused by alcohol exposure in utero. It is a spectrum where each individual with FASD is affected differently and will have their own profile of strengths and needs. FASD can result in cognitive, emotional, behavioural and physical challenges for the individual.

It is estimated that as many as 4% of the UK population may have FASD making it more prevalent than autism, but it is commonly undiagnosed or misdiagnosed. It is estimated that around 85% of those with FASD are adopted or are in the care of the local authority.

Background to the Project

In 2023, One Adoption South Yorkshire (OASY) commissioned the Sheffield Educational Psychology Service (EPS) to be part of their FASD project. It was a two-year project which commenced in October 2023. The broad aims of project were to increase the identification, awareness and inclusion of adopted children and young people (CYP) with (or suspected of having) FASD.

Early stages of the project involved the formation of:

- An overarching steering group.
- Prevention and awareness working group.
- Intervention and support working group.
- Assessment and diagnosis working group.
- EP team.

The EP team has consisted of:

- 0.5 full time equivalent (FTE) Assistant Educational Psychologist.
- 0.2 FTE Educational Psychologist.
- 0.1 FTE Senior Educational Psychologist (each week).

From the outset, the project has been evaluated by Oxford Brookes University. This document is intended to be in addition to that evaluation, focussing solely on the work of the EP team in relation to Key Performance Indicators (KPIs) that were set at the start of the project.

EP Team Activities

There were three main strands to the work carried out by the EP team, in addition to a number of other discrete activities:

- Training.
- Individual casework.
- Multi agency working.
- Other activities.

1. *Training:*

The aims of the training were as follows:

- Develop awareness and knowledge of FASD.
- Develop an understanding of how FASD affects CYP's development and their key strengths and needs.
- Develop staff awareness and confidence of strategies and resources that can be used to support CYP with FASD.

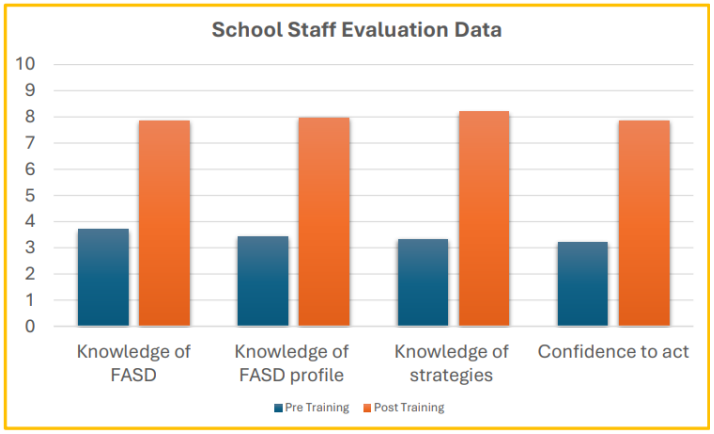
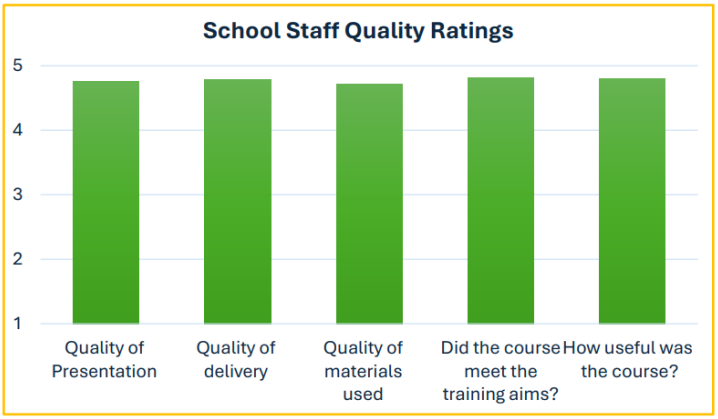
The training was developed using and was informed by interviews carried out with adoptive parents. Training has been delivered to a range of practitioners across the South Yorkshire region and to adoptive parents. The number having received training is as follows:

Role	**Total in receipt of training[1]**
School staff	535
Adoptive parents	30
Post adoption social workers	40
Educational Psychologists and Virtual School colleagues	61
Youth Justice colleagues	18
Total	**684**

<table>
<tr><th colspan="2">KPIs for training delivery</th></tr>
<tr><td>1. 60% of schools in South Yorkshire have one or more staff attend training (face to face or virtual)</td><td>When setting this KPI we acknowledged that the percentage figure was subjective as we could not dictate whether school settings would take up the offer of the training. A total of 535 school staff accessed the training either online or face to face from 121 schools across the South Yorkshire region.
<table>
<tr><th>Local authority</th><th>Total number of schools in the area[2]</th><th>Number of schools accessing training</th><th>Percentage</th></tr>
<tr><td>Barnsley</td><td>86</td><td>19</td><td>22.09%</td></tr>
<tr><td>Doncaster</td><td>124</td><td>44</td><td>35.48%</td></tr>
<tr><td>Rotherham</td><td>136</td><td>31</td><td>22.79%</td></tr>
<tr><td>Sheffield</td><td>177</td><td>50</td><td>28.25%</td></tr>
<tr><td>Total</td><td>523</td><td>150</td><td>28.68%</td></tr>
</table></td></tr>
<tr><td>2. All schools where an adopted child attend have one or more staff attend training (face to</td><td>It has not been possible to ascertain progress towards this KPI as there does not seem to be accurate data on which schools have an adopted child in attendance.</td></tr>
</table>

[1] Data accurate up to 30.07.25.

[2] Number of schools taken from data gathered via an internet browser search carried out on 05.08.25 using the search criteria *'number of schools in (name of LA) DfE'*

face or virtual)	
3. Increase in feedback score of two points or more regarding the attendees understanding of FASD and the strategies that they can use to support CYP with or suspected of having FASD	Feedback from the training has been extremely positive. Attendees were asked to rate their knowledge and confidence in relation to the training aims (listed previously) on a scale of 1-10 (1 being low) before and after the training session. Feedback from the training delivered has indicated an increase in awareness and confidence in understanding CYPs needs and strategies that can be used to support them. An example of the increase in feedback scores is illustrated below in the pre training scores (blue) and post training scores (orange).  Attendees were also asked to rate the quality of the training sessions on a scale of 1-5 (1 being low). The quality of the training was consistently regarded as being high as illustrated below.  <u>School staff:</u> With regard to the training for school staff: • 100% increased by 3 points or more for all four training aims. • 53.57% increased by 4 points or more for all four training aims. Qualitative feedback was also gathered from attendees. Staff reported back that understanding the psychology behind the

recommended strategies gave them a stronger rationale to implement them and the confidence to persist in using them.

Six months after attending the initial training, attendees were asked for further feedback. They were asked to give a rating of 1-10 (where 1 is 'not confident' and 10 is 'very confident') in relation to two questions. Of the 43 evaluations received back at the time writing this report, the following quantitative feedback was received from school staff:

Question	**School staff average rating**
How confident have you been acting on your knowledge of FASD?	7.16
How confident have you felt embedding strategies shared at the training?	7.28

School staff shared that since attending the training, they had shared their learning at staff meetings, had shared resources and had also held meetings with key class teachers.

They had found a number of strategies to be effective, including breaking down instructions, using visuals, ensuring that there are clear routines and structures and providing additional processing time. They had also implemented strategies relating to emotional regulation and approaches to meet CYPs sensory needs. They had focused on building relationships with CYP and using a calm and patient approach.

Staff reflected on a number of changes to their practice since attending the training. They shared how they were now considering FASD more readily in addition to other types of neurodiversity and were more confident in speaking to parents and practitioners about it. They reflected that they were able to apply new strategies and that the training had helped them to be more aware of different reasons that may underly presenting behaviours.

<u>EPS and Virtual School colleagues:</u>

With regard to the training for EPS/Virtual School staff:

- 100% increased by 2 points or more for all four training aims.
- 50% increased by 3 points or more for all four training aims.

Six months after attending the initial training, attendees were asked for further feedback. They were asked to give a rating of 1-10 (where 1 is 'not confident' and 10 is 'very confident') in relation to two questions. Of the 5 evaluations received back at the time writing this report, the following quantitative feedback was received from EPS/Virtual School staff:

Question	EPS/Virtual School staff average rating
How confident have you been acting on your knowledge of FASD?	7.4
How confident have you felt in identifying need and provision regarding FASD?	6.8

In the six-month evaluations, EPS/Virtual School colleagues reflected that the training had increased their knowledge of FASD and had helped them to consider it more readily alongside other areas of neurodiversity. It had helped them to consider the impact of executive functioning difficulties. They had been sharing their learning through discussions with others.

Adoptive parents:

By embedding the lived experiences of adoptive families within the training, prospective adopters have been able to understand more about FASD and the strengths and challenges that other parents have experienced to prepare them for their own adoption journey, therefore reducing risks of failed adoption placements. Current adoptive parents have also felt validated and that the "*missing jigsaw pieces"* of information, have helped them understand their CYPs needs better and how to approach situations differently at home, as well as how to advocate for them in discussions with school staff.

Six months after attending the initial training, attendees were asked for further feedback. They were asked to give a rating of 1-10 (where 1 is 'not confident' and 10 is 'very confident') in relation to three statements. Of the 3 evaluations received back at the time writing this report, the following quantitative feedback was received from adoptive parents:

Question	Adoptive parent average rating
Confidence to act on knowledge	8.67
Confidence to embed strategies	8.67
Understanding of the graduated approach	9

In the six-month evaluation, parents reflected that breaking down instructions had been an effective strategy that they had used since attending the training.

Social workers:

With regard to the training for social workers there was the following average increases seen in the pre- and post-training evaluations:

- Knowledge of FASD: +1.94.
- Knowledge of a typical FASD profile: +2.24.
- Knowledge of strategies to support CYP: +3.2.
- Confidence to act on knowledge of FASD: +2.53.

Key themes arising from the training feedback were that it would enable social workers to understand the needs of the adopted CYP within a FASD framework and consider ways to support parents, to meet the needs of CYP at home and advocate for them in school meetings.

Six months after attending the initial training, attendees were asked for further feedback. They were asked to give a rating of 1-10 (where 1 is 'not confident' and 10 is 'very confident') in relation to two statements. Of the 4 evaluations received back at the time writing this report, the following quantitative feedback was received from social workers:

Question	**Social worker average rating**
Confidence to act on knowledge	6.25
Confidence to embed strategies	6

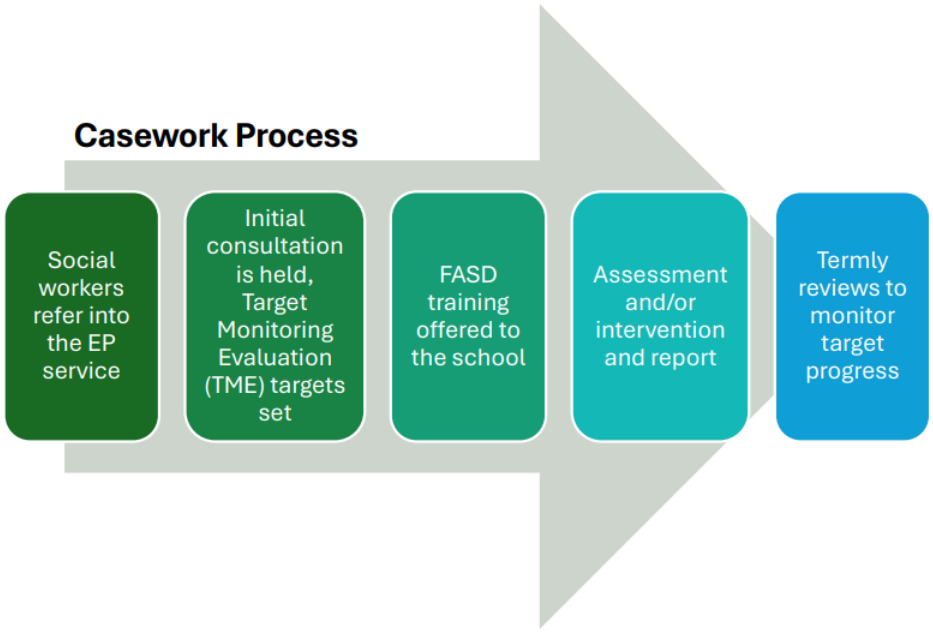
In the six-month evaluation, social workers told us that they had shared their learning from the training in meetings, discussions and that they had encouraged others to attend the training. They reflected that it had increased their knowledge and understanding of the needs of children with FASD and that they had found the preferred language guide useful. Please see FASD: Preferred UK Language Guide - National FASD)

Please see Appendix 1 for a sample of quotes from adoptive parents, school staff and social workers in relation to the training delivery.

2. *Individual casework:*

A referral process was set up for CYP from across the South Yorkshire region to be referred to the EP team. To be referred into the service, the CYP needed to be an adopted child, with an active post adoption social worker, and who had (or were suspected of having) FASD.

