HEALTH SELECT COMMISSION

Date and Time:- **Thursday 14 May 2026 at 5.00 p.m.**

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

Membership:- **Councillors Keenan (Chair), Yasseen (Vice-Chair), Adair, Ahmed, Baum-Dixon, Brent, Clarke, Duncan, Garnett, Harper, Havard, Knight, Reynolds, Tarmey, Thorp, Fisher and Harrison.**

Co-opted Member David Gill representing Rotherham Speak Up.

This meeting will be webcast live and will be available to view via the Council's website. 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. Apologies for Absence

To receive the apologies of any Member who is unable to attend the meeting.

2. Minutes of the previous meeting held on 26 March 2026 (Pages 5 - 20)

To consider and approve the minutes of the previous meeting held on 26 March 2026 as a true and correct record of the proceedings and to be signed by the Chair.

3. Declarations of Interest

To receive declarations of interest from Members in respect of items listed on the agenda.

4. Questions from members of the public and the press

To receive questions relating to items of business on the agenda from members of the public or press who are present at the meeting.

5. Exclusion of the Press and Public

To consider whether the press and public should be excluded from the meeting during consideration of any part of the agenda.

For Discussion/Decision:-

6. Adult Social Care CQC Inspection Outcome (Pages 21 - 103)

This item is to receive a report and presentation in relation to the outcome of the CQC inspection of Adult Social Care.

7. NHS 10 Year Plan; Local Implications incorporating Neighbourhood Health Services (Pages 105 - 129)

This item is to receive an update from Rotherham Place Partners in relation to how the NHS 10 Year Plan translates into the Rotherham context, including implications for Neighbourhood Health Services.

8. Menopause Review Report (Pages 131 - 146)

This item is to consider the Menopause Scrutiny Review Report. The report is a result of the workshop undertaken in 2025, subsequently re-framed as a spotlight review.

9. Health Select Commission Work Programme - 2026/27 (Pages 147 - 148)

To consider the Health Select Commission's proposed work programme for 2026/27.

For Information/Monitoring:-

To receive and note the contents of any reports routinely submitted to the Health Select Commission for information and awareness.

10. South Yorkshire, Derbyshire and Nottinghamshire Joint Health Overview and Scrutiny Committee

To receive and consider the minutes and recommendations of the South Yorkshire, Derbyshire and Nottinghamshire Joint Health Overview and Scrutiny Committee.

The minutes of the last JHOSC meeting held 7 January 2026 were shared with members as soon as they became available and are available via the link below:

7 January 2026 JHOSC Meeting Minutes

The subsequent meeting scheduled to take place on 11 March 2026 was cancelled, and the calendar of meetings for the 2026/27 municipal year are not

yet confirmed.

Health Select Commission Members will be advised of proposed dates and topics for consideration once this information is made available.

11. Urgent Business

To consider any item(s) which the Chair is of the opinion should be considered as a matter of urgency.

JOHN EDWARDS,
Chief Executive.

The next meeting of the Health Select Commission will be held on Thursday 18 June 2026 commencing at 5.00 p.m. in Rotherham Town Hall.

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HEALTH SELECT COMMISSION
Thursday 26 March 2026

Present:- Councillor Keenan (in the Chair); Councillors Adair, Ahmed, Brent, Clarke, Garnett, Harper, Tarmey, Thorp, Fisher and Harrison.

Apologies for absence:- Apologies were received from Yasseen, Duncan, Havard and David Gill (Co-optee).

The following Officers and Partners were in attendance:

Kym Gleeson, Manager of Healthwatch Rotherham
Emily Parry-Harries, Director of Public Health/Health Select Commission Link Officer
Ian Spicer, Executive Director of Adult Care, Housing and Public Health
Bob Kirton, Managing Director, The Rotherham NHS Foundation Trust (TRFT)
Jodie Roberts, Operations Director, TRFT
Jo Evans, Improvement Director, Sheffield Teaching Hospitals
Richard Maxted, Operations Director, Sheffield Teaching Hospitals
Mark Tuckett, Chief Strategy Officer, Sheffield Teaching Hospitals
Julia Jessop, Managing Director, South Yorkshire and Bassetlaw Cancer Alliance

The webcast of the Council Meeting can be viewed at:-
https://rotherham.public-i.tv/core/portal/home

53. MINUTES OF THE PREVIOUS MEETING HELD ON 22 JANUARY 2026

Resolved:-

That the minutes of the meeting held on 22 January 2026 were approved as a true and correct record of the proceedings.

54. DECLARATIONS OF INTEREST

The following declarations of interest were made:-

Member	Agenda Item	Interest Type	Nature of Interest
Councillor Fisher	Agenda Item 7	Personal Interest	Partners employment within organisation.

55. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

There were no questions from members of the public or the press.

56. EXCLUSION OF THE PRESS AND PUBLIC

There were no items on the agenda that required the exclusion of the press or members of the public.

57. SOUTH YORKSHIRE CANCER ALLIANCE LUNG CLINIC UPDATE

This item was to receive an update report and presentation in relation to the Non-Surgical Oncology Transformation Programme and resultant Joint Lung Clinic implementation serving both Rotherham and Barnsley patients from the Rotherham Hospital site.

Members had previously received information regarding the proposals for the Lung Clinic in May 2025, following a broader update provided to the South Yorkshire, Derbyshire and Nottinghamshire Joint Health Overview and Scrutiny Committee earlier that year. Consideration of this item was augmented by a site visit to the facility undertaken by members of the Health Select Commission, along with their counterparts from Barnsley Council on 19 March 2026. The Chair offered sincere thanks to all of the staff involved in supporting that valuable scrutiny activity.

The Chair welcomed Jo Evans, Improvement Director, Specialised Cancer Services at Sheffield Teaching Hospitals, Richard Maxted, Operations Director, Specialised Cancer Services at Sheffield Teaching Hospitals, Mark Tuckett, Chief Strategy Officer at Sheffield Teaching Hospitals and Julia Jessop, South Yorkshire and Bassetlaw Cancer Alliance Managing Director to the meeting and invited them to introduce the report and presentation.

The Chief Strategy Officer at Sheffield Teaching Hospitals explained that the purpose of the presentation was to report on progress since implementation of the Joint Lung Clinic, and noted their expectation that Members had had the opportunity to read and digest the report provided in the agenda pack ahead of the meeting, and noted that some members had visited the clinic.

They set out the intended flow of the presentation:

- Context
- What had been implemented
- How it was operating
- Next steps

The Improvement Director, Specialised Cancer Services at Sheffield Teaching Hospitals described their role in co-ordinating the work to open and embed the Joint Clinic.

They summarised the case for change which was a national shortage of Consultant Oncologists alongside rising demand driven by new

treatments and increasingly complex pathways, compounded by regional variation that created uneven patient experiences and inconsistent service resilience.

The Improvement Director explained that these pressures had led to the Non-Surgical Oncology (NSO) Transformation Programme. Although this had started with outpatient redesign, it had broadened to consider end-to-end pathways, including how outpatient assessment and decision-making shaped the onward patient journey.

They outlined the programme's aims which were:

- To improve clinical safety and reduce clinical risk
- Address inequalities in access and experience across the region
- Strengthen workforce sustainability by planning around known workforce constraints

They added that the programme had been organised into three phases and that the Joint Lung Clinic sat in Phase 1, the 'Stabilisation' phase.

The Improvement Director explained that the model for Barnsley and Rotherham patients had been shaped by patient, public and staff feedback. There was the need to consolidate the number of sites providing face-to-face appointments, as the system did not have sufficient consultant capacity to run multiple separate clinics with the required resilience.

They explained that the change was expected to:

- Increase consultant cover and senior oversight so clinics were less vulnerable to single-handed working and vulnerabilities through absence
- To standardise pathways and reduce unwarranted variation so care felt consistent regardless of postcode
- To minimise unnecessary travel and, where possible, offer appointments closer to home for patients needing face-to-face review.

The presentation then turned to Lung Outpatients specifically, describing that the service had historically relied on a single consultant providing outpatient support with one located in Barnsley and one in Rotherham. That separate clinic model left little resilience. They explained that initially, telephone appointments had been increased where clinically appropriate, but when face-to-face review was required Barnsley patients had often travelled to Weston Park Cancer Centre, creating a level of travel that was inconsistent with arrangements elsewhere.

They described the Joint Lung Clinic as a measure intended to reduce variation and create a more robust outpatient model and outlined how an options appraisal had recommended locating the joint clinic in Rotherham, building on the existing Rotherham Clinic and consolidating Barnsley

patients and the Barnsley consultant into a single combined service.

They outlined the establishment of a multidisciplinary working group that comprised of clinical and non-clinical colleagues from Sheffield, Barnsley and Rotherham that met weekly to prepare for launch ahead of the implementation and noted that the Sheffield involvement reflected the wider referral relationship with Weston Park Cancer Centre even though the outpatient clinic delivery for this cohort took place in Rotherham.

They confirmed that the Joint Clinic had gone live on 27 November 2025. Operational readiness had centred on clear communication and standardisation. Patient information leaflets had been designed and tested with a patient group and refined for clarity, and staff were supported with jointly developed Standard Operating Procedures and documentation to ensure consistent ways of working.