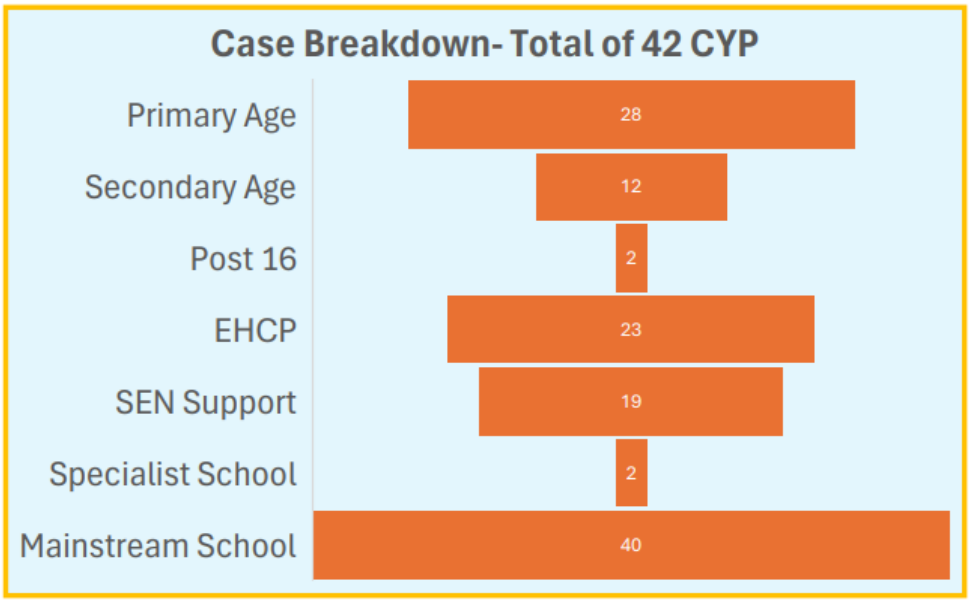
The referral process is illustrated below:



The aims of the individual casework were to:

- EPs to work collaboratively with CYP (with a confirmed or suspected diagnosis of FASD), their families, school staff and social workers.
- Consider CYP's strengths and needs holistically.
- Identify the provision required to support CYPs needs using knowledge of what works for CYP with FASD.

A total of 42 CYP were referred to the EP team. Ten (23.80%) of the CYP who were referred had received a diagnosis of FASD and 32 were suspected of having FASD. Information about their education phase, school type and SEN category can be found in the chart below.



Of the CYP referred to the service, four (9.52%) had attended school on a reduced timetable and six (14.28%) had received suspensions during their school career.

Towards the end of the project, the referral process changed so that rather than the casework process illustrated above, the offer was of a consultation session for the referring social worker. This was in view of the limited time that was remaining and to allow for us to begin evaluating work

completed to date. We received one request for a consultation, although this was later cancelled, with the social worker stating that they no longer required advice from the EP team.

KPIs for individual casework	
1. All referrals responded to within 10 working days	100% of referrals for individual casework were responded to within 10 working days. This has meant that there has been efficient access to support for CYP referred to the EP team.
2. Minimum of four, one to one interventions per year	A total of 42 CYP were referred into the project, spread across the four local authorities as follows: • Barnsley: 9. • Doncaster: 3. • Rotherham: 10. • Sheffield: 20. The number of contacts for each referral (a contact being a meeting, visit, consultation etc) ranged from 2 to 11 with an average of five contacts made per CYP. At the time of writing this report 38 of the referrals have now closed and 4 will close in the autumn term of 2025 once final meetings/actions have taken place.
3. Expected level of progress (or better) achieved for 75% of casework as measured using Target Monitoring and Evaluation (TME)	Target Monitoring Evaluation (TME)[3] targets were set for CYP. This involved setting a baseline measure of where the CYP was at the time the initial consultation, identifying a 'hoped for' level of progress and then reviewing the progress achieved. Progress was as follows: • 95.45% of CYP made at least 'some' progress with one of their TME targets. • 81.82% of CYP made at least 'expected' progress with one or more of their TME targets. • 54.55% of CYP made 'better than expected' progress with one or more of their TME targets. • Only one child (4.54%) made 'worse' progress with one or more of their TME targets. • 6 children (27.27%) made 'better than expected' on all of their TME targets.
4. Children and young people report improved well-being following direct work (using tools/measures relevant to the specific piece of work completed) in no less than 75% of casework	It has not been possible to gather evaluation feedback or data directly from the CYP referred into the project due to several factors including the severity of their needs or the nature of the work that has been completed. However, the project has allowed the voices of CYP to be listened to and heard and adjustments made accordingly. Themes regarding improvements for CYP did feature in feedback from school staff and parents and can be inferred from the Strengths and Difficulties (SDQ) questionnaires completed by adoptive parents and school staff. These were completed at the

[3] TME is used to assess the impact of Educational Psychology interventions. It involves setting SMART targets (Specific, Measurable, Achievable, Realistic and Time-bound) for CYP. Progress is rated at three stages – baseline, expected (hoped for) outcome and actual outcome. It is used to monitor change over time.

start of EP involvement and when individual cases were closed. Please see below.

Please also see Appendix 2 for a sample of quotes from adoptive parents, school staff and social workers in relation to the impact on CYP following individual casework.

<u>SDQ:</u>

Of the pre- and post-SDQs completed by adoptive parents (total of 10 at the time of writing this report):

- 60% of pupils had reduced scores for emotions (i.e. a positive change).
- 50% of pupils had reduced scores for hyperactivity (i.e. a positive change).
- 30% of pupils had reduced scores for conduct (i.e. a positive change).
- 30% of pupils had reduced scores for peer problems (i.e. a positive change).
- 50% of pupils had an increased scored for pro-social behaviour (i.e. a positive change).
- 70% of pupils had reduced scores for total difficulties (i.e. a positive change).
- 20% of pupils reduced scores for general impact (i.e. a positive change).

Of the pre- and post-SDQs completed by school staff (total of 8 at the time of writing this report) the following improvements have been reported:

- 25% of the pupils had reduced scores for emotions (i.e. a positive change).
- 37.5% of pupils had reduced scores for hyperactivity (i.e. a positive change).
- 50% of pupils had reduced scores for conduct (i.e. a positive change).
- 37.5% of pupils had reduced scores for peer problems (i.e. a positive change).
- 12.5% of pupils had increased scores for pro-social behaviour (i.e. a positive change).
- 25% of pupils had reduced scores for total difficulties (i.e. a positive change).
- 12.5% of pupils had reduced scores for general impact (i.e. a positive change).

It is important to note that in some cases, a different member of staff completed the pre- and post-SDQs which may impact on the data. Furthermore, not all of the CYP referred to the EP team had social, emotional or behavioural needs and therefore the SDQ was not necessarily the most appropriate measure in all cases. It also reflects the difficulty that there often is in measuring the impact of EP involvement.

<table>
<tr>
<td>5. Parents report improved understanding of their child's strengths and needs and knowledge of how to support their child using a self-report measure (such as the Thinking About Your Child questionnaire where applicable) in no less than 75% of casework</td>
<td>Thinking About Your Child (TAYC) questionnaires were completed by adoptive parents at the start and the end of EP involvement. Of the pre- and post-TAYCs completed by adoptive parents (total of 9 post-TAYCs received at the time of writing this report):

• 77.78% of parents felt they had increased their skills and knowledge.
• 11.11% of parents felt their relationship with their child had improved.
• 33.33% of parents felt their child was more responsive to care.
• 11.11% of parents felt their placement was more stable.
• 66.67% of total scores improved.

Evaluations were also completed when cases were closed. Adoptive parents were asked to rate a series of statements on a scale of 1-5 (where 1 was 'strongly disagree' and 5 was 'strongly agree.' Of the 8 evaluations received back at the time writing this report, the following quantitative feedback was received:

<table>
<tr><th>Statement</th><th>Adoptive parent average rating</th></tr>
<tr><td>The work has helped me/us to understand why our child displays certain behaviours</td><td>4.25</td></tr>
<tr><td>The work has started to reduce any stress I/we may have been experiencing around supporting my/our child at school</td><td>3.87</td></tr>
</table>

Therefore, adoptive parents are more informed about why their son/daughter may be presenting with certain behaviours and a reduction in stress has been reported.</td>
</tr>
<tr>
<td>6. FASD has been factored into the education plan for all those who have received 1-1 support</td>
<td>The project led to increased access to EP involvement for many CYP who were previously not known to their local authority EPS. During the period of involvement from the EP team, CYP's needs have been better understood from a neurodevelopmental perspective and advocated for within their educational settings. One indicator of this is through recognition of their needs:

• Six children, who prior to EP involvement were not recorded as having SEN, were moved to SEN Support level on the SEN register at their school.
• 12 children moved from SEN Support to having an EHCP. The work of the EP team and the focus on collaborative working ensured that EHCPs were detailed and reflected contributions from all involved.
• Three children with EHCPs transitioned from a mainstream to a specialist setting.
• Through collaborative working and sensitive challenge, the EP team used psychology to promote changes to the way schools to understand and subsequently reframe CYP's</td>
</tr>
</table>

needs. This led to a reduced risk of permanent exclusions for at least two of the CYP who were referred to the team. One social worker shared, "*Previously **** has been subject to exclusions and suspensions due to his behaviour, but the meetings have helped to frame his behaviour in his early experiences and FASD and helped school, parents and professionals think differently about how to support **** in a school setting."*

The use of TME allowed for small steps of progress to be monitored and celebrated. It enabled suggested strategies and provision to be tailored to each CYP according to their profile of strengths and needs and based on effective provision for CYP with FASD. The targets and associated provision then fed into broader documents such as SEN Support based plans and EHCPs based on the verbal and written feedback provided by the EP team.

As noted previously, evaluations were completed when individual cases were closed. School staff and social workers were asked to rate a series of statements on a scale of 1-5 (where 1 was 'strongly disagree' and 5 was 'strongly agree.' Of the 13 school staff and 18 social worker evaluations received back at the time writing this report, the following quantitative feedback was received:

Statement	**School staff average rating**	**Post adoption social worker average rating**
The work has helped me to understand how FASD could affect CYP	4.31	4.67
School staff and I have confidence to act upon the advice given by the EPs	4.54	4.44

Therefore, staff and social workers have substantial confidence in the advice that they have been given and have confidence to act upon it. It is hoped that this increase in understanding and confidence from practitioners would then translate into the plans that are developed to support CYP.

One social worker shared, "*Having the input of the FASD project has been invaluable to putting together a solid support plan for ****."*

3. *Multi-agency working:*

KPI for multi-agency working	
1. Relationships will have been created with key groups to support CYP, parents and school staff	Multi-agency working has been at the heart of the work of the EP team throughout the project. Individual casework:

Referrals for individual casework were completed by post adoption social workers and following acceptance of a referral, an initial consultation meeting took place between the adoptive parents, school staff and the referring social worker. This was vital to develop a clear understanding of the CYPs strengths and needs, and to identify appropriate targets and next steps with clear actions for all stakeholders to take away. Targets were then reviewed.

Social workers shared how working collaboratively with the EP team has helped to develop their confidence to advocate and sensitively challenge school practice and provision, and to become more familiar and confident with language and systems that they are less familiar with.

As noted previously, evaluations were completed when individual cases were closed. Adoptive parents, school staff and post adoption social workers were asked to rate a series of statements on a scale of 1-5 (where 1 was 'strongly disagree' and 5 was 'strongly agree.' Of the evaluations received back at the time writing this report, the following quantitative feedback was received in relation to collaborative working:

Statement	**Adoptive parent average rating**	**School staff average rating**	**Social worker average rating**
The work has felt collaborative between school staff, colleagues from the EP team, parents and agencies	4.75	4.69	4.83

Therefore, all parties felt that there was strong multi-agency collaboration during individual casework.

Networking events:

The training delivery has led to the development of education networking events for school staff and a regional FASD special interest group for EPs and Virtual School colleagues. Content of the networking events has included:

- Sharing anonymised casework examples.
- Group supervision through the use of solution circles.
- Further training on key topics relevant to FASD such as executive functioning skills and confabulation.
- Sharing psychological tools and approaches to understand CYP's needs and associated provision.
- Sharing local and regional updates.

School staff who accessed the networking events expressed that they enjoyed the sharing of best practice delivered and found the

	more detailed content informative. Regionally and nationally, both EPs and trainee EPs, who accessed the training and working groups, have shared that they feel more informed about understanding FASD and the profile in CYP. They felt more confident in writing future EHC advices or supporting school consultations linked to pupils needs especially in relation to their executive function and confabulation needs, and the provision they would need in schools regardless of whether they were suspected of having FASD or had received a diagnosis. Please see Appendix 3 for a sample of quotes from adoptive parents, school staff and social workers in relation to the impact of the project on multi-agency working.

4. *Other activities:*

In addition to the main three strands listed above, a variety of other activities have taken place over the course of the project. This has included:

- Attendance at multi agency steering groups across South Yorkshire.
- Development of parent and post-16 toolkits.
- Speaking at OASY conferences and a Multi-Disciplinary Approaches conference in London in December 2024.
- June 2025: poster presentation about the project at the FASD conference at the University of Salford.
- July 2025: webinar delivered for the Association of Educational Psychologists (AEP) National Union.
- July 2025: recording of webinars for Adoption England which will be live on their website in September 2025 for future adopters, adoptive parents, social workers and school staff which can be accessed nationally.
- February 2025: meeting with a representative from Life Lessons to discuss the addition of content regarding FASD on the Relationship, Sex and Health Education (RSHE) curriculum.
- Autumn 2025: training sessions to be delivered at the Universities of Sheffield and Nottingham for EPs undertaking their doctoral training.

Events such as these have been helpful in raising awareness of the work that is taking place regarding FASD in the South Yorkshire region.

EPS Reflections

Elements of the project that have worked well or have proved to be challenging have been alluded to previously in this document. However, key points that we wish to highlight are included in more detail below.

1. *Strengths and what worked well:*

Strength	Reflection
1. Recruitment of an EP team rather than one individual practitioner	Initially the intention was to recruit one EP to work on the project. However, difficulties in recruitment and the need to think creatively led to the role being shared amongst three members of staff. Given that this was a new project, having three colleagues meant that ideas could be shared and innovative suggestions given that might not otherwise have

	been possible. It also ensured that the team were able to provide supervision for one another which is vital for practitioners engaging in complex casework. If a project of this kind were to be commissioned again in the future, we would recommend that a similar model be used.
2. Increased access to EP time for adopted CYP with (or suspected of having FASD) across the South Yorkshire region	During the planning phase of the project, it was anticipated that we would work with a small number of CYP, likely to be 4-5 at any time. By the end of the project, 42 CYP had had involvement from the EP team. These CYP spanned a wide age range, had a range of needs (from pre-SEN Support to EHCP level) and were from schools across the South Yorkshire region. Many of them were not previously known to their local EPS and therefore the FASD project increased access to EP time that might not otherwise have been available to them. This allowed for earlier identification of need in many cases.
3. Scope to work with CYP, families, practitioners and schools over time	The involvement of EPs over time is something that was identified in recent research as being valued by families (Please see *"Foetal Alcohol Spectrum Disorders (FASD); The Parent Perspective on Education and Implications for Educational Psychologists (EPs)"* by Rebecca Griffiths which can be found here: 2022GriffithsREdPsyD.pdf). However, typically there is a shortage of EPs in local authorities and this means that often, it is not possible for EPs to have involvement with CYP over a period of time. In contrast, this project allowed the EP team to work with CYP over a much longer time frame, with some having involvement for over 12 months. This allowed for the development of positive relationships with the EP team, adoptive parents, school staff and social workers.
4. Multi-agency collaborative working	A focus on multi-agency working has been a priority in all elements of the project. This has worked particularly well within the casework strand, where the referral and initial consultation meeting structure were set up to include families, school staff and social workers from the outset. This has created a shared responsibility and has upskilled practitioners in both education and care professions. Social workers have reported having gained greater insight into the world of education and how the project has increased their confidence to attend school-based meetings.
5. Whole school training delivery	The training delivered to school staff involved different models. One option was for individual members of staff to book a place on the course; a second option was for training to be delivered to the staff team around a specific child and thirdly whole school training was delivered. In terms of impact, the latter option was most effective in terms of all members of staff receiving consistent key messages all at the same time. It also gave them the opportunity to discuss and reflect as a team around specific children within their setting.

2. *Challenges and reflections:*

Challenge	Reflection	Implications/next steps
1. Lack of data/information	There have been limitations in the information available to us about which settings have children attending who are adopted. This made it difficult for us to know where to target our training and support. However, it is appreciated that this	In the event of future projects taking place, it would be helpful if there was greater intelligence to enable the support to be offered in a more targeted way, particularly regarding the training offer.

	will in part be due to safeguarding and data protection requirements. Similarly, there is a lack of information regarding CYP with (or suspected of having) FASD.	
2. Greater need for support for families in the home	It became apparent early on that there was a need for adoptive parents to have support regarding strategies that they can use within the home. This is something that as education-based practitioners that we are not typically as readily involved with or to such an extent. The supervision that we provided to one another was helpful in us feeling confident in being able to provide appropriate support.	If a similar project were to be developed in the future, consideration could be given to there being the offer of structured Emotion Coaching sessions for families although this would be dependent on staffing. It may also be of benefit to consider whether there is a need for more intensive post adoption involvement, to be part of a multi-disciplinary team who could provide regular support, guidance and modelling of strategies in the home from an FASD perspective.
3. Lack of diagnostic pathway	Although the EP team was never intended to have a diagnostic role, a recurring theme from training, casework and networking was frustration from all stakeholders around the lack of a diagnostic pathway. There also appeared to be mixed messages being given. A lack of a diagnostic pathway means that there are many CYP who have accessed costly assessments via private providers.	There is a need for the development of an assessment pathway for FASD in South Yorkshire.
4. Equality of delivery across the four local authorities in the South Yorkshire region	The offer from the EP team was the same to all four local authorities within the county. However, as can be seen from the training and casework data shared in the tables above, there were big differences in the take up from the four areas. The majority of the training and individual casework took place in Sheffield with the least occurring in Barnsley (training) and Doncaster (casework). The EP team are mindful that as a Sheffield based service, it is likely that this may account for the greater 'buy in' seen from settings within our own local authority. Our names will be familiar to schools and other settings and there was perhaps a greater openness or confidence to working with us. It was also easier to	If there were to be a similar project in the future, it would be helpful if there were to be greater coordinated and centralised business support to be able to publicise forthcoming events to ensure that all four areas are aware of what is on offer.

	share information about forthcoming training and other events whereas publicising our work in other areas was more challenging and we were reliant upon colleagues in OASY, EP services and Virtual Schools sharing information for us. Although we were able to deliver training to 28% of schools across the South Yorkshire region, we feel that there was the potential for this to be higher had there been easier channels of communication/publicity.	
5. Time limited nature of the project	The project has had a significant impact on CYP, families, schools and social workers, as evidenced by progress towards the KPIs illustrated above. However, due to the time needed to establish referral processes and protocols early on in the project, this meant that there was a necessary delay before individual casework could begin. It would have been beneficial if we could have had involvement with some of the CYP referred to us over a longer period of time, particularly in view of forthcoming transitions to new settings that many of them were due to have. This would have enabled us to be a familiar person for the adoptive family at a time when many of the people involved in providing support for their son/daughter would be changing, It would enable us to provide training and support to the receiving schools and to upskill them in supporting CYP with FASD. Please see "*Syne, J., Green, R., and Dyer, J., (2012) Adoption: The lucky ones or the Cinderellas of children in care? Educational & Child Psychology, Vol. 29. No 3"* which highlights the need for EPs to provide ongoing support especially around key educational transitions.	As noted, the time spent developing processes and data sharing agreements was a necessary one but did take time. If a project of this kind were to be developed again in the future, time should be spent working on such processes beforehand in order to make it a more streamlined and efficient process once practitioners are in post and so that more time can be spent working with CYP, parents and their educational settings.

The EP team would like to thank the CYP, their families, school staff and the post adoption social workers who we have worked with over the course of this project. We would also like to thank OASY and Sheffield EPS for giving us this opportunity.

Dr Emma Lambley

Senior Educational Psychologist

Dr Ellie Salter Jones

Educational Psychologist

Miss Hollie Hughes

Assistant Educational Psychologist

28th August 2025

Appendix 1 – Qualitative feedback from training:

Adoptive parents said that the training helped with:

- *"Addressing ideas on how to respond to emotions and behaviour."*
- *"Highlighting the range of strengths and difficulties."*
- *"Ideas and strategies to use in our home life."*
- *"Know what we can access and how much help is available."*

School staff said that the training helped with:

- *"Use the knowledge gained through the course to support certain pupils in a more individualised way."*
- *"Understanding the variety of ways in which FASD can affect a child…"*
- *"Practical strategies to help children with FASD."*
- *"The call to attention when it comes to the terminology used when talking to parents in order to avoid blame."*

Social workers said that the training helped with:

- *"Being more mindful of my approach with children…"*
- *"Confidence in helping families within their own home."*
- *"Understanding resources I can use and how to support adopters."*
- *"Think more about FASD and the impact on children and their families."*

Appendix 2 – Qualitative feedback from individual casework reflecting the positive impact on CYP:

Feedback from adoptive parents:

- *"I can provide strategies and resources to use, as well as upskilling professionals who work with our child."*
- *"The team were knowledgeable and professional. I felt that they took time to understand our child's needs."*
- *"I was really impressed by the level of detail in your report."*
- ‘‘*We noticed a better, more effective, relationship between **** and his 1:1 support."*
- *"*** is learning much more with less need for sensory breaks now that he is in the sensory room for 2-3 hours a day."*
- *"More settled at school and happier to go into school. He is more settled after school and taking less time to regulate / decompress."*
- *"Helped me see the difficulties in a different way, that she wasn't lazy, that her brain works differently and that I need to adapt and respond to her in a different way."*

Feedback from school staff:

- *"The child is able to identify when she is starting to feel anxious and is more able to co-regulate with adults."*

Feedback from social workers:

- *"I feel the support has been individualised to the child's needs and provided a range of realistic interventions and advice."*
- *"School have noted an increase in confidence."*
- *"Parents and school have shared that they are seeing small but positive changes in how **** is progressing, which is lovely to know."*
- *"There has been an observable change in **** presentation in school, particularly in transition periods… he left school in a much more settled manner."*
- *"… the child has been more regulated in school."*
- *"I think it is helpful for **** to have an understanding of his FASD diagnosis and also to have looked at some future life planning."*
- *"*** has made more friendships at school which is significant for him."*
- *"*** presents as more settled in school since the plan was implemented. There are fewer instances of dysregulation, and he is also less aggressive."*
- *"I think the service has been invaluable for our families. It has really helped to think about the support which can be provided in school and for the wider service."*
- *"I am sure that without this support ****'s transition to Year 1 would not be as smooth or prepared as it is, and that his academic achievements may have been negatively impacted."*
- *"****'s final term at school was more positive and the language used about him by school staff started to be framed more positively."*

Appendix 3 – Qualitative feedback regarding multi-agency/collaborative working:

Feedback from adoptive parents:

- "T*hank you everyone for providing such clear and evidenced reports that identify ****'s needs. I feel this is a fabulous example of what collaborative working should look like and evidences what it can achieve for those that cannot advocate for themselves."*

Feedback from school staff:

- *"Working together with other professionals and the child's parent has ensured continuity in approaches and support offered."*
- *"Working with expert advice from EPS has been very beneficial to helping staff understand ****'s needs and how we can meet these as a school. Working together with other professionals and ****'s parent has ensured continuity in approaches and support offered. As a staff team, we are more aware of children who may have FASD, and this will help us identify and support other children in the future."*

Feedback from social workers:

- *"This has allowed me to work in a really joined up way with the school to offer the best support for the child and their family."*

End of Project Report

Project title	Foetal Alcohol Syndrome Disorder
Grantee organisation	One Adoption South Yorkshire
Person submitting this report	Chris Clark
e-mail address	Chris.clark2@doncaster.gov.uk
Total Grant Funding	£243,000
Period of Grant	01/04/23 – 31/03/25

1. PROJECT BACKGROUND

The proposal was to engage a specialist educational psychologist to contribute to the initial assessment of children who may be affected by foetal alcohol spectrum disorder and produce effective education plans to meet the specific needs of affected children.

The new Integrated Care Board in South Yorkshire and the Regional Adoption Agency have already identified FASD as likely to be having a significant impact on the health and well-being of many children in South Yorkshire and a significant proportion of children affected by FASD are likely to be adopted children.

Although FASD is often difficult to diagnose and there are no specific medical treatment options, research is suggesting that the best way to support affected children is through targeted education plans, as the impact is often most clearly seen in the child's approach to learning and their specific educational needs.

The Health Service is keen to develop initial support services for children and an educational psychologist would then be able to deliver practical advice and assistance to schools and parents.

The idea of an educational psychologist with a specific brief to work with adopted children would bring together multi-disciplinary work across South Yorkshire. Our colleagues in the Virtual Heads Teams would support this proposal as they too have identified a significant gap in services around this area.

The Integrated Care Board has the same footprint as the South Yorkshire RAA and the FASD would be amongst the first services for children they would be developing on a South Yorkshire wide basis. As a RAA we have been working with our colleagues in the Virtual Schools to develop South Yorkshire wide services where appropriate so this would be a real opportunity to bring key services for children together in a single integrated offer across the sub-region.

As OASY we are in regular contact with our adopters as we aim to develop services to meet identified need and multi-disciplinary assessment and services working together to support our children and their families is very much what they are encouraging us to consider. FASD has been raised many times as an issue affecting a significant number of our adopted children. We have adopters involved in various working groups to develop services and we would ensure that OASY adopters from across South Yorkshire are involved in the development of this project. We would ensure that there are adopter representatives on the project steering groups, and we have effective feedback loops to the wider group of adopters through our 'WhatsApp' groups and the adopter pages on our web-site. We also have two very active adopter-voice workers who are able to actively engage South Yorkshire adopters in projects and service development.

PROJECT OBJECTIVES

The central purpose of this proposal is to get agencies working together in a multi-disciplinary way around the specific issue of FASD. As yet it is not clear what agencies might be able to contribute beyond existing committed resources but even if we can get those to be co-ordinated, we have already found, as a OASY working across South Yorkshire that it is much more effective to work together than try to create four distinct services. Working relationships across services are already good but the introduction of the Integrated Care Board is at once an opportunity, as it brings Health on the same footprint as some other services such as the OASY and a challenge in that many people in Health Services now have changed roles and responsibilities. This is a really good time to start to build new relationships based on the new structures and develop new ways of working together.

The idea behind this project is to give a focus to gather partners around and to explore how we would develop joint evidence and joint reporting and together achieve improved outcomes for in this case a specific group of children but ultimately modelling provision for other groups of children.

In terms of financial sustainability of this specific post we will be considering contributions from partners if it is proved to be successful and necessary. Partners would include the OASY itself, if there is funding available and Partners on the Board agreed.

A key area of development within this project are the relationships with individual schools and Trusts across South Yorkshire (SY). We currently have a mailing list of over a thousand adopters. Given that most of them will have at least one child in school that is potentially a million pounds of adoption premium in schools and we know that not all of this is currently being claimed. Potentially we could work with our adopters and schools to ensure that we are claiming more of this and that a portion is being used to fund the OASY Educational Psychologist if the post has the successful outcomes we expect.

2. PEOPLE AND THEIR INVOLVEMENT

South Yorkshire Integrated Care Board (ICB) have been involved since conception and have worked closely to support the development of Prevention & Awareness services across SY. We have worked closely to start developing a FASD pathway to diagnosis and support across SY, whilst ensuring that we utilise developments from other agencies.