Reflecting on the early position since 'go-live', the Improvement Director noted that experiences shared indicated improved patient and clinical safety through increased resilience and senior cover, with a combined team in one location providing oversight if one consultant was unavailable, supporting continuity and reducing the risk of service disruption.

They clarified that the change related to Outpatient Clinics and that treatment continued to be delivered locally for both Barnsley and Rotherham patients, and added that the practical impact on Rotherham patients had been limited in terms of appointment day, location and process, whilst the system monitored whether the combined model created any detriment for either population.

They explained that an evaluation framework had been agreed drawing on patient engagement which focussed on what mattered to patients, staff engagement which focussed on workforce and operational issues, alongside feedback from forums such as the Health Select Commission which focussed on assurance and impact.

As the Joint Clinic had only operated since 27 November 2025, it was acknowledged that there were limitations to the available evaluation data, the offer to return after a 12-month evaluation to allow more robust assessment of trends and outcomes was reiterated. Nonetheless, it was noted that in that context early months showed a reduction in Barnsley referrals, which the team had reviewed and interpreted as likely natural variation influenced by fluctuation and seasonal effects which had reinforced the need for longer-term evaluation to validate assumptions made.

The Improvement Director summarised the information gleaned from the patient questionnaire. 52 patients had responded when the presentation was prepared, which had risen to 79 on the day of the meeting, but noted that the additional responses had not changed the themes identified in the

report.

Feedback was largely positive about the care received at Rotherham, including staff interactions, reception welcome and the clinic environment with 93% of respondents said they had been informed about the change, although one person reported not feeling informed and had needed to ring for clarity.

They explained that there had been issues with appointment letters from the Sheffield side, but these were largely resolved. It was reported that the most consistent negative theme was parking at the Rotherham Hospital site. The Improvement Director indicated that the question had been included deliberately because transport and travel had formed part of the considerations that had led to the identification of Rotherham Hospital as the preferred Joint Clinic site. They confirmed that they had made TRFT aware of the feedback, whilst noting it was not within Sheffield Teaching Hospitals' or the Cancer Alliance's direct control to remedy.

The Improvement Director also outlined staff feedback, which reflected that the Clinic set-up and jointly developed SOPs had supported clearer expectations and more consistent processes. They identified IT and specifically Wi-Fi connectivity as an ongoing operational challenge that was being addressed in conjunction with the relevant TRFT staff. They particularly highlighted a positive cultural impact in that the Barnsley team had felt incredibly welcomed by Rotherham colleagues and in day-to-day practice, staff had worked cohesively, such that organisational boundaries were barely distinguishable.

The Chair invited questions and comments from members in relation to the report and presentation.

Councillor Brent queried the adequacy and reliability of communication methods with patients along the cancer pathway. They wanted to understand how standard communications operated before and after appointments or treatments, and how the service accounted for communication failures, particularly given increasing reliance on electronic patient records and the risks that poor communication could delay diagnosis or treatment.

Richard Maxted, Operations Director for Specialised Cancer Services at Sheffield Teaching Hospitals explained that once a referral was received, the patient's details were logged into the electronic patient record (EPR) and the patient was contacted by telephone to arrange an appointment. This phone call was used to ensure the patient had heard and understood the appointment details, which significantly increased attendance reliability. A written confirmation letter was then issued. Following appointments, letters summarising outcomes and next steps were issued both to patients and, where appropriate, clinicians and GPs.

They also described how communication failures were identified and explained that all cancer pathway patients were ‘tracked’ which meant their progress was monitored at every stage. If a patient failed to attend an appointment, the service contacted them to explore reasons. Sometimes this was because of outdated contact details and sometimes due to disengagement related to the emotional burden of diagnosis. In the latter case, Clinical Nurse Specialists often telephoned patients to check on wellbeing and encourage re-engagement.

Councillor Brent raised sought reassurances regarding oncologist shortages particularly in the context of staffing gaps contributing to diagnosis and treatment delays.

The Operations Director provided broader context and clarified that the shortage stemmed partly from workforce planning issues arising from a reduced number of junior doctors choosing oncology, and partly from consultants retiring earlier than predicted during the pandemic. They noted a longstanding disparity between the north and south of England with respect to consultant numbers, with the north having fewer oncologists relative to population need but reassured members that significant efforts had been made to improve that position with recent indications of an improved position as a result of successful recruitment campaigns and other innovative approaches to retaining talent beyond training rotations. Those approaches included a focus on improving the appeal of the workplace, enhancing specialist registrar experiences to encourage them to stay, and workforce diversification. To qualify that they explained that whilst consultants remained essential for initial treatment planning, ongoing monitoring could often be conducted by advanced practitioners, junior doctors, and other staff. They described a shift to ‘consultant-led and team-delivered’ model which provided resilience amid both rising demand and workforce shortages.

Councillor Harper enquired about service resilience in the Joint Clinic, specifically, the response when one of the two consultants were absent.

The Operations Director explained that historically, lone consultants prepared their teams in advance of leave however, the new joint working arrangement ensured that one senior consultant would always be present, as the two consultants coordinated leave. In cases of long-term absence, the service would seek locum support or redistribution of consultant cover across the region. Training junior and advanced staff to work across both consultants’ teams had further improved service resilience.

Councillor Harrison wanted to understand whether there were any factors under the Joint Clinic model that could compromise safe cover.

The Operations Director reiterated that planned leave was carefully coordinated, and whilst there was always the possibility of unexpected medium or long-term sickness, this would be mitigated through redeployment within the wider regional consultant pool or use of locums if

required. No other factors were expressed as being considered to have the potential to compromise safe cover.

Councillor Harper wanted to understand long-term succession planning given recruitment difficulties cited.

The Operations Director explained the training pathway from medical school through foundation years and into specialty training. They described how early interests developed and how Sheffield sought to create positive experiences for trainees entering oncology to encourage retention. The service monitored expected CCT (Certificate of Completion of Training) dates to anticipate future gaps and influence training rotations. The Chief Strategy Officer added that although recruitment remained challenging, the situation had improved compared with three or four years earlier, and highlighted recent successful consultant appointments where other centres had failed to recruit.

Councillor Clarke referred to concerns about transport and parking reflected in patient feedback. They welcomed efforts to review transport, particularly given that 13% of patients relied on taxis which represented an unwelcome additional financial burden that had the potential to further disadvantage cancer patients who may already be exposed to financial vulnerabilities. Of further concern was the low satisfaction rate with car parking at the hospital site and the effect of stress and anxiety caused by overcrowded and often dangerous parking conditions on cancer patients and their families who were undoubtedly already managing challenging personal circumstances.

The Operations Director acknowledged those concerns, and recognised the challenge across many hospital sites. They described a potential role for Western Park Cancer Charity, which operated minibus routes from several locations, although demand from Rotherham had been limited to date. There was the possibility of creating a combined Barnsley to Rotherham route, but only where sufficient patient demand emerged.

Bob Kirton, Managing Director of Rotherham Hospital acknowledged the parking issues at Rotherham Hospital. They outlined recent steps taking to improve parking organisation and availability which had included:

- Creating 200 new staff parking spaces to free patient spaces
- Implementing ANPR
- Plans to introduce enforcement to address unsafe parking behaviours

They described that a new estates strategy was under development, with the potential to revisit a previous application for a multi-storey car park at the hospital site. They further noted ongoing discussions with the Council and South Yorkshire Transport, and in turn SYMCA (South Yorkshire Mayoral Combined Authority) about improving public transport access.

Councillor Tarmey commented that issues with parking at the hospital was

a frequent cause of complaint to Ward Members, but emphasised the need to balance the enforcement response with the need for compassion carefully to not cause further distress. They suggested that the relevant Council Service could consider the sufficiency of the roads infrastructure and enforcement around the hospital site to consider whether anything could be done to help TRFT manage the issue given its impact on Rotherham residents.

The Chair agreed that a recommendation could be made to explore Councillor Tarmey's suggestion.

The Councillor Clarke was concerned that the patient survey, notwithstanding the increased number or responses at the time of discussion, was too short-term and small to be considered a representative sample yielding meaningful data for analysis and asked whether there was scope to extend beyond the planned conclusion in March 2026.

The Improvement Director confirmed survey uptake was strong and aided by the simple in clinic delivery approach, and gave an undertaking to continue collecting responses as part of the 12-month evaluation.

Councillor Fisher queried whether there had been any unintended consequences, either positive or negative, from the establishment of the Joint Clinic.

The Improvement Director noted that staff had initially been apprehensive but found unexpected benefits, such as strong teamworking and a welcoming environment at Rotherham. A survey of staff experiences would be included in the evaluation which would seek to capture more detail regarding similar unintended consequences.

Councillor Brent wanted to know whether lessons learned from the experience of establishing the Joint Clinic and from the patient survey would be shared with TRFT, to allow dissemination of good practice and to further harness the power of collaborative working within the system. The Improvement Director confirmed that this was already being explored, as Rotherham Hospital had expressed interest in applying the insights elsewhere within the hospital's operations.

Councillor Harrison was keen to understand whether the Joint Clinic had generated any efficiency savings and who would be responsible for commissioning a permanent solution for Non-Surgical Oncology in Rotherham.