One Adoption West and One Adoption North & Humber have supported where appropriate to develop a Yorkshire approach to bringing FASD to the fore across a range of services and have allowed us to attend and deliver awareness sessions at their annual conference.

SY Adopters have been involved throughout bringing lived experience to all the meetings and specific examples of their lived experience, especially the difficulties around getting a diagnosis. Attendance from adopters across all working groups has been key to ensuring that experience of services is reflected in all the work we complete.

The virtual schools (VS) heads meet regularly to ensure FASD remains a key topic across the service and we have delivered training to all VS staff across SY.

All SY schools have been given the opportunity to attend face to face or online FASD training and this continues to be part of the legacy to develop a FASD eLearning package that can be accessed by schools, adopters and other service providers.

Worked closely with North Yorkshire & Humber ICB to develop an FASD Pathway document, which will hopefully be adopted across Yorkshire and create a clear FASD Pathway that meets the needs of all those requiring FASD diagnosis and post diagnosis support.

Joined with North Yorkshire & Humber ICB to influence NHS England to set up and run a Yorkshire FASD Community of Practice event.

3. ACHIEVEMENTS AND BENEFITS

The predicted benefits of the project were to highlight FASD as a condition that effects many CYP across SY and to develop an understanding of FASD with those who come into contact with these CYP.

As part of the project, we have been able to deliver training to key staff across SY, these include school staff, virtual schools staff, OASY social workers, SY Educational Psychologists and adopters. All training has been bespoke and developed for individual groups, to identify and meet their needs and current awareness of FASD.

We have created three distinct working groups:

- **Prevention & Awareness**: Working across SY to develop and deliver strategies such as;
    - Ensuring all Midwifes across SY ask questions around alcohol use to all service users at each appointment and that this is recorded.
    - REED Codes for Pre Natal Alcohol Exposure & FASD added to all NHS recording systems and rolled out across the NHS.
    - Working to get FASD warning added to Ovulation, pregnancy testing and folic acid kits.
    - Working with local licencing authorities to highlight the risks of drinking in pregnancy, including posters and beer mats across SY pubs.

  - Discussions with local MP's to introduce a bill around awareness and prevention of FASD.
  - Introduction of an FASD specific WhatsApp group.
  - FASD is a key focus for Public health across SY.
- **Support working group**: Working to identify current support services around FASD, where there are gaps and who we need to work with to fill these gaps. Focus on:
  - Developing local support group, run by those with lived experience and open to anyone who has a diagnosis or suspected FASD.
- **Assessment & Diagnosis**: Looking at the development of services to support FASD diagnosis.
  - Currently working with Sheffield ICB who have opened up their supervision with Professor Raja Mukherjee to all SY Paediatricians.
  - Sheffield CAHMS now carry out FASD assessment & Diagnosis.
  - Developed a draft FASD Pathway for diagnosis and support.
  - Working to get FASD added to all SY neurodevelopmental pathway assessments.

Educational Psychologists have supported 43 CYP across SY offering a range of bespoke support, whilst ensuring that local Educational Psychologists, school staff adopters and the CYP are fully involved in decision making, future planning and support services. The use of baseline emotional well being screeners and executive function screeners (BRIEF) have helped key areas of need within cognitive, emotional and behavioural regulation skills, which has then informed the type of interventions and provision required in school. More EP involvement for cases that would not have been picked up, despite being very complex.

Increased use of multi-disciplinary approach to dealing with complex cases, across schools, social care and adopters, ensuring better communication and outcomes for CYP with suspected or diagnosed FASD. Upskilling and developing confidence of practitioners and parents (how to respond and develop a personalised approach to pupils with suspected FASD). As a result of more social workers being aware of FASD (EP training and in casework), there are more conversations happening between social care and health professionals about assessment pathways for pupils. In one LA (out of the 4) formal medical discussions are taking place around the identification of FASD.

Attendance at numerous events have given us the opportunity to highlight the project across a wide range of authorities and at different service levels, raising the awareness of FASD across SY and beyond.

The benefits not realised at this point of the project are to have a fully integrated assessment & diagnosis pathway. Although some progress has been made across SY in getting a diagnosis, mainly through Sheffield services, getting agreement on a neurodiversity pathway that includes FASD, seems some way off at present. We will continue to push for FASD to be included in pathways and have a draft agreement ready but there appears reluctance to implement this across SY.

4. OUTCOMES

Describe what your project has achieved this far. What have been your main successes? What went well? What would you do again if you were to start again?

We have seen the set up of three multidisciplinary FASD working groups in 3 of the four Local Authorities (LA), with discussions continuing to take place with the 4th, although they include FASD in their 0-24 month programme.

Our Educational Psychology team have trained over 650 members of staff across SY schools, adoptive parents, post adoption Social workers and educational psychologists and virtual school staff.

Role	Total in receipt of training[1]
School staff	535
Adoptive parents	30
Post adoption social workers	40
Educational Psychologists and Virtual School colleagues	61
Youth Justice colleagues	18
Total	**684**

Please see Appendices 1 for evaluation of feedback.

We have helped in the setting up and development of the Yorkshire FASD Community of Practice, currently meeting quarterly.

Joined other initiatives to ensure FASD is a focus in neurodevelopmental projects across SY, including Neurodevelopment and Eating Disorders, Partnerships for Inclusion of Neurodiversity in Schools (PINS).

Ensured FASD continues to be considered through Safeguarding, Health & Wellbeing Board and neurodevelopmental working groups.

Influenced the training for FASD across Sheffield and Doncaster and persuaded both authorities to open up their FASD Training to SY staff.

Worked with Sheffield City Council, Doncaster City Council to hold FASD conferences, including and FASD conference with a criminal justice theme. This was promoted and attended by SY Police, SY Fire, SY HMPS and YoP personnel.

Worked with 4 LA's to develop and implement an Alcohol in Pregnancy eLearning package that is now available across all 4 LA'S.

Involved in the development of an FASD Animation which is available for use across SY.

Worked on the development of an FASD information video with NHS England which will be available for professionals by the end of October 2025.

Educational Psychologists have created a series of FASD Webinars, which will be available on the Adoption England website from early October 2025.

5. BARRIERS

It was a challenge to recruit staff to all positions once funding was agreed. The project focus changed due to being unable to recruit to the Educational Psychology roles initially. The funding was utilised to bring in a Project Manager and support the commissioning of Educational Psychology services from a partner LA.

There were delays in signing the data sharing agreement with all 4 authorities and this resulted in delays for the One-to-One work planned for the Educational Psychology team.

There was and still is issues around engagement for the SY ICB, especially in attempting to set up an assessment & diagnosis working group. Although this is now in place it is still felt that we do not have the right people to be able to influence change within the ICB.

Even though several authorities have made changes to their neurodiversity pathways and General Development Assessment (GDA) Pathways, it has proved difficult to get FASD considered as part of these redevelopments.

6. FUTURE AND SUSTAINABILITY

There is a raised awareness of FASD across SY and more trained staff thanks to the project. More staff across SY have received FASD training and the feedback from this training has been excellent. Adopters, both new and existing now have a better understanding of FASD and where to gain support with their adoptees.

The educational Psychologists are creating an FASD toolkit that will be available across SY with tools for parents, schools and educational psychologists.

We are working with authorities across SY to develop and FASD eLearning package that is available to all staff across SY.

The changes to the questions and recording systems for midwifes across SY should help with diagnosis of FASD in the future, where all alcohol consumption during pregnancy is recorded on both the parents and child's records.

Reed codes for FASD and suspected FASD available for use on EMISS and System One for the recording of FASD.

All midwives across SY ask about alcohol exposure at all appointments and record findings.

FASD Amination and video available for use across SY.

7. LESSON LEARNED

Key lessons are around the funding and how to implement the project with short time scales from bid to acceptance. Getting the staffing in place seems to be an issue across all projects and it would have been helpful to have scoped out LA's about commissioning at an earlier time in the bidding process. We should have started the data sharing agreement at the onset of the project, as this would have resulted in a timelier completion and prevented delays in the one-to-one work.

If anyone is thinking about a similar project, I think getting agreement with senior management within the NHS is vital, as it feels we are pushing against a locked door when it comes to getting FASD recognised by services across SY.

8. RECOMMENDATIONS

A longer lead time from the grant agreement to starting the project to allow for recruitment to positions across the project.

I felt that the community of practice events were well received. There were clear opportunities to share best practice, issues and risks at the various meetings throughout the duration of the projects.

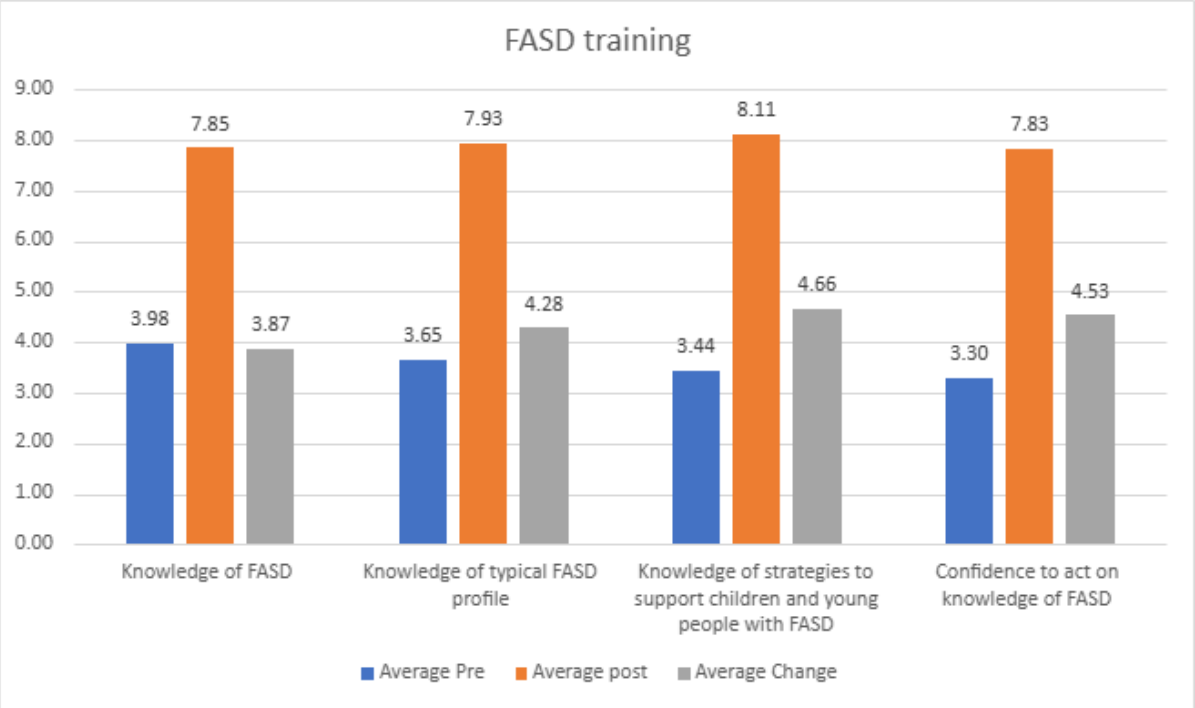
Overall I think the process worked well, except for our ability to engage NHS colleagues fully with the project.

9. FINANCIAL SUMMARY

Please provide a breakdown of how your funding has been used across each year of your grant period			
	Year 1	Year 2	TOTAL
Staff costs	£120,000	£120,000	£240,000
Overheads			
Travel	£600	£750	£1350
Training			
Other costs Room hire	£750	£500	£1250
TOTAL			£242,700
Other costs: Please provide brief detail			

Appendices 1

FASD Training feedback



Snapshot from one training session (Meerbrook Bank)

Qualitative feedback
What will you do differently as a result of this course? • Think about strategies for children in and outside of the class • Consider lunch time 20 minute slots, break down risks. • Be more aware of needs, provide scaffolding with 'first next then' resources including sensory breaks • Have a proactive approach to certain children presenting with FASD • I learnt new things • Use less language • Be more understanding with the children • Pay more attention to the possible needs that a child may require • Have more understanding and patience • Simple language • Use strategies more in class, used phased introductions, more movement breaks • Use strategies offered. Reduce verbal overload • Understand the child and their needs more, use more strategies and talk and listen more • Think before acting / speaking. Be less heat of the moment • Think a little bit more before I speak or react to a comment or incident

- Know a child isn't doing impulsive things on purpose so to have more time for them. To use ASD and ADHD strategies with child
- Explore some of the resources / websites shared to support planning / interactions
- Consider alternative provisions and interventions that may be required
- Use language, more resources and support in place
- Not judge, consider the language I use
- Use of language
- Carefully consider provision
- Look out for signs
- Put in place preventative strategies to support children with FASD
- Pay more attention.
- Visual aids and concrete examples, Use the break it down board consistently with conflicts.
- Plan strategies for child coming into Y1

What has been the most helpful part of the course?

- A chance to match the theory to real children
- Practical ideas to support
- Better awareness of profile
- Tips in how to implement and support those children suspected to have FASD
- Executive functioning, attention and memory
- Interesting to hear about FASD as I was not aware of the spectrum.
- Being informed about the effects of FASD
- Being given booklets and leaflets which help aid in the learning
- Being informed about the effects of FASD
- Seeing the FASD resources
- Everything has been helpful and very informative. It has given me a better insight to FASD.
- Not having any understanding of FASD, information given today was very beneficial
- Learnt more understanding and strategies
- All of it
- Understanding that FASD is a neurodevelopment disorder and can be thought of as ADHD or ASD
- Knowing the signs of a child with FASD
- Giving focus to FASD and awareness of how common it is
- Raising awareness / improving knowledge
- Group discussions - understanding greater depth of FASD
- Chatting to others
- Group discussions - sharing experience and knowledge
- To know in detail what causes it and how it affects behaviour and to raise awareness in all staff, so that we are all able to identify children through school
- Background information what FASD is
- Learning new techniques
- Advice on how to support children throughout the school day

- Insight to this condition
- Emotional Regulation Ideas
- Finding out more about FASD and strategies to support

Was there anything else that you would have liked to have been included?

- A chance to talk as a whole school - afterwards may be more appropriate
- I would like to learn different things
- Tea and Coffee!
- Parents - when they don't say the truth it is hard to work out needs
- Further information about working with parents and supporting them with their child's behaviours.

Rotherham Metropolitan Borough Council

NHS South Yorkshire Integrated Care Board

BRIEFING	**TO:**	Health and Wellbeing Board
	DATE:	Wednesday, 28th January 2026
	LEAD OFFICER	Steph Watt Health and Care Portfolio Lead, SYICB/RMBC E-mail: steph.watt@nhs.net
	TITLE:	HWBB Report for Rotherham BCF 2025/26 Quarter 3 Reporting Template

Background

1.1 The purpose of this report is to agree the contents of the BCF Q3 Reporting Template which will be submitted to NHS England regarding the metrics and expenditure of Rotherham's Better Care Fund Plan for 2025/26.

1.2 The overall delivery of the Better Care Fund continues to have a positive impact and improves joint working between health and social care in Rotherham.

Key Issues

2.1 The BCF Quarter 3 template covers reporting on: national conditions, metrics and expenditure.

2.2 Below is a summary of information included within the BCF submission:

2.3 National Conditions

There are a total of 4 national conditions for 2025/26 which continue to be met through the delivery of the plan as follows:

- Plans to be jointly agreed.
- Implementing the objectives of the BCF.
- Complying with grant and funding conditions, including maintaining the NHS minimum contribution to adult social care (ASC).
- Complying with oversight and support processes.

3. BCF Metrics

There are three BCF metrics within the BCF Q3 Template for 2025/26 which measures the impact of the plan as follows:

3.1 **Emergency admissions to hospital for people aged 65+ per 100,000 population** - This measure was reported as not on target to meet goals.

	It was noted In the Q3 template, the BCF updated the population counts for people aged 65 and over, to use the latest 2024 mid-year estimates from the Office for National Statistics (ONS). This population figure is now used as the denominator when calculating the planned rate of emergency admissions to hospital for people aged 65+ per 100,000. As a result, the rates have changed slightly. **Achievements** - This indicator measures the rate of emergency hospital admissions among people aged 65 and over, expressed as a crude rate per 100,000 population. Emergency admissions are unplanned, urgent admissions that may occur via A&E, direct referral from a GP, or other clinical pathways. As part of quarterly reporting, figures are provided for each month. Using locally held SUS data, there has been some month-on-month variation across the quarter. In October, the actual figure was 2207.6 compared with a planned 2088.0, above plan. In November, the actual was 2020.0 against a planned 1955.6, slightly above plan. The data currently available for December is incomplete and therefore does not provide an inaccurate comparison at the current time. **Challenges and any support needs** - A key priority for the Rotherham urgent and emergency care recovery plan in 2025-26, is to reduce avoidable conveyances and admissions in order to meet the national 4-hour standard, G&A occupancy levels and no criteria to reside. **Variance from Plan –** Overall, the quarter 3 figures are slightly higher than the planned values across October and November 2025. **Mitigation for Recovery –** There is a significant amount of activity happening to reduce avoidable conveyances and admissions, however due to the aging population and Rotherham's health inequalities, we are continuing to see high levels of demand. Winter schemes were enacted from November 2025, and the acute respiratory infection hub was opened early due to flu hitting early. Additional activity has been put in place to increase the uptake in vaccination rates as well as additional capacity in the Hospital at Home (virtual ward) pathways. There is ongoing work with Yorkshire Ambulance Services to promote PUSH models to reduce avoidable conveyances, and targeted work is planned to support the top 5 GP practices and care homes that convey to hospital.
3.2	**Average length of discharge delay for all acute adult patients, derived from a combination of:** **• proportion of adult patients discharged from acute hospitals on their Discharge Ready Date (DRD)** **• for those adults patients not discharged on their DRD, average number of days from the DRD to discharge -** This measure was reported as on track to meet goals. **Achievements** - The Discharge Ready Date (DRD) is the specific date that a patient is ready to be discharged from the acute setting either to their 'home' or to any intermediate level of care. It can be used to identify any delay between DRD and the actual date of discharge.

	The indicator metric used is an average derived from a combination of proportion of adult patients discharged from acute hospitals on their Discharge Ready Date (DRD) and the average number of days patients that are not discharged on their discharge ready date take to be discharged. This report covers data for the third quarter of 2025–26 relating to the Discharge Ready Date (DRD) metric. Local SUS data shows that in October, the recorded average was 0.58 compared with a planned 0.65. The figure increased in November to 0.74 above the planned 0.65, and provisional data for December shows an increase to 0.80, above the planned 0.65. Across the three months of Quarter 3, the average proportion of adult patients discharged on their date of discharge was 85.5% in October, 81.9% in November, and 81.8% in December. For adult patients not discharged on their DRD, the average number of days from DRD to discharge decreased during the first two months of Quarter 3 compared with September's figure, at 4.00 days in October and 4.08 days in November. Provisional data for December currently shows an increase to 4.40 days, this is expected to change. **Challenges and any support needs** - Discharge pathways have been pressured due to increased demand and acuity. There has been an increase in complex discharge referrals of 10% from December 2024 to December 2025, and 34% from December 2023 to December 2025. Taking a snapshot at the turn of the year, from 2023 there were 42 patients awaiting complex discharge. This rose to 60 in 2024, and 70 in 2025. At the equivalent time at the start of 2026, this reduced to 58 discharges, against the backdrop of significant increases in referrals. The team are currently carrying some vacancies and response times are expected to improve when these are filled. **Variance from Plan –** In Q3 2025–26, the Discharge Ready Date (DRD) metric showed mixed variance from the plan. October's average (0.58) was below the planned 0.65, November was above plan at 0.74 vs. 0.65, and December exceeded the planned 0.65 with an actual of 0.80. **Mitigation for Recovery –** TRFT have carried out extensive work to reduce discharge delays for Pathway 0 patients including senior management long length of stay reviews and consistent reviewing of discharge delays and action cards. The Transfer of Care Hub continues to embed, with real time MDT discussions reducing delays. General and acute bed occupancy rates in Rotherham hospital were reduced from a high of 97.5% on 19th December to 78.46% on Christmas morning, meeting the national target of 80% occupancy. This was achieved through activity such as the 12 days of Christmas MADE event (multi-agency discharge event) and strong partnership working.
3.3	**Long-term admissions to residential care homes and nursing homes for people age 65 and over per 100,000 population –** On track according to the BCF dashboard/CLD. Adult Social Care (ASC) has been undergoing a change in how statutory information is collected. Up to 2024 the data was collected at year end, compiled onto spreadsheets and submitted to government. During 24/25 this process continued but there was a quarterly submission of data extracted direct from the adult social care database and processed centrally – this is called Client Level Data (CLD). Some data such as safeguarding is still collected using the previous method, however CLD is now entirely used for calculating admissions data.

The BCF return has always been populated using the local definitions that previously populated the spreadsheets. BCF has now shifted to using the CLD return and the CLD definitions are different than the previously used local ones.

This data has always historically revised down before it becomes stable. Looking back at Quarter 1 the two numbers are very alike, but at the point of collection for Q3 they are very different. According to the BCF dashboard that is now available nationally, Rotherham is on target, according to the latest local data Rotherham is over target – but this data always historically revises down over the year.

The issue is further compounded by the fact that the return demands data being run almost at the point of the end of the quarter and this does not give time for write up processes to fully conclude. CLD itself is not submitted until the end of the month following quarter end and therefore the CLD number presented below is the indicative number prior to validation.

Both numbers are presented below. The most reliable quarter we have at this point is Q1 which appears to be right around target regardless of the method used.

The two numbers for Q3 vary by a greater margin than in previous quarters, the data will be rerun at month end prior to submission, where it is expected the numbers will be closer together:

	Q1	Q2	Q3
Local Actual	83	95	106
Local per 100,000	154.94	177.34	197.87
CLD Actual	81	84	68
CLD per 100,000	151.2	156.8	126.94
Target Actual	**82**	**82**	**82**
Target per 100,000	**153.07**	**153.07**	**153.07**

Achievements - Rotherham's strategic aim is to support more people to remain independent for longer at home and BCF funding is being used to support this. An impact of the strategy is therefore to reduce admissions to care homes. However, this needs to be balanced in the context of an ageing population and Rotherham's challenging levels of deprivation.

The Council have completed a review of in-house services with changes in roles and responsibilities of teams including the discharge team, enablement and in house community beds. This is leading to improved partnership working and releasing capacity.

Adult Social Care are continuing to work with Health partners to reduce short term placements in care homes, many of which translate into long term stays.

The Council also continues to closely monitor the rates of admission with a focus on home first, and residential care being only considered where there are no other appropriate alternatives to meeting needs.

Approval has been given to a Place review of intermediate care provision and the commissioned community bed base. An anticipated benefit is to support more people at home and reduce long term placements.

	Activity and outturn data is subject to amendments and additional system recording with revised admissions totals for each month. The 2025-26 BCF target has been set to a population rate of 563.6, which equates to 317 admissions over the year. **Challenges and any support needs** – Shortage of capacity in Pathway 1 can result in increased numbers of short stay placements. National and local evidence shows that those placed in short term care often convert to longer term care. **Variance from Plan –** BCF dashboard/CLD better than plan. Local data currently over plan but traditionally revises down. **Mitigation for Recovery –** The next phase of the discharge to assess model is planned for January 2026. This is funded by in year BCF monies but has been delayed due to recruitment challenges. There has been a review of the discharge processes at each of the 3 commissioned bed bases and action plan is in place. The aim of both is to reduce length of stay and return more people home quicker.
4. **4.1**	**Bench Marking** The BCF Operational Group are requesting South Yorkshire and regional data to enable a benchmarking exercise.
5. **5.1**	**Expenditure** The Q3 Year-to-Date Actual Expenditure for BCF funded schemes. covering the period from 1st October to 31st December 2025, has been included in the Q3 template.
Key Actions and Relevant Timelines	
6.1	**The Better Care Fund Executive Group held on Monday 19th January 2026 approved (on behalf of the Health and Wellbeing Board) the:** **i) Documentation for submission to NHS England (NHSE) on 30th January 2026.**
Implications for Health Inequalities	
7.1	Addressing health inequalities is integral to the allocation of BCF resource and funded schemes. This includes contributing to achieving the strategic aims of developing healthy lifestyles and prevention pathways, supporting prevention and early diagnosis of chronic conditions and targeting variation.
7.2	BCF funded schemes which reduce health inequalities include carer support, social prescribing, Breathing Space and project support for the implementation of Population Health Management (PHM) priorities.
Recommendations	

8.1	**That the Health and Wellbeing Board notes the:** **i) Documentation for submission to NHS England (NHSE) on 30th January 2026.**

Better Care Fund 2025-26 Q3 Reporting Template

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1. Guidance

Overview

The Better Care Fund (BCF) reporting requirements are set out in the BCF Planning Requirements for 2025-26 (refer to link below), which supports the aims of the BCF Policy Framework and the BCF programme; jointly led and developed by the national partners Department of Health and Social Care (DHSC), Ministry for Housing, Communities and Local Government (MHCLG), NHS England (NHSE).

https://www.england.nhs.uk/long-read/better-care-fund-planning-requirements-2025-26/#introduction

https://www.gov.uk/government/publications/better-care-fund-policy-framework-2025-to-2026/better-care-fund-policy-framework-2025-to-2026

As outlined within the planning requirements, quarterly BCF reporting will continue in 2025-26, with areas required to set out progress on delivering their plans by reviewing metrics performance against goals, spend to date as well as any sigificant changes to planned spend.

The primary purpose of BCF reporting is to ensure a clear and accurate account of continued compliance with the key requirements and conditions of the fund. The secondary purpose is to inform policy making, the national support offer and local practice sharing by providing a fuller insight from narrative feedback on local progress, challenges and highlights on the implementation of BCF plans and progress on wider integration.

BCF reporting is likely to be used by local areas, alongside any other information to help inform HWBs on progress on integration and the BCF. It is also intended to inform BCF national partners as well as those responsible for delivering the BCF plans at a local level (including ICBs, local authorities and service providers) for the purposes noted above.

In addition to reporting, BCMs and the wider BCF team will monitor continued compliance against the national conditions and metric ambitions through their wider interactions with local areas.

BCF reports submitted by local areas are required to be signed off HWB chairs ahead of submission. Aggregated data reporting information will be available on the DHSC BCF Metrics Dashboard and published on the NHS England website.

Note on entering information into this template

Please do not copy and paste into the template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data needs inputting in the cell

Pre-populated cells/Not required

Note on viewing the sheets optimally

To more optimally view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance tab for readability if required.

The row heights and column widths can be adjusted to fit and view text more comfortably for the cells that require narrative information.

Please DO NOT directly copy/cut and paste to populate the fields when completing the template as this can cause issues during the aggregation process. If you must 'copy and paste', please use the 'Paste Special' operation and paste Values only.

The details of each sheet within the template are outlined below.

Checklist (2. Cover)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be complete before sending to the BCF Team.
2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'
3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
5. Please ensure that all boxes on the checklist are green before submission.