The Operations Director confirmed that the Joint Clinic was cost-neutral excepting for travel expenses for Barnsley staff. The South Yorkshire and Bassetlaw Cancer Alliance Managing Director clarified that outpatient redesign was the responsibility of the Integrated Care Board, whilst specialised commissioning involved NHS England. They clarified that the

aim of establishment of the Joint Clinic was improved patient experience and outcomes rather than cost reduction.

Councillor Thorp was concerned about the ratio of face-to-face versus telephone appointments, and in particular the variation between Clinics.

The Operations Director explained that distance and patient preference were key factors, particularly in the context of appointments in Sheffield. First appointments were usually face-to-face, but follow-up clinical checks could be conducted via phone where appropriate. The Improvement Director added that Barnsley numbers reflected a temporary backlog of telephone consultations due to earlier space constraints, and potentially a familiarity and comfort with the approach taken regarding telephone appointments prior to the Joint Clinic's implementation. The expectation remained that there would be gradual return to more balanced provision.

Councillor Harper reflected on the practical challenges experienced by clinicians, raising concerns shared with Members during the site visit in relation to the reliability of Wi-Fi connectivity in clinical spaces. The Improvement Director advised that they understood that this was a longstanding issue in that part of the hospital building and did not affect Joint Clinic staff in isolation. They were working with staff at TRFT to address the issue, with wired connectivity in clinical spaces one proposed solution. The matter was due for further review at the working group's final meeting.

Resolved:

That the Health Select Commission:

1. Noted the implementation and initial appraisal of the NSO joint Lung Clinic for Rotherham and Barnsley patients.

2. Noted that a formal clinic evaluation would be undertaken 12-months post go-live, which would enable more meaningful data analysis to influence recommendations for future service provision.

3. Requested that South Yorkshire and Bassetlaw Cancer Alliance provide the data and metrics requested by the Health Select Commission following the briefing received in May 2025 be provided following conclusion of the planned clinic evaluation, given that it had not been possible to provide the full detail at the time of the meeting. The means via which this would be provided were to be agreed outside of the meeting.

4. Requested that South Yorkshire and Bassetlaw Cancer Alliance considered the public and community transport needs, including the availability and infrastructure of onsite parking in conjunction with The Rotherham NHS Foundation Trust (TRFT), following the planned clinic evaluation.

5. Requested that relevant Council Officers consider the roads network and transport infrastructure in the hospital's immediate vicinity, including car parking restrictions and enforcement to seek to ensure that this supports traffic flow and actively contributes to reducing travel and parking frustrations for Rotherham residents accessing the hospital site.

58. SDEC (SAME DAY EMERGENCY CARE) CENTRE IMPLEMENTATION UPDATE

This item was to receive an update in relation to the success and impact of the Same Day Emergency Care (SDEC) Centre since implementation. This followed the initial proposal regarding the SDEC being presented to the Health Select Commission in March 2025.

The Chair welcomed Bob Kirton, Managing Director of TRFT (The Rotherham NHS Foundation Trust) and Jodie Roberts, Director of Operations at TRFT to the meeting and invited them to introduce the presentation.

The Director of Operations delivered a presentation regarding TRFT's development and implementation of the new Same Day Emergency Care (SDEC) Centre, and set out the pressures that had driven the change, the capital funding that had enabled it, and the early impact on flow, performance and both patient and staff experience.

They explained that Emergency Department (referred to as UECC, the Urgent and Emergency Care Centre) demand had been rising year on year and that attendances had increased by 12% from the previous year into the current financial year, which had contributed to crowding, limited assessment space, longer waits and a poorer experience for patients and staff.

In response, the Trust had pursued a time-limited NHS England capital opportunity, had prepared a business case at short notice, and secured £7 million in funding. They emphasised that this funding had supported a broader programme of enabling works and service moves, not just the SDEC in isolation.

The Director of Operations outlined the delivery timeline, from bid to opening and the considerations taken at each stage. The Trust had then designed new 'front door' services with the intent that patients could be seen in the right place, at the right time, by the right clinicians. The new build had increased the Emergency Department footprint, eased overcrowding, created more clinical spaces and improved waiting times, whilst also enabling the creation of an urgent Primary Care area and relocating the Minor Injuries Unit into the new SDEC footprint to free

additional space in the UECC.

She described the wider reconfiguration required to unlock the space:

- The Fracture Clinic had moved from the front of the hospital, with the new location expected to open toward the end of 2026
- Sexual Health had moved out to create the necessary Fracture Clinic space, with its revised front-of-hospital location due to open within the next few months
- Pre-operative assessment had moved to allow Sexual Health to relocate, with pre-op assessment now based at the back of the hospital

The Director of Operations noted that several services had therefore benefited from improved accommodation, but that delivering this had required significant organisational operational and logistical effort, which had included moving around 600 staff whilst retaining focus on the wider benefits despite understandable sensitivities around change and disruption.

They described that a former corridor and room layout had been knocked through and rebuilt into the dedicated SDEC environment with individual cubicles, seating areas, two waiting rooms and multiple clinical spaces, including rooms supporting minor injuries as patients entered the service.

Turning to access and pathways, the Director of Operations described a key enhancement introduced after opening: a direct access pathway that had not been available when the unit opened in July, enabling Yorkshire Ambulance Service (YAS) crews to bring suitable patients straight into SDEC and avoid attendance at the UECC. From August 2025, local GPs had also been able to refer directly into SDEC, and they reported positive feedback from Primary Care and other professionals.

They described that the model had also supported planned next-day returns for follow-up treatment and had enabled community ‘in-reach’ meaning that so where safe and appropriate, patients could be treated and returned home and unnecessary admissions avoided. The Director of Operations explained how the team had made SDEC clearer for patients through a plain-language infographic which explained that whilst many people expected care to fit the four-hour emergency standard, SDEC was designed for patients likely to need longer assessment and treatment without requiring admission, typically up to around eight hours. The infographic was supported by QR codes and paper leaflets that set out the core elements of the pathway.

They shared early activity and performance observations, noting that SDEC attendances had increased markedly in 2025, and contrasting this with 2024 when the previous medical SDEC area had sometimes been used for inpatient bedding over winter and emphasised that the new facility had been designed specifically to prevent beds being placed there,

protecting same-day capacity and reinforcing the principle that people were generally better at home when admission was not necessary.

The Director of Operations linked the programme to wider improvements in four-hour performance, whist acknowledging multiple contributory initiatives, but highlighting that the extra clinical space had helped patients be assessed and reviewed by medical teams in a more timely manner.

They closed with examples of positive patient feedback gathered through a variety of feedback routes including the Friends and Family Test and direct emails, and noted how encouraging it had been when patients referred to staff by name and recognised the multidisciplinary team's contribution.

The Chair thanked the Director of Operations for the presentation and invited questions and comments from Members in relation to the update provided.

Councillor Thorp offered thanks for both presentation and preceding visit to the facility. They explained that prior to attending, they had imagined the facility might feel like a collection of isolated areas where patients waited without understanding their place in the process. However, after first-hand experience, they had observed a system that worked smoothly and created a positive, calm patient experience. Councillor Thorp queried the rising attendance figures from 2024 to 2025. They wanted to understand whether the figures were linked to what used to be Ward B6 and whether the sharp increase had caused any difficulties.

The Director of Operations explained that although attendance had risen significantly, this was what the team had anticipated and wanted. They explained that Ward B6 had not been an environment suitable for expansion, as its configuration previously included beds which restricted patient flow. In the new SDEC Centre, the space had been purposely designed to cope with growing demand. It was acknowledged that attendance had recently reached more than 70 patients in a single day, alongside high UECC volumes, but confirmed that the workforce structure remained adequate, whilst adding that the team continued to monitor capacity closely.

Councillor Thorp asked what had become of Ward B6 following the opening of the SDEC.

The Director of Operations explained that Ward B6 had been repurposed as a 'decamp' ward to support temporary moves during ward refurbishments, including the current Haematology Ward project. They noted that B6 had originally been built during COVID as a high-specification critical-care overspill area, making it valuable for inpatient or day-service use as and when required.

Councillor Rajmund Brent wanted to know if the Trust understood why

there had been a 12% year-on-year increase in attendance.

The Director of Operations advised that this was difficult to pinpoint but reflected rising patient acuity, increased walk-in presentations, and a notable upturn in working-age adults using the UECC. The system was exploring ways to ensure patients accessed the most appropriate services rather than defaulting to emergency care.

Councillor Brent observed that as awareness of the new facility grew, demand would likely continue to increase, creating the risk of future overcrowding. He expressed concern that the calm, comfortable environment could be compromised if that trend continued unabated.

The Director of Operations assured Members that the unit had been built with future adaptability and growth in mind. The clinic-room capacity exceeded current demand, and the layout could be reconfigured quickly to respond as care models evolved. They added that long-term sustainability would depend on strong collaborative work with Primary Care and Yorkshire Ambulance Service to ensure patients were directed to the best setting from the outset.

TRFT's Managing Director offered a broader perspective, praising the clinical and operational teams for managing what had been an extremely challenging winter. They described how SDEC provided an essential pathway for patients whose needs had been assessed by clinicians and who required same-day intervention without the delays associated with traditional Emergency Department delays. They further explained that Rotherham had become one of the few areas in Yorkshire and the Humber able to 'pull' patients directly from ambulance workloads into SDEC, easing system pressure and emphasised that although the model had strong potential, significant cultural change across the public and partner organisations would be required to address uncontrolled growth in emergency care attendances.