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. Once you select your HWB from the drop down list, relevant data on metric goals from your BCF plans for 2025-26 will pre-populate in the relevant worksheets.
2. HWB Chair sign off will be subject to your own governance arrangements which may include a delegated authority.
3. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to:
england.bettercarefundteam@nhs.net
(please also copy in your respective Better Care Manager)
4. Please note that in line with fair processing of personal data we request email addresses for individuals completing the reporting template in order to communicate with and resolve any issues arising during the reporting cycle. We remove these addresses from the supplied templates when they are collated and delete them when they are no longer needed.

3. National Conditions

This section requires the Health & Wellbeing Board to confirm whether the four national conditions detailed in the Better Care Fund planning requirements for 2025-26 (link below) continue to be met through the delivery of your plan. Please confirm as at the time of completion.
https://www.england.nhs.uk/long-read/better-care-fund-planning-requirements-2025-26/
This sheet sets out the four conditions and requires the Health & Wellbeing Board to confirm 'Yes' or 'No' that these continue to be met. Should 'No' be selected, please provide an explanation as to why the condition was not met for the year and how this is being addressed. Please note that where a National Condition is not being met, an outline of the challenge and mitigating actions to support recovery should be outlined. It is recommended that the HWB also discussed this with their Regional Better Care Manager.
In summary, the four National conditions are as below:
National condition 1: Plans to be jointly agreed
National condition 2: Implementing the objectives of the BCF
National condition 3: Complying with grant and funding conditions, including maintaining the NHS minimum contribution to adult social care (ASC) (and section 75 in place)

National condition 4: Complying with oversight and support processes

4. Metrics

The BCF plan includes the following metrics (these are not cumulate/YTD):
1. Emergency admissions to hospital for people aged 65+ per 100,000 population. (monthly)
2. Average number of days from Discharge Ready Date to discharge (all adult acute patients). (monthly)
3. Admissions to long term residential and nursing care for people aged 65+ per 100,000 population. (quarterly)
Plans for these metrics were agreed as part of the BCF planning process outlined within 25/26 planning submissions.
Populations are based on 2024 mid year estimates, please note this has been updated from the Q2 template to match the DHSC metrics dashboard.

Within each section, you should set out how the ambition has been reached, including analysis of historic data, impact of planned efforts and how the target aligns for locally agreed plans such as Acute trusts and social care.

The bottom section for each metric also captures a confidence assessment on achieving the locally set ambitions for each of the BCF metrics.
The metrics worksheet seeks a short explanation if a goal has not been met - in which case please provide a short explanation, including noting any key mitigating actions. You can also use this section to provide a very brief explanation of overall progress if you wish.

In making the confidence assessment on progress, please utilise the available metric data via the published sources or the DHSC metric dashboard along with any available proxy data.

https://dhexchange.kahootz.com/Discharge_Dashboard/groupHome

5. Expenditure

This section requires confirmation of an update to actual income received in 2025-26 across each fund, as well as spend to date at Q3. If planned expenditure by activity has changed since the original plan, please confirm that this has been agreed by local partners. If that change in activity expenditure is greater than 5% of total BCF expenditure, please use this box to provide a brief summary of the change.

On the 'DFG' row in the 'Source of Funding' table, 'Updated Total Planned Income for 25-26' this should include the total funding from DFG allocations that is available for you to spend on DFG in this financial year 2025-26. 'Q3 Year-to-Date Actual Expenditure' should include total amount that has been spent in Q3, even if the application or approval for the DFG started in a previous quarter or there has been slippage.

The template will automatically pre-populate the planned income in 2025-26 from BCF plans, including additional contributions. Please enter the update amount of income even if it is the same as in the submitted plan.

Please also use this section to provide the aggregate year-to-date spend at Q3. This tab will also display what percentage of planned income this constitutes; [if this is 50% exactly then please provide some context around how accurate this figure is or whether there are limitations.]

HM Government

NHS England

Better Care Fund 2025-26 Q3 Reporting Template

2. Cover

Version 2.0 [unlocked]

Please Note:

- The BCF quarterly reports are categorised as 'Management Information' and data from them will be published in an aggregated form on the NHSE website. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.

- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.

- All information will be supplied to BCF partners to inform policy development.

- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

		Checklist Complete:
Health and Wellbeing Board:	Rotherham	
Completed by:	Emma Royle	Yes
E-mail:	emma.royle2@nhs.net	Yes
Contact number:	0333 041 0021 (Option 5)	Yes
Has this report been signed off by (or on behalf of) the HWB Chair at the time of submission?	No	Yes
If no, please indicate when the report is expected to be signed off:	Sun 01/03/2026	Yes

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

Complete

	Complete:
2. Cover	Yes
3. National Conditions	Yes
4. Metrics	Yes
5. Expenditure	Yes

For further guidance on requirements please refer back to guidance sheet - tab 1.

<< Link to the Guidance sheet

etter Care Fund 2025-26 Q3 Reporting Templat

3. National Conditions

Selected Health and Wellbeing Board: Rotherham

Confirmation of Nation Conditions			Checklist Complete:
National Condition	Confirmation	If the answer is "No" please provide an explanation as to why the condition was not met in the quarter and mitigating actions underway to support compliance with the condition:	
1) Plans to be jointly agreed	Yes		Yes
2) Implementing the objectives of the BCF	Yes		Yes
3) Complying with grant and funding conditions, including maintaining the NHS minimum contribution to adult social care (ASC) and Section 75 in place	Yes		Yes
4) Complying with oversight and support processes	Yes		Yes

Better Care Fund 2025-26 Q3 Reporting Template

4. Metrics for 2025-26

Selected Health and Wellbeing Board: Rotherham

For metrics time series and more details: BCF dashboard link

For metrics handbook and reporting schedule: BCF 25/26 Metrics Handbook

4.1 Emergency admissions

Plan

		Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan	Sep 25 Plan	Oct 25 Plan	Nov 25 Plan	Dec 25 Plan	Jan 26 Plan	Feb 26 Plan	Mar 26 Plan
Emergency admissions to hospital for people aged 65+ per 100,000 population	Rate	1,915.1	2,073.3	2,032.9	1,957.4	1,878.3	1,893.0	2,088.0	1,955.6	2,104.6	2,297.8	1,997.9	2,202.1
	Number of Admissions 65+	1,041	1,127	1,105	1,064	1,021	1,029	1,135	1,063	1,144	1,249	1,086	1,197
	Population of 65+	54,357.0	54,357.0	54,357.0	54,357.0	54,357.0	54,357.0	54,357.0	54,357.0	54,357.0	54,357.0	54,357.0	54,357.0

Assessment of whether goal has been met in Q3:	Not on track to meet goal
You may use this box to provide a very brief explanation of overall progress if you wish.	This reporting covers Quarter 3 of 2025–26. Using locally held SUS data, there has been some month-on-month variation across the quarter. In October, the actual figure was 2207.6 compared with a planned 2088.0, above plan. In November, the actual was 2020.0 against a planned 1955.6, slightly above plan. December's data is currently incomplete and woudl provide an inaccurate comparision.

4.2 Discharge Delays

Original Plan

	Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan	Sep 25 Plan	Oct 25 Plan	Nov 25 Plan	Dec 25 Plan	Jan 26 Plan	Feb 26 Plan	Mar 26 Plan
Average length of discharge delay for all acute adult patients (this calculates the % of patients discharged after their DRD, multiplied by the average number of days)	0.65	0.72	0.65	0.63	0.68	0.66	0.71	0.65	0.65	0.69	0.66	0.71
Proportion of adult patients discharged from acute hospitals on their discharge ready date	84.1%	84.1%	84.1%	84.1%	84.1%	84.1%	84.1%	84.1%	84.1%	84.1%	84.1%	84.1%
For those adult patients not discharged on DRD, average number of days from DRD to discharge	4.09	4.52	4.10	3.97	4.28	4.12	4.46	4.09	4.09	4.36	4.15	4.43

Assessment of whether goal has been met in Q3:	On track to meet goal
You may use this box to provide a very brief explanation of overall progress if you wish.	This report covers data for the third quarter of 2025–26 relating to the Discharge Ready Date (DRD) metric. Local SUS data shows that in October, the recorded average was 0.58 compared with a planned 0.65. The figure increased in November to 0.74 above the planned 0.65, and provisional data for December shows and increase to 0.80, above the planned 0.65. Across the three months of Quarter 3, the average proportion of adult patients discharged on their date of discharge was 85.5% in October, 81.9% in November, and 81.8% in December. For adult patients not discharged on their DRD, the average number of days from DRD to discharge decreased during the first two months of Quarter 3 compared with Septembers figure, at 4.00 days in October and 4.08 days in November. Provisional data for December shows an increase to 4.40 days.

4.3 Residential Admissions

Actuals + Original Plan

		2023-24 Full Year Actual	2024-25 Full Year CLD Actual	2025-26 Plan Q1 (April 25-June 25)	2025-26 Plan Q3 (July 25-Sept 25)	2025-26 Plan Q3 (Oct 25-Dec 25)	2025-26 Plan Q4 (Jan 26-Mar 26)
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Rate	556.3	590.5	150.9	150.9	152.7	152.7
	Number of admissions	298.0	321.0	82.0	82.0	83.0	83.0
	Population of 65+*	54357.0	54357.0	54357.0	54357.0	54357.0	54357.0

Assessment of whether goal has been met in Q3:	On track to meet goal
You may use this box to provide a very brief explanation of overall progress if you wish.	The national team have changed how this information is recorded. This is now drawn from CLD. This is a change to previous council practice which has used local data. It was agreed at the BCF Executive Group that we would review this data immediately prior to submission as previous experience shows this is subject to change prior to submisison. CLD and local data in the BCF report with further detailed information.

Checklist

Complete:

Yes

Yes

Yes

Yes

Yes

Yes

Better Care Fund 2025-26 Q3 Reporting Template

5. Income & Expenditure

Selected Health and Wellbeing Board: Rotherham

Source of Funding	2025-26 Planned Income	Updated Total Plan Income for 25-26	DFG Q3 Year-to-Date Actual Expenditure	Checklist Complete:
DFG	£3,801,597	£3,801,597	£442,308	Yes
Minimum NHS Contribution	£28,410,232	£28,410,232		Yes
Local Authority Better Care Grant	£17,864,126	£17,864,126		Yes
Additional LA Contribution	£2,582,038	£4,493,038		Yes
Additional NHS Contribution	£0	£0		Yes
Total	**£52,657,993**	**£54,568,993**		

	Original	Updated	% variance	
Planned Expenditure	**£52,657,993**	**£54,568,993**	**4%**	Yes

		% of Planned Income	
Q3 Year-to-Date Actual Expenditure	£35,717,285	**65%**	Yes

If planned expenditure by activity has changed since the original plan, please confirm that this has been agreed by local partners. If that change in activity expenditure is greater than 5% of total BCF expenditure, please use this box to provide a brief summary of the change.	Planned expenditure change agreed at Quarter 1 Reporting	Yes

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Minutes	
Title of Meeting:	Rotherham Place Board: **ICB Business**
Time of Meeting:	11:00 – 11.30am
Date of Meeting:	Wednesday 17 September 2025
Venue:	John Smith Room, Rotherham Town Hall
Chair:	Chris Edwards
Contact for Meeting:	Lydia George: lydia.george@nhs.net/ Wendy Commons: wcommons@nhs.net

Apologies:	W Allott, Director of Financial Transformation Rotherham, NHS SYICB J Edwards, Chief Executive, Rotherham Metropolitan Borough Council I Spicer, Deputy Chief Executive, Rotherham Metropolitan Borough Council R Jenkins, Chief Executive, The Rotherham NHS Foundation Trust T Lewis, Chief Executive, Rotherham, Doncaster and South Humber NHS Foundation Trust M Cottle-Shaw, Chief Executive Officer, Rotherham Hospice Dr A Barmade, Medical Director, Connect Healthcare Rotherham Cllr J Baker Rogers, H&WB Board Chair, RMBC Gordon Laidlaw, Head of Communications – Rotherham, NHS SY ICB Bob Kirton, Managing Director, The Rotherham NHS Foundation Trust Alex Hawley, Interim Director of Public Health, Rotherham MBC
Conflicts of Interest:	General declarations were acknowledged for Members as providers/commissioners of services.
Quoracy: (Quorate)	No business shall be transacted unless at least 60% of the membership (which equates to 4 individuals) and including the following are present: (1) Executive Place Director and (2) Independent Non-Executive Member.

Members:
Chris Edwards (**CE**), Executive Place Director (Rotherham) NHS South Yorkshire Integrated Care Board
Claire Smith (**CS**), Director of Partnerships (Rotherham) NHS SY ICB
Andrew Russell (**AR**), Director of Nursing – Rotherham & Doncaster, NHS SY ICB
Dr Jason Page (**JP**), Medical Director, (Rotherham), NHS SY ICB
Shahida Siddique (**SS**), Independent Non-Executive Member, NHS SY ICB

Participants:
Jude Archer (**JA**), Assistant Director of Transformation, NHS SY ICB
Andrew Brankin (**AB**), Rotherham Care Group Director, Rotherham, Doncaster and South Humber NHS Foundation Trust
Lydia George (**LG**), Transformation & Partnership Portfolio Manager (Rotherham), NHS SY ICB
Shafiq Hussain (**SH**), Chief Executive, Voluntary Action Rotherham
Sue Panesar (**SP**), Public Health Specialist, Rotherham MBC
Eloise Summerfield (**ES**), Senior Pharmacist – Rotherham, NHS SY ICB
Sarah Boul (**SB**), Portfolio Director for Mental Health, NHS SY ICB

In attendance
Wendy Commons, (minute taker) Business Support Officer (Rotherham), NHS SY ICB

Item Number	Discussion Items
I42/09/25	**Place Integrated Performance Report**

JA updated Members on performance highlighting:

Urgent & Emergency Care (UEC)

- Attendance: 71.3%
- Category 2 Ambulance Response: 22:49 minutes exceeding 30 minute target
- Ambulance Handover: 74.2% below the 78% target
- 97.9% of patients were admitted, transferred, or discharged within 12 hours

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Community & Virtual Care

- Community Referrals: Target met in June – good performance.
- Virtual Ward: 83% occupancy and meeting target – strong delivery.