Councillor Harper then reflected on experiences of Ward B6, and commented that the new facility was incomparable in terms of quality of the environment. They wanted to understand whether the SDEC was an enhanced version of Ward B6 or a fundamentally different service, and whether it had directly improved waiting times in A&E.

The Director of Operations clarified that the new facility was not an extension of B6 but a purpose-built facility informed by national best practice. They confirmed that it had contributed to improved performance in areas such as ambulance handover times, time-to-clinician, and four-hour targets, though she emphasised that multiple initiatives across the Trust had also contributed to those improvements.

Councillor Harrison asked how success would be measured for the new facility and how success measures had been developed.

The Director of Operations explained that the evaluation model aligned with national Emergency Care Access Standards, assessing how efficiently patients were seen, treated, discharged, or admitted. Low readmission rates suggested safe decision-making, while staff satisfaction, boosted by the predictable midnight closing time and improved working environment, was also a key indicator. A comprehensive analysis would take place after a full year of operation.

Councillor Ahmed echoed the positive impressions but raised concerns about public awareness regarding the facility, and reflected that many residents still defaulted to A&E even for minor concerns. They also noted that residential and care homes frequently called 999 to transfer responsibility to the hospital when other means of accessing care were more appropriate. They asked how cultural change could be encouraged and enquired whether a sensory room could be incorporated into the SDEC footprint for patients with learning disabilities.

The Director of Operations confirmed that a sensory room existed within the SDEC but had not yet been fully equipped due to budget constraints. The hospital charity had undertaken fundraising to allow its completion. They agreed that culture change would require strong system-wide communication and collaboration. TRFT's Managing Director reinforced this, noting that differences even between care homes in their 999 call rates demonstrated the scale of the cultural challenge. They highlighted that many frequent attenders at UECC had social, housing, or wellbeing needs rather than medical ones, stressing the importance of multi-agency work to address systemic stressors.

Councillor Ahmed suggested more community-based engagement, including with groups such as REMA (Rotherham Ethnic Minority Alliance) and VAR (Voluntary Action Rotherham, and encouraged the Trust to adopt a firmer stance when redirecting people to more appropriate services.

Councillor Adair shared their personal positive experience of SDEC praising the speed and reassurances taken from the service received.

Councillor Brent reiterated others' views regarding the quality of the environment and noted the visible LGBTQ+ positive signage, lanyards, and badges. They asked whether similar visibility could be introduced for neurodiversity and learning disabilities, and whether this was indicative of local leadership within the SDEC or part of a wider Trust policy around overt inclusivity.

The Director of Operations confirmed that no equivalent materials for neurodiversity or learning disabilities currently existed but committed to take the suggestion forward. They explained that the organisation aimed to be open and welcoming for all, and that inclusivity was embedded in the Trust's philosophy. The Managing Director added that although some areas were delivering excellent inclusive practice, consistency across all

patient-facing areas remained a development goal.

Resolved:

That the Health Select Commission:

1. Noted the update in relation to the SDEC and its impact on patient care.

2. Requested that TRFT provided further data regarding the impact on waiting times, ambulance handover, staff and patient satisfaction following 12 months of operation or following a suitable period of adoption of direct referral routes to all partners for whom this was intended to assist members to fully understand the impact of the SDEC for Rotherham residents. The means via which the data would be provided, along with any specific considerations around metrics and a finite timeline would be agreed with TRFT in due course.

59. HEALTH SELECT COMMISSION WORK PROGRAMME - 2025/26

Resolved:-

That the Health Select Commission:

1. Approved the work programme.

2. Agreed that the Governance Advisor was authorised to make any required changes to the work programme in consultation with the Chair/Vice Chair and report any such changes back to the next meeting.

60. SOUTH YORKSHIRE, DERBYSHIRE AND NOTTINGHAMSHIRE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

The Chair advised Members that the most recent JHOSC meeting took place on 7 January 2025 as the meeting scheduled to take place on 11 March 2026 was cancelled. The minutes of this January meeting were circulated to members upon publication, and a link to them was provided in the agenda pack for this meeting.

The next JHOSC meeting date was to be confirmed and would be shared with Health Select Commission members as soon as arrangements were in place. It was anticipated there would be no further meetings in the 2025/26 municipal year.

The Chair requested that Health Select Commission Members who had comments, queries or questions they would like raised regarding the 7 January JHOSC minutes, or any suggestions of items for consideration by

JHOSC in the 2026/27 municipal year refer these to the Health Select Commission Chair and Governance Advisor at the earliest opportunity so these could be addressed accordingly.

61. SUPPLEMENTARY PUBLIC HEALTH GRANTS FOR 2026/27 - CABINET REPORT

The Chair requested that Health Select Commission Members who had comments, queries topics they would like to suggest for consideration by the Health Select Commission arising from the Supplementary Public Health Grants for 2026/27 Cabinet Report channel these via the Chair or Governance Advisor.

62. URGENT BUSINESS

There was no urgent business to consider.

Rotherham Metropolitan Borough Council

Public Report with Exempt Appendices
Health Select Commission

Committee Name and Date of Committee Meeting
Health Select Commission – 14 May 2026

Report Title
Care Quality Commission Assessment of Rotherham Adult Social Care 2025.

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

Executive Director Approving Submission of the Report
Ian Spicer, Executive Director of Adult Care, Housing and Public Health

Report Author(s)
Dania Pritchard, ASC Assurance Lead
dania.pritchard@rotherham.gov.uk

Ward(s) Affected
Borough-Wide

Report Summary
This report summarises the key strengths and areas for development as detailed in the Care Quality Commission's (CQC) assessment report of Rotherham Adult Social Care, which took place 14 – 17 July 2025. This includes a score for each quality statement and an overall rating of Rotherham Adult Social Care.

Recommendations
Health Select Commission notes the contents of this report including the areas of strength and the areas of focus, as detailed in the CQC assessment report.

List of Appendices Included

Appendix 1 Care Quality Commission assessment report Rotherham 2025
Appendix 2 Scoring information

Background Papers
None

Consideration by any other Council Committee, Scrutiny or Advisory Panel
Cabinet – 08 June 2026

Council Approval Required
No

Exempt from the Press and Public
No

Care Quality Commission Assessment of Rotherham Adult Social Care 2025.

1. Background

1.1 From April 2023, The Health and Care Act 2022 gave CQC new regulatory powers to undertake independent assessment of local authorities' delivery of regulated care functions as set out in Part 1 of the Care Act 2014. Local authorities are assessed against four domains:

i.) Working with people
ii.) Proving support
iii.) How the local authority ensures safety
iv.) Leadership

To ensure that the Council and Adult Social Care were appropriately prepared for assurance, and to understand how well Adult Social Care was delivering on its improvement journey, the Association of Directors of Adult Social Services (ADASS) were commissioned to conduct a peer review in January 2025.

Prior to this, in December 2023, a peer review was conducted by the Local Government Association (LGA), which sought to understand strengths, areas for consideration and ongoing improvements.

Both peer reviews supported Adult Social Care's improvement journey as well as its readiness for assessment by the CQC.

1.2 On the 31 July 2025 Adult Social Care attended Health Select Commission to share the findings of the ADASS peer review and to update on progress in the areas suggested for consideration. At the time of attendance at the Health Select Commission, CQC had recently concluded its assessment of Adult Social Care, with the onsite element taking place 15 – 17 July 2025.

2. Key Issues

2.1 The assessment notice was received from the CQC 10 February 2025. This officially began the assessment period and a series of submissions to CQC began. This included the submission of over 300 pieces of evidence to CQC on the 28 February 2025. This evidence covered 38 Information Return statements which form the basis of CQC's understanding of a local authority and builds a picture of how they function and meet and deliver their care functions.

2.2 Between February 2025 and arriving onsite in July 2025 various information was provided, and several elements of the assessment progressed. These included:

- Submission of timetable information.
- Submission of 50 case files to be reviewed (consent was gained from these people).

- A virtual 3-hour opening presentation (this included 3 members of the CQC assessment team and leadership from the Council, including the Chief Executive).
- Submission of the final 10 case files with detailed information provided about these people (consent was gained from these people).
- Eight pre-site visit interviews with various people including the data/performance lead, provider representatives, and the Mental Health Trust.

2.3 The on-site assessment team consisted of seven people and included the following roles:

- Deputy Director
- Assessment Manager
- Lead Inspector
- Specialist Advisor
- Executive Reviewer
- 2 x Inspectors.

The on-site assessment consisted of interviews over 3 days which were a mix of group and individual interviews. Overall, staff, partners and stakeholders, and people with lived experience described the experience as positive.

2.4 The draft report was received on the 3 February 2026, this unusual delay was due to sickness within the assessment team. This allowed a 10-working day review process for the local authority and required the Council to complete a response which included typographical/numerical errors, accuracy of the evidence and additional/omitted information. This was completed with two key areas being challenged – processes within assessing needs and processes within safeguarding – and for both areas the score applied was raised from 2 to 3 (see appendix 2). The final report was shared on the 4 March 2026 with Rotherham Metropolitan Borough Council Adult Care being rated as ‘Good’ with a score of 73%.

2.5 This outcome places Rotherham joint second in Yorkshire and the Humber out of the 13 local authorities whose reports have been published to date (see appendix 2). The report was published by CQC on the 20 March 2026 with communications being shared with the workforce, partners and stakeholders, and commissioned services the same day.