Primary Care

- Appointments Available: 162K – highest in South Yorkshire, excellent access.
- GP Experience: High satisfaction – positive patient feedback above target

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Elective & Diagnostics

- Elective Waits: 800 patients waiting 52 weeks, improving month-on-month
- Diagnostics: 95.2% – strong performance and improving.

Cancer Pathways

- 28-Day Faster Diagnosis: 77% – improving from 69.4% month-on-month.
- 62-Day Treatment: Dropped to 62.8% – area of concern and under review.
- 31-Day Treatment: 88.4% – significant reduction and area of focus.

System flow and capacity performance is good mainly due to work carried out internally by the Trust.

The Place Board acknowledged the month's performance and expressed appreciation to partners for their continued commitment to improvement.

I43/09/25	**Rotherham Place Prescribing Report – Quarter 4**

ES explained that there has been a negative cost growth of -0.41% for Rotherham Place GP practice prescribing compared to 2023/24 which is below cost growth in South Yorkshire and across England. However there is still strong item growth of 4.31%, above SY and England averages.

There have been positive outcomes from work on new first-line blood thinning agents in collaboration with GP practices using MECC (Making Every Contact Count) to undertake blood monitoring through a one-stop shop approach has proved effective.

We have faced cost pressure from diabetes monitoring as monitors have become more expensive. Work has been carried out to support practices with upgrades.

Savings of £1.4m have been made across practices through the use of drugs like Mounjaro for diabetes patients. Incentive schemes have been agreed with practices to generate savings against targets and there has been strong performance with the safety dashboard where but two practices have excelled.

The transfer of responsibility for prescribing and managing nutritional products is now with the Trust as is nutritional products and this has produced considerable cost savings.

Continence and stoma prescribing and management is overseen by a team of specialist nurses from TRFT and the services benchmarks well for costs and savings have been reinvested to increase community provision.

ES confirmed for EPH that mothers were given additional breastfeeding support and advice when mothers seeing dieticians in relation to infant feeding and allergies. JP suggested that there was a further opportunity for improvement with health visitors sending patients to GPs with potential milk allergy issues. JP was happy to provide additional context to EPH outside of the meeting.

KG explained that Healthwatch was receiving lots of queries from the public about Mounjaro query. EPH highlighted that there are risks associated with unregulated use and emphasised the importance of adhering to clinical guidelines for diabetes patients. For individuals seeking weight loss, alternative options are available, and the recommended course of action is to consult their GP for appropriate advice.

Place Board noted the contents of the prescribing report and thanked ES for the update.

I44/09/25	**ICB Board Assurance Framework, Risk Register & Issues Log**

All members had received and reviewed the board assurance framework, risk register and issues log.

JP advised that a risk relating to the implementation of key changes to the 2025/26 GP contract from 1 October 2025 about access will be added to the risk register. It relates to GP Connect Access and poses a potential safety risk. Negotiation continues between the GPC and NHS England.

Place Board agreed to add the above risk as well as one around future plans for HealthWatch which KG is drafting (as agreed in the public partnership session).

It was noted that in future consideration may need to be given to resourcing the neighbourhoods pilot.

Place Board agreed that the two new risks will be added to the risk register.

Action: CE/LG

Members were encouraged to advise the Chair at any time with details of any potential additions.

I45/09/25	**Quality, Patient Safety and Experience Dashboard**

AR presented this month's report

It was noted that a recent CQC inspection undertaken RDaSH adult acute wards had identified concerns. RDaSH received a rating of requiring improvement and a plan has been put in place.

From a hospital perspective, Queensway Hospital (Ellen Mead Group) provides complex mental health services after a change in CQC registration. Some safety concerns have arisen. SY ICB has oversight and started engagement around quality assurance.

Across the ICB, there remains a strong national and local focus on Continuing Healthcare and the associated cost pressures. Rotherham continues to face significant workforce challenges

due to ongoing staff absences and vacancies, resulting in capacity risks within the clinical team. Mitigation measures are in place to manage these risks. While the QIPP plan targets are being met, and no direct savings have been achieved, the overall overspend is reducing. Collaborative work with external partners remains focused on maintaining and improving quality.

JP advised that in relation to primary care, Shakespeare Road has improved its CQC rating to good. There are two Rotherham GP practices that are rated as requiring improvement.

AR confirmed that governance and improvement work is ongoing in relation to Yusuf Nasir, with close scrutiny by NHS England who is leading the process. Any emerging challenges or risks will be reported to the Place Board for assurance.

Referring to the LeDer report, AR advised that it contained some specific learning for Rotherham for Members to note. The reports will continue to be shared with Place Board going forward.

EPH noted the positive developments regarding the Waverley practices. However, the Pharmaceutical Needs Assessment has identified some service gaps, prompting local efforts to challenge NHS England on provision. Regarding pharmacy services at Waverley, EPH will follow up with JA and ES to explore how we can influence commissioning decisions and improve patient choice.

CE thanked AR and Members noted the contents of the report.

I46/09/25	**Feedback from Rotherham Place Executive Team (RPET)**

CS advised that RPET had considered the following items:

National Neighbourhood Health Implementation Programme

- A new national programme was launched, offering an opportunity for Rotherham to submit a bid.
- The programme supports a "test and learn" approach, targeting adults with long-term conditions and rising risk—aligning with local priorities.
- RPET endorsed submitting a first-wave bid, with Place Board partners agreeing to proceed.
- Two preparatory workshops are scheduled for September.

RDaSH – Direct Award A

- RPET supported a direct award contract (2025–2030) to RDaSH, agreed with SY ICB, Doncaster City Council, Nottingham ICB, and Rotherham Place.
- The decision aligns with NHS Provider Selection Scheme Regulations 2003.
- RPET approved the publication of the decision notice on the UK Government's Find a Tender Service portal.

Qwell Service Benefit Review

- RPET reviewed the Qwell digital mental health service (delivered by Kooth plc).
- Supported continuation for 12 months, with an option to extend another 12 months via the G-Cloud Call-Off Contract 14 framework.
- Further discussions will assess whether current funding levels can maintain service activity.

Place Board Members noted the business conducted through Rotherham Place Executive.

I47/09/25	**Minutes and Action Log and Assurance Report from the last Meeting**

The minutes from the meeting held on Wednesday 16 July 2025 were accepted as a true and accurate record.

The action log was reviewed. An amber-rated action was raised following BK's enquiry regarding the potential impact of transitioning from the Rotherham Health Record (RHR) to the Yorkshire & Humber Care Record. Specifically, concerns were noted about possible loss of functionality currently available through RHR. Andrew Clayton has been invited to provide a digital update at the November Place Board meeting, where further clarification will be given. The assurance report for the Integrated Care Board noted that there are no actions arising from the minutes to be escalated.	
I48/09/25	**Communication to Partners/Promoting Consultations & Events**
• Health & Wellbeing Strategy Setting – Thursday 2 October 2025, Town Hall	
I49/09/25	**Risks and Items for Escalation**
None.	
I50/09/25	**Forward Agenda Items**
Standing Items – Rotherham Place Performance Report (monthly) – Risk Register (Monthly for information) – Place Prescribing Report (Quarterly) – Quality, Patient Safety and Experience Dashboard (Bi- monthly) – Quarterly Medical Director Update (November)	
I51/09/25	**Date of Next Meeting**
The next meeting will take place on **Wednesday 15 October 2025** in the John Smith Room, Rotherham Town Hall.	

Membership

Chris Edwards (Chair)	Executive Place Director/Deputy Chief Executive, ICB	NHS South Yorkshire Integrated Care Board
Claire Smith	Director of Partnerships, Rotherham Place	NHS South Yorkshire Integrated Care Board
Wendy Allott	Director of Financial Transformation, Rotherham	NHS South Yorkshire Integrated Care Board
Andrew Russell	Director of Nursing, Rotherham & Doncaster Places	NHS South Yorkshire Integrated Care Board
Dr Jason Page	Medical Director, Rotherham Place	NHS South Yorkshire Integrated Care Board
Shahida Siddique	Independent Non-Executive Member	NHS South Yorkshire Integrated Care Board

Participants

Alex Hawley	Acting Director of Public Health	Rotherham Metropolitan Borough Council
Shafiq Hussain	Chief Executive	Voluntary Action Rotherham
Ian Spicer	Strategic Director, Adult Care, Housing & Public Health	Rotherham Metropolitan Borough Council
Richard Jenkins	Chief Executive	The Rotherham NHS Foundation Trust
John Edwards	Chief Executive	Rotherham Metropolitan Borough Council
Toby Lewis	Chief Executive	Rotherham, Doncaster and South Humber NHS Foundation Trust
Cllr Joanna Baker-Rogers	H&WB Board Chair	Rotherham Health and Wellbeing Board/ Rotherham Metropolitan Borough Council
Dr Anand Barmade	Medical Director	Connect Healthcare Rotherham
Bob Kirton	Managing Director	The Rotherham NHS Foundation Trust
Kym Gleeson	Service Manager	Healthwatch Rotherham
Mat Cottle-Shaw	Chief Executive	Rotherham Hospice
Lydia George	Transformation & Partnership Portfolio Manager (Rotherham)	NHS South Yorkshire Integrated Care Board
Gordon Laidlaw	Head of Communications (Rotherham)	NHS South Yorkshire Integrated Care Board

Minutes	
Title of Meeting:	Rotherham Place Board: **ICB Business**
Time of Meeting:	11:00 – 11.30am
Date of Meeting:	Wednesday 15 October 2025
Venue:	John Smith Room, Rotherham Town Hall
Chair:	Claire Smith
Contact for Meeting:	Lydia George: lydia.george@nhs.net/ Wendy Commons: wcommons@nhs.net

Apologies:	W Allott, Director of Financial Transformation Rotherham, NHS SYICB C Edwards, Executive Place Director (Rotherham) NHS South Yorkshire Integrated Care Board J Edwards, Chief Executive, Rotherham Metropolitan Borough Council I Spicer, Deputy Chief Executive, Rotherham Metropolitan Borough Council R Jenkins, Chief Executive, The Rotherham NHS Foundation Trust T Lewis, Chief Executive, Rotherham, Doncaster and South Humber NHS Foundation Trust M Cottle-Shaw, Chief Executive Officer, Rotherham Hospice Dr A Barmade, Medical Director, Connect Healthcare Rotherham Cllr J Baker Rogers, H&WB Board Chair, RMBC S Hussain, Chief Executive, Voluntary Action Rotherham B Kirton, Managing Director, The Rotherham NHS Foundation Trust A Brankin, Rotherham Care Group Director, Rotherham, Doncaster and South Humber NHS Foundation Trust E Parry Harries, Director of Public Health, RMBC
Conflicts of Interest:	General declarations were acknowledged for Members as providers/commissioners of services.
Quoracy: (Quorate)	No business shall be transacted unless at least 60% of the membership (which equates to 3 individuals) and including the following are present: (1) Executive Place Director and (2) Independent Non-Executive Member.

Members:
Claire Smith (**CS**), Director of Partnerships (Rotherham) NHS SY ICB
Andrew Russell (**AR**), Director of Nursing – Rotherham & Doncaster, NHS SY ICB
Dr Jason Page (**JP**), Medical Director, (Rotherham), NHS SY ICB
Shahida Siddique (**SS**), Independent Non-Executive Member, NHS SY ICB

Participants:
Jude Archer (**JA**), Assistant Director of Transformation, NHS SY ICB
Lydia George (**LG**), Transformation & Partnership Portfolio Manager (Rotherham), NHS SY ICB
Kym Gleeson (**KG**), Healthwatch Manager, Healthwatch Rotherham

In attendance
Wendy Commons, (minute taker) Business Support Officer (Rotherham), NHS SY ICB

Item Number	Discussion Items
I52/10/25	**Place Integrated Performance Report**

JA advised that the report circulated did not appear to contain the correct data for this month and gave highlights of the performance she had since obtained.

Urgent & Emergency Care (UEC)

- **A&E 4-hour target:** 71.5% (below 78% target), an improving position
- **Category 2 ambulance response and ambulance handover:** continue to meet target on response times and handovers improved from last month to meet the national target
- **Urgent Community Response (UCR):** 77.6%, consistently above 70% target. The position with community waits over 52 weeks had improved but the target of 0 is challenging

Primary Care

- **Appointments:** a significant number are available with Rotherham offering highest number in South Yorkshire.
- **Patient experience:** 75.3% satisfaction – above 71.1% local ambition target.

Elective & Diagnostics

- **Elective waits over 52 weeks:** 2% of waiting list – double the 1% target.
- **Diagnostics within 6 weeks:** 94.2% – just below national standard and a decline on last month.

Cancer

- **28-day Faster Diagnosis Standard & 62-day referral to treatment:** neither standard being met and discussion to understand the position will be undertaken with the Trust
- **31-day treatment standard:** 90.9% – below 96% target, although improved position.

The Place Board noted performance. The revised version of the report will be circulated to members for information.

I53/10/25	**ICB Board Assurance Framework, Risk Register and Issues Log**

All members had received and reviewed the board assurance framework, risk register and issues log.

CS provided an update following last month's discussion regarding the potential addition of a new risk to the register. The risk relates to changes in the GP contract that could affect patient access. After further consideration, it was agreed that this issue is both national and relevant across South Yorkshire and therefore should be added to the NHS South Yorkshire ICB risk register, rather than being specific to Rotherham Place.