2.6 Reflection sessions and a celebration event are taking place to acknowledge areas of strength and inform development actions to be progressed, as follows:

- Senior Management Team CQC away day – 25 March 2026.
- Operational managers, team managers, and service leads CQC planning session – 22 April 2026.
- Celebration event – 22 May 2026.

2.7 Key strengths highlighted in the report include:

Theme One – Working with People

1. Multiple ways for people to access advice and support.
2. Occupational Therapy and Assistive Technology accessible at the 'front door' via the Adult Contact Team.
3. Timely and effective advocacy.
4. Transparent decisions with clear letters and a separate appeals process. No appeals were made in the prior 12 months to CQC being onsite.
5. Person-centred, strength-based ethos with competent assessment teams and responsive out-of-hours arrangements.
6. A robust prevention and early intervention model.
7. A Complex Lives team that delivers trauma-informed support flexibly and engages rapidly with those in need.
8. A Supported Employment team that provides bespoke support for residents and works with teams such as Learning Disability.
9. A diverse workforce that aids cultural competence.
10. Clear strategies that include Equality, Diversity, Inclusion and Digital Inclusion.
11. Broad inclusion tools such as interpreters, BSL, multi-lingual staff and feedback loops to shape services.

Theme Two – Providing Support

1. Understanding of local need to align supply to need such as domestic abuse.
2. Effective brokerage which supports sufficient provision.
3. Quality oversight of services which includes risk-based dashboards, on-site assessment, early-warning system and public 'eyes and ears' reporting.
4. Work on sustainability of the market including a redesigned homecare model and workforce development support for providers.
5. Mature and aligned system partnership which makes measurable impact.
6. A one-team approach including co-location, regular multi-agency forums and data-sharing tools i.e. integrated discharge.
7. Voluntary & community sector (VCS) relationships are strong (grants, commissioning, peer-led models, social prescribing).

Theme Three – Ensuring Safety

1. Safety is prioritised with clear escalation, shared records (read-only in places), and robust cross-boundary guidance.
2. Transitions and pathways are timely and work well.
3. Contingency planning is strong (24/7 access, carers' emergency cover, respite options) and out-of-area placements are tightly risk-managed.
4. A central safeguarding hub with triage, clear application of 3-point test, and strong multi-agency board oversight and learning.
5. Making Safeguarding Personal (MSP) is embedded and advocacy use is high.

6. Timeliness around Deprivation of Liberty Safeguards (DoLs) referrals which are screened based on risk.

Theme Four – Leadership

1. Clear governance and accountability with stable leadership.
2. Strategic planning that is data driven and co-produced i.e. Adult Social Care Strategy 2024–27.
3. A culture of learning and improvement i.e. the supervision framework and the reverse mentoring programme.

2.8 Areas to be considered for development in the report include:

Theme One – Working with People

1. Assessment delays, particularly relating to annual reviews.
2. Strength-based approaches are not always evident in unpaid carer assessments and mixed outcomes.
3. No agreed local standard for timescales relating to financial assessment decisions.
4. Data shows that the proportion of 65+ year olds receiving enablement/rehab after discharge from hospital is below the national average.
5. Some moderate waits for assessment relating to equipment.
6. Sustained action is needed to reduce inequalities across seldom-heard groups.
7. Accessibility to be strengthened i.e. independent website access for neurodivergent people.

Theme Two – Providing Support

1. Low number of carers accessing services.
2. Gaps in provision for working-age residential, early age dementia and specialist MH/LD provision. Some waits for complex cohorts.
3. Quality team capacity means assessments can be less frequent than intended.

Theme Three – Ensuring Safety

1. Some read-only constraints limit cross-agency updating.
2. Carers reporting, they feel safe is below England average which presents an opportunity to understand and improve.
3. Initial screening can exceed 2 working days in some cases (while mitigations are applied).
4. Not all S42 enquiries are complete within 80 working days though local standard under review to align regionally.

Theme Four – Leadership

1. Audits highlighted practice improvements needed around contingency planning, advocacy use, and MCA decision recording.
2. Partner feedback indicates a need for strengthening of communication.
3. Co-production arrangements do not always enable meaningful involvement.

3. Options considered and recommended proposal

3.1 This report is intended to highlight the publicly available CQC feedback within the published report and, therefore, no options require consideration.

4. Consultation on proposal

4.1 As this is a publicly available report consultation is not required.

5. Timetable and Accountability for Implementing this Decision

5.1 Agreed development areas will be captured on a work programme plan with a time frame of 18 months.

5.2 In terms of governance, progress will be monitored monthly via the Regulatory Assurance Board.

6. Financial and Procurement Advice and Implications

6.1 This report is intended to highlight the publicly available CQC feedback within the published report and, therefore, this section is not applicable.

7. Legal Advice and Implications

7.1 This report is intended to highlight the publicly available CQC feedback within the published report and, therefore, this section is not applicable.

8. Human Resources Advice and Implications

8.1 This report is intended to highlight the publicly available CQC feedback within the published report and, therefore, this section is not applicable.

9. Implications for Children and Young People and Vulnerable Adults

9.1 This report is intended to highlight the publicly available CQC feedback within the published report and, therefore, this section is not applicable.

10. Equalities and Human Rights Advice and Implications

10.1 This report is intended to highlight the publicly available CQC feedback within the published report and, therefore, this section is not applicable.

11. Implications for CO_2 Emissions and Climate Change

11.1 This report is intended to highlight the publicly available CQC feedback within the published report and, therefore, this section is not applicable.

12. Implications for Partners

12.1 Partners were involved in the assessment process and have been communicated with throughout. Partners will be engaged as part of the development of the action plan and its delivery.

13. Risks and Mitigation

13.1 Given that the report in publicly available it is important that an action plan is progressed to address key areas for development and to drive service improvements.

Accountable Officer(s)
Dania Pritchard, ASC Assurance Lead

Approvals obtained on behalf of:

	Name	Date
The Executive Director with responsibility for this report	Ian Spicer, Executive Director of Adult Care, Housing and Public Health	23/04/26
Consultation undertaken with the relevant Cabinet Member	Cabinet Member for Adult Social Care and Health - Councillor Baker-Rogers	29/04/26

Report Author: Dania Pritchard, ASC Assurance Lead

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This report is published on the Council's website.

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Metropolitan Borough of Rotherham assessment

How we assess local authorities.

Assessment published: <date of publication>

About

Demographics

Rotherham Metropolitan Borough Council serves a population of approximately 260,000 people within the South Yorkshire region. Rotherham is a metropolitan borough, meaning the council is a single-tier authority responsible for the full range of local government services. The borough includes both urban and rural areas, with Rotherham town at its centre and a number of surrounding towns and villages. While some parts of the borough are relatively prosperous, Rotherham experiences significant levels of deprivation, with several neighbourhoods ranking among the 10 most deprived in the country. The borough faces ongoing challenges related to health inequalities, employment, and access to services, particularly in more isolated or rural areas. Rotherham has an Index of Multiple Deprivation decile of 3, (with 1 being the most deprived and 10 being the least deprived).

Demographically, around 21% of Rotherham's population is aged 0–17, around 59% are of working age (18–64), and approximately 20% are aged 65 and over. The older population is expected to grow over the next decade, increasing demand for health and social care services. Rotherham is predominantly White British, but the borough has a growing and increasingly diverse population, with around 15% of residents from Black, Asian, and Minority Ethnic (BAME) backgrounds particularly concentrated in central Rotherham.

Rotherham Borough Council is part of the South Yorkshire Integrated Care System (ICS), working in partnership with local NHS organisations and neighbouring authorities to improve health and care outcomes across the region. The local authority is currently Labour led with a stable leadership team across both elected members and senior officers.

Financial facts

- The local authority estimated that in 2023/24, its total budget would be **£423,042,000.** Its actual spend for that year was **£463,014,000** which was **£39,972,000** more than estimated.
- The local authority estimated that it would spend **£121,418,000** of its total budget on adult social care in 2023/24 Its actual spend was **£135,739,000** which is **£14,321,000** more than estimated.
- In 2023/24, **29.32%** of the budget was spent on adult social care.
- The local authority has raised the full adult social care precept for 2023/24, with a value of **2%**. Please note that the amount raised through ASC precept varies from local authority to local authority.
  Approximately **4835** people were accessing long-term adult social care support, and approximately **820** people were accessing short-term adult social care support in 2023/24. Local authorities spend money on a range of adult social care services,

including supporting individuals. No two care packages are the same and vary significantly in their intensity, duration, and cost.

This data is reproduced at the request of the Department of Health and Social Care. It has not been factored into our assessment and is presented for information purposes only.

Overall Summary

Local Authority rating and quality statement scores

Good: Evidence shows a good standard 73%

Summary of people's experiences

Overall, we heard positive feedback from people about their experiences of contact with and receiving support from the local authority. However, we did hear that some people had waited considerable time for assessments. There were a variety of ways in which information about the services available could be accessed, including talking directly with a wellbeing advisor who provided initial contact and assessment. The website included signposting people to other organisations for support which some people told us was helpful for them.

People were communicated with whilst they waited for an assessment, with a letter explaining the process and guiding people to contact alternative sources and emergency services should their needs change. The Supporting Independence Team could visit people whilst they were waiting.

Assessments were person centred, with a focus on working with people, not 'doing to' people and a good use of advocacy and person-centred safeguarding practices ensured people retained control.

Carers told us their needs were assessed in their own right as a carer and that there was good support provided through Carers support in Rotherham. However, some carers had found it difficult to find out about the support available to them and found the amount of information overwhelming at times whilst others told us that they had found it really helpful.

Summary of strengths, areas for development and next steps

There was a broad range of early intervention services in place, with practical support to improve people's wellbeing, offered through the Supporting Independence Team. This early intervention sought to direct people to draw on community resources and maintain independence for longer.

The Complex Lives Team offered trauma informed support for people who needed preventative and risk management support. This team provided a holistic, person-centred service for people experiencing multiple challenges including histories of trauma, homelessness, drug and alcohol misuse and offending behaviour. Support was available to people who did not meet the eligibility criteria for support under the Care Act.

Assessments were strength based and person centred, considering a whole family approach, however there were some waits for people to receive an assessment. Unplanned and annual reviews showed waits for people, which meant the local authority were not fully appraised of a service meeting needs in a strength-based person centred way. However, people were prioritised on risk to ensure those most in need received timely support.

The local authority had opportunities to strengthen its approach to co-production to create meaningful partnerships with people and communities. Outcomes for unpaid carers had the opportunity to improve with closer partnership working. Section 75 agreements and the use of the Better Care Fund provided opportunities for joined up, system working. There was a strong use of enablement, equipment and telecare to maximise independence.

Safeguarding was everyone's business, with a strong emphasis on the Making Safeguarding Personal principles. Support was available 24/7 and there was a strong focus on partnership working to keep people safe. People were supported to grow and thrive through the employment service which was redesigned with people through co-production activities.

People experienced safe transitions between services, for example between Children's to Adults services and through hospital discharge activity. Staff were co-located to reduce the number of teams people were referred to, improving communication and outcomes.

Rotherham staff and leaders knew its community well. Staff felt connected to the leadership team. They were encouraged to share ideas and innovation as systems changed to improve processes and outcomes for people. Staff were nurtured to thrive in a positive and encouraging culture with opportunities to develop careers led by compassionate and available leaders. The local authority sought to improve by gaining feedback from peer reviews and audits of performance.

Theme 1: How the local authority works with people

This theme includes these quality statements:

- Assessing needs
- Supporting people to live healthier lives
- Equity in experience and outcomes

We may not always review all quality statements during every assessment.

Assessing needs

Score: 3 - Evidence shows a good standard

What people expect:

I have care and support that is coordinated, and everyone works well together and with me.

I have care and support that enables me to live as I want to, seeing me as a unique person with skills, strengths and goals.

The local authority commitment:

We maximise the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Key findings for this quality statement

Assessment, care planning and review arrangements

People could easily access the local authority's care and support services through multiple channels, including online and self-assessment options. People received a letter to tell them they could expect to be contacted within 30 days of their referral being triaged. The letter included information on the next stages of assessment, for example what a financial assessment was. People were provided with information on how to contact the local authority urgently, and also voluntary sector partners whilst waiting. Staff monitored the wait time, and when people were identified who may need to wait over 30 days, the local authority asked the enablement team to offer to visit them to address any needs and provide advice or equipment to reduce risks whilst people continued to wait for a Care Act assessment.

Partners told us that the local authority undertook robust risk assessments to prioritise Care Act assessments with those waiting offered the supporting independence visits. Partners were aware of the 'waiting safely' policy and told us the principles of this ensured people were known about whilst they waited and could reach out for support should their circumstances change. Data from the Adult Social Care Survey (ASCS) showed 70.57% people were satisfied with care and support, which was better than the England average of 65.16%.

The approach and ethos toward assessment and care planning was person-centred and strength-based, however the local authority's self-audit across 2024 showed opportunities to improve the consistency of recording for advocacy as well as decision making and recording regarding the Mental Capacity Act. The approach reflected people's right to choice, built on their strengths and assets and reflected what they want to achieve and how they wish to live their lives. We reviewed people's records and saw evidence of strength-based, person centred recording.

The local authority had assessment teams who were competent to carry out assessments, including specialist assessments, supporting independence team (SIT), hospital discharge teams and an Approved Mental Health Professional (AMHP) team. The local authority had an out of hours service which operated to ensure people's safety outside of traditional office hours. An example of this was supporting the urgent placement of two young adults whose carer was suddenly unavailable. Their assessments were prioritised for the duty team the following day with a robust handover identifying the risks and mitigations.

Assessments for people with sensory needs were supported by the SIT and by a commissioned sensory support service providing wrap-around input. As part of this offer, the commissioned service was able to provide a specialist sensory rehabilitation officer during periods when the local authority experienced recruitment challenges, ensuring continuity of support for people with visual or hearing impairments. Although waiting lists for sensory assessments fluctuated at times, people were offered advice and guidance while waiting.

Occupational therapists were present at the front door team to screen and prioritise referrals. There was a clear escalation route with senior staff screening and advising. These staff were employed by both the local authority and the NHS via a Section 75 agreement. Section 75 is a provision within the NHS Act 2006 that permits the NHS and local authorities to establish partnership arrangements, including pooled budgets and shared delivery of functions, to support integrated care.

People's experiences of care and support ensured their human rights were respected and protected, that they were involved throughout in decisions and their protected characteristics under the Equality Act 2010 were understood and incorporated into care planning. People's wishes and feelings were central to decision-making. We heard, for example, about a family who declined formal care services and were supported to draw on their own family network, and another instance where a person chose to leave a rehabilitation setting earlier than planned, with equipment and care arrangements put in place to ensure a safe discharge. This demonstrated a culture toward positive risk taking and supporting people to reduce the level of restrictions care can sometimes bring.

When people were placed outside the borough, the local authority remained responsible for carrying out their reviews. These reviews were prioritised based on the level of risk or any intelligence about the placement. The local authority assured itself that people continued to be appropriately supported, regardless of where their care was provided. When identified, people were supported to move back to Rotherham, when appropriate care and accommodation could be organised. However, people were supported to remain out of borough if this was their choice. The local authority provided several examples of people being supported to move out of restrictive residential accommodation to settings where people had their own front doors.

Timeliness of assessments, care planning and reviews

Assessment and care planning were not always completed in a timely way, and some people experienced delays. However, there was a clear and effective process in place to manage risks, and action taken to reduce waiting times had led to a 75% reduction over the previous 3 years. Assessment and care planning processes had been strengthened through a sustained operational improvement programme since 2022, with a consistently applied 30-day timeliness standard covering the full assessment journey from first contact to final sign-off. Performance was monitored through daily refreshed, RAG-rated caseload data to support early escalation and active case management, with standardised workflows and clear ownership for each stage of the pathway helping to maintain consistent and sustainable improvements.

The local authority measured waiting times from the point a person first made contact to the point a decision was made following completion of their Care Act assessment. As a result, the waiting list included people who were still waiting for an assessment to begin, as well as people who had been assessed and were waiting for care and support arrangements to be put in place. Data provided by the local authority showed there were 150 people waiting for a Care Act assessment with 103 people waiting under 30 days and 47 people waiting over 30 days to have their assessment started. However, people could expect a median wait of 15 days, indicating most assessments were completed within locally established timescales. Delays often related to complexity of need and interaction with other professionals to achieve the desired outcomes.

People had previously experienced delays in accessing occupational therapy (OT) due to increased demand and staffing pressures. In response, the OT service launched a 6-month improvement pilot in July 2025, designed to enhance the customer journey and reduce waiting times. This approach introduced daily triage of new referrals by dedicated workers, enabling urgent needs to be quickly identified and addressed. At the time of our site visit, the average wait for an assessment was 40 days, with a maximum wait of 123 days. For the 308 people on the waiting list, the longest wait had recently reduced from 132 days. Following our assessment, a leader told us, as of February 2026, the median wait for an OT assessment had reduced to 15 days, which demonstrated a sustained improvement trajectory.

New referrals were triaged daily to identify risk, prioritise people with the highest level of need and put urgent or interim solutions in place, including referral to the assistive technology (AT) team. The median wait for an AT assessment was 7 days, with 102 people waiting; the longest wait was influenced by reporting methods that included people not yet ready for assessment. The local authority was working with the commissioned provider to improve data accuracy, and a strengthened process ensured referrers were recontacted where a person could not be assessed. As a result, the OT service no longer held separate waiting lists, improving oversight and the timeliness of AT responses.

The local authority monitored two reviews waiting lists, one for unplanned reviews and one for annual reviews. The waiting lists for the unplanned reviews, for people already in receipt of some type of formal care was 149 people, who would expect to wait a median of 28 days, demonstrating most reviews were being undertaken within the expected timeframe. The longest reported review delay was 399 days which was examined during

our site visit and found to be the result of recording issues, rather than an active delay in service. This was being investigated further.

People waiting for an annual review of their care, both residential care and domiciliary arrangements was 1066 with a median wait of 253 days and a maximum wait of 1,372 days. Those people with the longest waits were regularly triaged, where risks were reviewed, and allocations were informed by priority. The Adult Social Care Activity report data showed 60.62 % of long-term support clients were reviewed (planned or unplanned), which was similar to the England average of 59.13%.