It was also noted that Rotherham GPs have adopted a pragmatic approach to implementing the changes, and no concerns have been reported to date.

The other risk identified last month relating to the future plans for Healthwatch and their support of the patient voice will be added for next month.

There were no new risks to be added, but Members were encouraged to advise the Chair at any time with details of any potential additions.

I54/10/25	**Feedback from Rotherham Place Executive Team (RPET)**

CS advised that RPET had considered the following items:

- Rotherham Medicines Optimisation Incentive Scheme – RPET had considered and approved the payment of the 2024-25 scheme for which the budget is held locally, to practices.
- Social Prescribing/Mental Health Community Connectors (MHCC) Future Commissioning Options Appraisal – RPET had agreed the option for offices to progress to integrate the MHCC service into the existing social prescribing contract and whilst exploring efficiencies also consider sustainability of VAR as part of the process and report back to RPET.
- Locally Enhanced Service – Optometry – RPET noted the paper and that further work was being undertaken to understand challenges and potential risks at which point a decision can be made as to whether to join the South Yorkshire proposal.
- Weight Management Pathway Update – RPET supported the updated pathway noting it had been approved at Clinical Management Referrals Committee and there was no financial impact as a result of the revision.

Place Board Members noted the business conducted through Rotherham Place Executive Team.

I55/10/25	**Minutes and Action Log and Assurance Report from the last Meeting**

The minutes from the meeting held on Wednesday 17 September 2025 were accepted as a true and accurate record.

The action log was reviewed with no areas for concern noted.

The assurance report for the Integrated Care Board noted that there are no actions arising from the minutes to be escalated.

I56/10/25	**Communication to Partners/Promoting Consultations & Events**

- The first learning workshop for National Neighbourhood Pioneers is taking place in Manchester on 22 October. A cohort from Rotherham will be attending and Place Board will be updated on progress.
- Covid and Flu vaccination programmes have commenced with local and targeted communications being co-ordinated to emphasise importance and focus. Recent changes to eligibility criteria have led to some public confusion. It was also noted that Covid vaccinations are no longer being offered to frontline staff.

I57/10/25	**Risks and Items for Escalation**

As mentioned above, Healthwatch risk will be added to the register for next month.

I58/10/25	**Forward Agenda Items**

Standing Items

- Rotherham Place Performance Report (monthly)
- Risk Register (Monthly for information)
- Place Prescribing Report (Quarterly)
- Quality, Patient Safety and Experience Dashboard (Bi- monthly)
- Quarterly Medical Director Update (November)

I59/10/25	**Date of Next Meeting**

The next meeting will take place on **Wednesday 19 November 2025** in the John Smith Room, Rotherham Town Hall.

Membership

Chris Edwards (Chair)	Executive Place Director/Deputy Chief Executive, ICB	NHS South Yorkshire Integrated Care Board
Claire Smith	Director of Partnerships, Rotherham Place	NHS South Yorkshire Integrated Care Board
Wendy Allott	Director of Financial Transformation, Rotherham	NHS South Yorkshire Integrated Care Board
Andrew Russell	Director of Nursing, Rotherham & Doncaster Places	NHS South Yorkshire Integrated Care Board
Dr Jason Page	Medical Director, Rotherham Place	NHS South Yorkshire Integrated Care Board
Shahida Siddique	Independent Non-Executive Member	NHS South Yorkshire Integrated Care Board

Participants

Alex Hawley	Acting Director of Public Health	Rotherham Metropolitan Borough Council
Shafiq Hussain	Chief Executive	Voluntary Action Rotherham
Ian Spicer	Strategic Director, Adult Care, Housing & Public Health	Rotherham Metropolitan Borough Council
Richard Jenkins	Chief Executive	The Rotherham NHS Foundation Trust
John Edwards	Chief Executive	Rotherham Metropolitan Borough Council
Toby Lewis	Chief Executive	Rotherham, Doncaster and South Humber NHS Foundation Trust
Cllr Joanna Baker-Rogers	H&WB Board Chair	Rotherham Health and Wellbeing Board/ Rotherham Metropolitan Borough Council
Dr Anand Barmade	Medical Director	Connect Healthcare Rotherham
Bob Kirton	Managing Director	The Rotherham NHS Foundation Trust
Kym Gleeson	Service Manager	Healthwatch Rotherham
Mat Cottle-Shaw	Chief Executive	Rotherham Hospice
Lydia George	Transformation & Partnership Portfolio Manager (Rotherham)	NHS South Yorkshire Integrated Care Board
Gordon Laidlaw	Head of Communications (Rotherham)	NHS South Yorkshire Integrated Care Board

Minutes	
Title of Meeting:	Rotherham Place Board: **ICB Business**
Time of Meeting:	10.45 – 11.30am
Date of Meeting:	Wednesday 19 November 2025
Venue:	John Smith Room, Rotherham Town Hall
Chair:	Claire Smith
Contact for Meeting:	Lydia George: lydia.george@nhs.net/ Wendy Commons: wcommons@nhs.net

Apologies:	Anthony Fitzgerald, Place Director – Rotherham & Doncaster, NHS SYICB W Allott, Director of Financial Transformation Rotherham, NHS SYICB C Edwards, Executive Place Director (Rotherham) NHS South Yorkshire Integrated Care Board J Edwards, Chief Executive, Rotherham Metropolitan Borough Council I Spicer, Deputy Chief Executive, Rotherham Metropolitan Borough Council R Jenkins, Chief Executive, The Rotherham NHS Foundation Trust T Lewis, Chief Executive, Rotherham, Doncaster and South Humber NHS Foundation Trust M Cottle-Shaw, Chief Executive Officer, Rotherham Hospice Dr A Barmade, Medical Director, Connect Healthcare Rotherham Cllr J Baker Rogers, H&WB Board Chair, RMBC B Kirton, Managing Director, The Rotherham NHS Foundation Trust E Parry Harries, Director of Public Health, RMBC Andrew Russell, Director of Nursing – Rotherham & Doncaster, NHS SY ICB
Conflicts of Interest:	General declarations were acknowledged for Members as providers/commissioners of services.
Quoracy: (Quorate)	No business shall be transacted unless at least 60% of the membership (which equates to 3 individuals) and including the following are present: (1) Executive Place Director and (2) Independent Non-Executive Member.

Members:
Claire Smith (**CS**), Director of Partnerships (Rotherham) NHS SY ICB (deputising)
Dr Jason Page (**JP**), Medical Director, (Rotherham), NHS SY ICB
Shahida Siddique (**SS**), Independent Non-Executive Member, NHS SY ICB

Participants:
Jude Archer (**JA**), Assistant Director of Transformation, NHS SY ICB
Andrew Brankin (**AB**), Rotherham Care Group Director, Rotherham, Doncaster and South Humber NHS Foundation Trust
Lydia George (**LG**), Transformation & Partnership Portfolio Manager (Rotherham), NHS SY ICB
Shafiq Hussain (**SH**), Chief Executive, Voluntary Action Rotherham
Kym Gleeson (**KG**), Healthwatch Manager, Healthwatch Rotherham

In attendance
Wendy Commons, (minute taker) Business Support Officer (Rotherham), NHS SY ICB

Item Number	Discussion Items
I60/11/25	**Place Integrated Performance Report**

JA presented the report and highlighted a snapshot of performance on ICB priorities:

Urgent & Emergency Care

- **A&E Performance:** Patients seen within 4 hours 71.5% improvement on previous period.
- **Bed Occupancy:** 93.9%, reflecting demand.
- **Ambulance Response Times and Handover:** Strong performance; met both the 45-minute standard with Category 2 response times ahead of national standard and handovers with 15 minutes.

Community Health Services

- **Urgent Community Referrals seen within 2 hours** – 77.6% meeting national target of 70%
- **Community Waiting List over 52 weeks** – 51 not meeting national target of 0 but improvement on previous performance reported of 91.

Elective Care

- **18-week RTT:** 74.8%, although not meeting national target an improvement on last month
- **Diagnostic Tests:** 94.2% completed within 6 weeks, just below the 95% national target

Cancer

- 28-day Faster Diagnosis at 78.1% against national target of 80%.
- 62-day combined performance of 64.3% an improvement on the previous period remains challenging.

Primary & Community Services

- **GP Appointments:** 142,449 appointments were offered by Rotherham GPs
- **Patient Experience:** Exceeded 71% target.

The Place Board noted this month's performance.

I61/11/25	**Quality Safety and Patient Experience Report**

Members noted the report covering September and October 2025 data providing an overview of safety, quality and patient experience across Rotherham Place for information.

I62/11/25	**Medical Directors Update**

Dr Page provided an update to members on recent and ongoing work, covering the following areas:

- **GP Practice Issues/Compliance:**
  Including specific attention to compliance matters at a Doncaster practice.
- **Neighbourhood Working:**
  Involvement in developing the new neighbourhoods approach.
- **Audits on Hips/Knees:**
  Oversight and review of clinical audits related to hip and knee procedures.
- **Locally Commissioned Services (LCS) Work:**
  development of locally commissioned healthcare services.

- **Proactive Care SRO:**
  Leadership and strategic oversight for proactive care initiatives.
- **System Deficit/New ICB Reorganisation:**
  Addressing system financial deficit and supporting the ongoing reorganisation of the Integrated Care Board (ICB).
- **Cancer Pathways:**
  Updates on cancer care pathways, including teledermatology improvements.
- **Urology Network:**
  supporting enhancements to Urology services and pathways.
- **Routine Work:**
  Other ongoing routine responsibilities and activities.

CS thanked JP for the update.

I63/11/25	ICB Board Assurance Framework, Risk Register and Issues Log

All members had received and reviewed the board assurance framework, risk register and issues log.

KG informed members that a meeting had taken place with the Department of Health and Social Care to discuss the timeline for the potential abolition of Healthwatch. The advice received was to plan for March 2027, although it is anticipated that this date may be subject to extension. Members agreed to retain the Healthwatch-related risk on the risk register but decided to lower its rating for the time being in light of the updated timeframe.

Action: KG/LG

There were no new risks to be added.

I64/11/25	Feedback from Rotherham Place Executive Team (RPET)

CS advised that RPET had considered the following items:

Rotherham Medicines Optimisation Incentive Scheme 2024–25:
RPET approved the payment of the 2024/25 incentive scheme to practices, with the budget managed locally.

Social Prescribing / Mental Health Community Connectors – Future Commissioning:
RPET agreed to move forward with integrating the Mental Health Community Connector (MHCC) service into the existing Rotherham Social Prescribing contract (option three). Further efficiencies and the sustainability of the provider will be explored.

Locally Enhanced Service – Optometry:
RPET acknowledged the paper and supported additional work to assess challenges and risks before making a decision on joining the South Yorkshire proposal.

Weight Management Pathway Update:
RPET endorsed the revised weight management pathway, which clarifies referral routes for primary care and other health and care colleagues. The update has no financial impact and was previously approved at CRMC

Place Board Members noted the business conducted through Rotherham Place Executive Team.

I65/11/25	Minutes and Action Log and Assurance Report from the last Meeting

The minutes from the meeting held on Wednesday 15 October 2025 were accepted as a true and accurate record.

The action log was reviewed and no concerns were identified. It was noted that, due to recent development sessions, the Digital update to the Place Board could not be delivered in person; however, AC fulfilled the action by sharing the required information with BK via email. The assurance report for the Integrated Care Board noted that there are no actions arising from the minutes to be escalated.	
I66/11/25	**Communication to Partners/Promoting Consultations & Events**
None.	
I67/11/25	**Risks and Items for Escalation**
The rating of the risk relating to the future of Healthwatch to be reduced as discussed above.	
I68/11/25	**Forward Agenda Items**
Standing Items – Rotherham Place Performance Report (monthly) – Risk Register (Monthly for information) – Place Prescribing Report (Quarterly) – Quality, Patient Safety and Experience Dashboard (Bi- monthly) – Quarterly Medical Director Update	
I69/11/25	**Date of Next Meeting**
The next meeting will take place on **Wednesday 17 December 2025** in the John Smith Room, Rotherham Town Hall.	

Membership

Chris Edwards (Chair)	Executive Place Director/Deputy Chief Executive, ICB	NHS South Yorkshire Integrated Care Board
Claire Smith	Director of Partnerships, Rotherham Place	NHS South Yorkshire Integrated Care Board
Wendy Allott	Director of Financial Transformation, Rotherham	NHS South Yorkshire Integrated Care Board
Andrew Russell	Director of Nursing, Rotherham & Doncaster Places	NHS South Yorkshire Integrated Care Board
Dr Jason Page	Medical Director, Rotherham Place	NHS South Yorkshire Integrated Care Board
Shahida Siddique	Independent Non-Executive Member	NHS South Yorkshire Integrated Care Board

Participants

Emily Parry-Haries	Director of Public Health	Rotherham Metropolitan Borough Council
Shafiq Hussain	Chief Executive	Voluntary Action Rotherham
Ian Spicer	Strategic Director, Adult Care, Housing & Public Health	Rotherham Metropolitan Borough Council
Richard Jenkins	Chief Executive	The Rotherham NHS Foundation Trust
John Edwards	Chief Executive	Rotherham Metropolitan Borough Council
Toby Lewis	Chief Executive	Rotherham, Doncaster and South Humber NHS Foundation Trust
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Mat Cottle-Shaw	Chief Executive	Rotherham Hospice
Lydia George	Transformation & Partnership Portfolio Manager (Rotherham)	NHS South Yorkshire Integrated Care Board
Gordon Laidlaw	Head of Communications (Roth)	NHS South Yorkshire Integrated Care Board