The local authority was acting to manage and reduce waiting times for assessment, care planning and reviews. This included actions to reduce any risks to people's wellbeing, while they were waiting for an assessment. The local authority sought to manage risks to people waiting for assessments by recruiting Enablement Liaison Officers (ELO). We heard these staff undertook visits quickly to consider immediate needs and any community or voluntary support that could be considered until a Care Act assessment was arranged. The risks to people were managed by the team managers with a clear line on communication and escalation route. Performance and waiting times were overseen through established governance forums, which maintained clear audit trails, escalation routes and shared accountability. This proactive oversight ensured people awaiting assessment or review were monitored and prioritised appropriately, with timely practice balanced against the need for proportionate responses in more complex situations.

Staff told us the duty pathway enabled those with the most urgent need to be prioritised. They went onto say that the enablement service was a successful method of proving a timely response to some people's needs and preventing people from waiting on a list by providing support so people could maintain or regain their independence. Enablement waits were reviewed weekly and people who had waited longer than one week were contacted for a safety check enquiry.

Occupational therapy staff told us they were confident in the service improvements they had seen as a result of increased staffing, including support workers and administrative support, removing much of the office-based work away from front line practitioners. Some non-Care Act activity had been moved across departments, enabling more time for community-based support. Prioritisation of risk was based on professional judgement with escalation to leaders to support through a reflective conversation.

Assessment and care planning for unpaid carers, child’s carers and child carers

The needs of unpaid carers were recognised as distinct from the person with care needs; data from the Survey of Adult Carers in England (SACE) showed 41.51% of carers were satisfied with social services. This was better than the England average of 36.83%. Assessments, support plans and reviews for unpaid carers were undertaken separately. However, a Casefile Audit Report from 2024 showed support for carers was inconsistent, strength-based approaches were not always evident in assessments, and information and advice provided did not consistently align with carers’ desired outcomes.

The local authority’s unpaid carers lead was seeking to improve outcomes for families based on feedback from carers and exploring ways to work with carers in more timely ways. Feedback from families included a request for a wider variety of options available for

their cared-for person to attend, to allow for more breaks from the caring role and increase the number of carers feeling they have more control over their lives. This aligned to the data from SACE which showed 16.67% of carers felt that they had control over their daily life, which was worse than the England average of 21.53%. SACE data also showed 25.76% of carers reported they had as much social contact as desired, which was also worse than the England average of 30.02%. Data provided by the local authority showed the opportunities for improvement for unpaid carers was a mixed picture, some improvements had been seen in information and advice and satisfaction with support. However, financial hardship and decline in wellbeing was noted. The local authority told us Carers' assessments were an area for improvement with 545 carers having had an assessment in 2024/25. Data showed there were 260 carers who accessed support services. The Borough That Cares Strategic Framework underpinned a refreshed carer support model, but low numbers of formal assessments were recognised as a priority to improve.

The local authority had carer link officers who undertook carers assessments, however unpaid carers could choose to have an assessment carried out by the worker assessing the person they cared for. At the time of our assessment 42 people were waiting a carers assessment, with a median wait of 21 days and a maximum wait of 158 days. Staff were invited to attend the ADASS regional carers group to hear good practice examples and understand themes and trends. This best practice information was brought back and shared across leaders to influence processes to improve outcomes for people. Transitional staff team members undertook assessments for carers and people who were moving from foster carers to supported living placements to ensure their needs were known. Carers benefited from emergency care services when a carer was unable to provide care, offering reassurance to families.

Help for people to meet their non-eligible care and support needs

People were given help, advice and information about how to access services, facilities and other agencies for help with non-eligible care and support needs. The local authority provided a standard letter sent to people who were not eligible under the Care Act for services and explained that the judgement made by the local authority was based on information gathered during the assessment. The letter also provided the eligibility criteria and signposted people to alternative support from the voluntary community sector. There was a clear process for appeals against eligibility decisions.

Staff told us they supported people with mental health needs who were not eligible for Care Act support by using the Mental Health Enablement Service which offered bespoke support to adults experiencing mental ill health. It provided short-term, preventative support aimed at reducing the likelihood of future need. Staff also referred people to the Complex Lives team when they did not meet eligibility criteria but required some support to prevent deterioration. The team described examples of supporting asylum seekers with no recourse to public funds and assisting a person who had been trafficked to move to safety and access community-based support. Staff told us the community connectors were central to delivering early intervention services for the local authority and were used to support people with non-eligible care and support needs as well as linking people to community organisations to reduce loneliness and isolation.

Social prescribing was partially funded by hospital services, and an example was given of a person being provided with a phone to enable them to improve their independence.

Following discharge from hospital, people received a follow up call the next day and a review 4 weeks later.

A voluntary organisation told us they received few referrals for younger adult carers. They had recognised this gap and were exploring the development of a support group for carers aged 18 and over. They added the local authority provided a lot of support and the local authority's webpage was 'really informative'.

Eligibility decisions for care and support

The local authority's framework for eligibility for care and support was transparent, clear and consistently applied. Decisions and outcomes were timely and transparent. Data provided by the Adult Social Care Survey (ASCS) showed 67.30% of people did not buy any additional care or support privately or pay more to 'top up' their care and support, this was similar to the England average of 63.73%, demonstrating a consistent approach to proportionate care to meet needs for those people.

The local authority had a clear appeals process for people and carers who disagreed with the outcome of their Care Act assessment. People were asked to contact their practitioner within 14 days of receiving their outcome letter, with a further 14 days to submit a formal appeal if they remained dissatisfied. Appeals were reviewed by a manager from a different service and responded to within 10 working days, or 20 days for more complex cases. The right of appeal was separate from the complaints process, and people could still make a formal complaint if they were unhappy with the appeal outcome. Standard letters were written in plain language, set out eligibility decisions, next steps, and who to contact, and offered support for people or carers who needed help to understand the information. Data provided by the local authority showed there were no appeals against eligibility decisions in the 12 months up to February 2024.

Financial assessment and charging policy for care and support

The local authority's framework for assessing and charging adults for care and support was clear, transparent and consistently applied. This was supported by clear policies and guidance for staff and information which was accessible for people. The local authority clearly demonstrated income maximisation as part of the financial assessment process. However, decisions and outcomes were not always timely. There was no agreed local standard for the timescale to complete a financial assessment. The service aimed to complete assessments within 10 working days where documentation was available, although complexity and the need for legal input meant decisions could take longer than the timescales applied to care assessments. An informal 60-day measure was used to support oversight. At the time of the assessment, 163 people were waiting, with 119 waiting under and 44 waiting over 60 working days. Data provided by the local authority showed a median wait of 21 working days, although the longest wait was 273 days.

A partner told us feedback they had gathered showed, financial assessments were a source of complaints and distress. People were not always given clear information about charges or means testing, leading to unexpected bills and, in some cases, debt. However, in contrast, the local authority had only received 2 complaints related to financial assessments between July 2024 and July 2025. Both of these complaints related to a dispute over liability or debt, 1 was upheld and 1 was not upheld.

Provision of independent advocacy

Timely, independent advocacy support was available to help people participate fully in care assessments and care planning processes. People told us advocacy was arranged promptly, when the need for it was identified. Staff told us the advocacy providers were swift at arranging appointments with follow up reports available in a timely manner, supporting a smooth social care journey for people. People who required more specialist advocacy, for example Relevant Persons Representatives (RPRs) had previously experienced delays in being appointed an RPR. However, an internal review showed these were primarily linked to the Deprivation of Liberty Safeguards (DoLS) scrutiny stage rather than the RPR appointment process itself. This had affected the timeliness of referrals being issued to the provider. An action plan introduced in August 2025 strengthened business support, improved workflow processes and increased oversight. As a result, the backlog was systematically addressed, and by January 2026 no one was waiting for an RPR appointment.

Providers told us the local authority had a good understanding of the role of advocacy with assessments, safeguarding processes and review processes being the majority of referral reasons.

Supporting people to lead healthier lives

Score: 3 - Evidence shows a good standard

What people expect:

I can get information and advice about my health, care and support and how I can be as well as possible – physically, mentally and emotionally.

I am supported to plan ahead for important changes in my life that I can anticipate.

The local authority commitment:

We support people to manage their health and wellbeing so they can maximise their independence, choice and control, live healthier lives and where possible, reduce future needs for care and support.

Key findings for this quality statement

Arrangements to prevent, delay or reduce needs for care and support

The local authority clearly demonstrated a commitment to prevention and early intervention across their services and relationships with key partners providing an extensive offer to individuals and communities. It worked with people, partners and the local community to make available a range of services, facilities, resources and other measures to promote independence, and to prevent, delay or reduce the need for care and support. One person and their relative described how regular care visits made a significant difference to their daily life. The same carers visited each time, providing personal care, light housework and meaningful conversation, which the person enjoyed and responded well to. This consistency helped build trust and a positive relationship. The relative explained that the support meant they could leave the house knowing the person was safe and well cared for, allowing them to attend their own medical appointments and reducing stress for both of them. They also received specialist input from a dementia nurse. They found this ongoing support extremely helpful and felt it enabled the person to remain at home, which was important to them both.

Staff provided a broad range of advice and information, telling us the emphasis was on people understanding the information and knowing what the next steps were. This approach ensured communication was meaningful and empowering.

The Adult Social Care plan showed the implementation of a borough-wide prevention and early intervention model which enabled people to remain independent for longer and reduced reliance on long-term care services. The local authority strengthened their own offer by providing a robust prevention and early intervention model, where needs were identified and managed with a view to preventing people requiring more intensive support, for example care and support or health services. Staff told us there was an extensive prevent model to help prevent, reduce and delay care and support needs. They told us this pathway was vast including community connectors, as part of the Supporting Independence Team, the Complex Lives Team, the Mental Health Enablement Team, the

Enablement Team (for physical needs) and teams supporting with equipment, aids and adaptations.

The Supporting Independence Team (SIT) offered timely, face-to-face support to adults who needed help to stay independent. Staff visited people at home to understand their circumstances and risks such as isolation, frailty or increasing need. They helped people strengthen informal networks by accompanying them to local groups or activities, supported income maximisation, and encouraged new opportunities and goals. The team also assisted people leaving care to manage the practicalities of living independently, including maintaining a tenancy, completing forms, paying rent and connecting with community support. This hands-on approach was particularly important for those without family or friends to help them navigate the adult social care system. Specific consideration was given to unpaid carers and people at greatest risk of a decline in their independence and wellbeing. The local authority understood the benefits of offering early intervention support to unpaid carers, recognising the valuable contribution made. One family told us the local authority organised several opportunities for breaks during the week for the carer to spend time doing things that were important to them, to help reduce and prevent their own health deterioration.

The Complex Lives Team supported people with intersecting needs such as mental ill health, homelessness, substance misuse, offending behaviour and poor physical health. Many had experienced significant trauma and were at high risk, despite not meeting the threshold for adult social care. The team provided intensive, trauma-informed support and worked closely with partners, including voluntary organisations, to help people access the right services and move towards recovery and stability. Their personalised model of care had been recognised for its targeted approach and was being extended beyond the borough so people who moved away could continue to benefit. People experienced life-changing outcomes, rebuilding their lives with greater safety, dignity and hope. The team built consistent relationships, offered practical help through key events such as court proceedings or release from custody, and responded quickly when risks increased. The local authority remained committed to evolving this support as people’s needs change across their recovery journey.

The Complex Lives team referred people to a trauma and resilience service, commissioned by the Integrated Care Board with data outcomes for 6 months of 2025 showing 63.54% of people reported maintained or improved mental health and wellbeing; 58.33% maintained or improved their self-perception; 59.38% experienced maintained or improved outcomes regarding trauma effects; 56.25% maintained or improved relationships.

The Complex Lives team also worked closely with the Vulnerable Adult Risk Management framework, and the domestic abuse worker. Staff told us about the variety of links they had formed with specialist workers and teams to ensure prevention support was in place. Staff said they went the extra mile to offer flexible visits and arrangements for people to support relationship building, with very few people needing a full Care Act assessment. They said it was about knowing not one size fitted all and making time and commitment to build relationships and trust. The team also referred to a new service set up to support men experiencing domestic abuse. System working was seen across suicide prevention with the voluntary sector, public health, adult social care and cabinet members. The roll out of

the Zero Suicide Alliance training – ‘Be the one’ campaign had opened up the conversation to enable more people to support people experiencing poor mental health.

The Rotherham Prevention and Health Inequalities Strategy and Action Plan 2022–2025 demonstrated the local authority’s commitment to Care Act-aligned prevention by strengthening early support for adults who may be less likely to come forward for help. It emphasised understanding people’s circumstances, reducing barriers to accessing adult social care, and promoting better outcomes by engaging with communities who are traditionally under-represented or reluctant to seek support. There was a commitment from health colleagues and the voluntary and community sector to deliver person centred opportunities for people to gain advice, information and services to help them improve their health. The mental health enablement pathway enabled people to receive tailored support to move them through poor health into more community focused peer support to maintain wellbeing. This team had close links with coffee shops to host events, community spaces and wider formal mental health services to support people who may need a formal intervention. This team bridged care whilst a person awaited a full assessment. People could make use of the pathway multiple times if it was felt to be beneficial and the team ensured they continued to be present at local café drop ins. They also provided a light touch for some people, with an example of one person who was still in contact with a support worker as he read his mail for him and could step in to support at any time if it was felt that would help improve their wellbeing.

The NHS 10 year plan and the shift towards neighbourhood-based working reflected the local authority’s ongoing development of neighbourhood-focused approaches within adult social care. The inequalities subgroup had been considering how to support the 23% of people without access to a car who live in the town to access services. A voluntary and community sector partner told us they were recently asked by the local authority to manage the prevent and early intervention grants, targeting lonely and isolated people. By working with community organisations, the local authority had created programmes to help these targeted groups feel more connected and engaged.

Preventative services were having a positive impact on well-being outcomes for people. The local authority provided multiple examples of groups across the borough set up specifically to support men who are seeking community support with their mental health. These groups were sport and hobby based to ensure a broad range of opportunities were available for men to access.

The supported employment service was accessed by people who were neurodiverse, people with a learning disability and people with mental ill health and had so far helped 60 residents to find employment. This was a preventative service which also supported those with non-statutory needs, although those with social care needs were prioritised. The success of the service had resulted in further funding from the Department of Work and Pensions which will be used to treble the size of the team. Staff told us of the many benefits of this service and how it was used across teams, for example the Learning Disability team and Preparation for Adulthood team. It supported with voluntary opportunities, work experience, internship, apprenticeships and paid work. They worked against short, medium and long term goals working alongside social workers and occupational therapists with a holistic approach and engaging with employers to provide opportunities.

Provision and impact of intermediate care and enablement services

The local authority worked with partners to deliver intermediate care and enablement services that enabled people to return to their optimal independence. The local authority defines enablement as flexible support to people for up to 6 weeks in their own home and in the community to maximise independence with everyday living skills. Staff told us this service saw the potential in everyone and gave every opportunity for people to lead healthy, fulfilling, and happy lives.

The local authority told us about two enablement service options. The mental health enablement pathway and a enablement service to support immediate care needs. All new referrals into the local authority were screened with a first response consideration for appropriateness for enablement support, with examples of people being enabled to meet their goal of walking to the shops to get their morning paper and managing access in their homes to promote independence. People receiving enablement care were reviewed on a weekly basis to ensure goals were clear and any additional support to meet their needs was considered, for example aids, technology enabled care and equipment with any on-going care being organised by the local authority. Adult Social Care Outcomes Framework (ASCOF) data showed the positive impact of the enablement service offer from the local authority, with 93.67% of people who had received short term support who no longer requiring support, which was much better than the England average of 79.39%.

ASCOF data also showed 2.16% of people 65+ received enablement/rehabilitation services after discharge from hospital which was worse than the England average of 5.77%. However, the local authority provided updated data showing the number of adults starting enablement services increased from 213 in 2024/25 to 230 in 2025/26, and hospital discharge referral activity increased from 93 to 122. This suggested a projected 31% increase in hospital-referred enablement starts. Data provided by the local authority showed in the last 12 months, people would expect to wait a median of 1.7 days and a maximum of 17.4 days for their enablement package to start.

Most enablement packages were 3 weeks in duration, with the maximum duration being 11 weeks. Knowing the averages helped the local authority plan the service for the maximum benefit of the community. Enablement was predominantly referred into the hospital discharge services and then the adult contact team demonstrating a commitment to timely discharge and admission avoidance principles.

The local authority demonstrated an ‘always improvement’ ethos. A review of the service in late 2024 led to the introduction of Enablement Liaison Officers. This had increased the enablement capacity and reduced waiting times. Further improvements had been seen with increased investment with an aspiration for 80% of all referrals for care having enablement support to maximise independence, prior to a formal Care Act Assessment. In December 2025 the local authority was introducing an improved internal IT system that they hoped would ease recording of enablement services, ensuring outcome recording is easier, enabling further shaping of the service.

Access to equipment and home adaptations

People could access equipment and minor home adaptations to maintain their independence and continue living in their own homes. The local authority told us the assessment process started with information, advice and support from the wellbeing officer

and referral onto relevant / multiple pathways for targeted interventions. Each pathway triaged referrals and added their own advice, and information before a Care Act Assessment was considered. Aids, technology and equipment was considered as part of this front door offer, with a team of occupational therapists triaging calls and supporting wellbeing advisors to ensure they had accurate information to share with people at first contact.

The local authority recruited an occupational therapist (OT) within the medical equipment store to maximise the use of equipment on offer, manage the stock, establish a route to reuse equipment and act as a speedy link between the equipment provider and the wider teams. The special equipment panel discussed requests for equipment which were being proposed to reduce the reliance on physical care in people's homes, this had resulted in successful outcomes for people, for example bespoke feeding devices to support an unpaid carer to maintain their role and not require a package of care. OTs also supported young people moving through the preparing for adulthood pathway to ensure all necessary equipment was in place for homelife and educational settings.

Staff told us they worked collaboratively in the equipment market place to seek affordable equipment and maximise available grants to support purchases. However, they were concerned there were still people who were vulnerable to not having the equipment they needed due to some moderate waits for assessments and poor access to appropriate housing. Staff were developing a letter to send to people to offer an early financial assessment to establish the person's ability to pay privately or establish contribution. Staff told us the technology enabled care provider had a longstanding commissioning arrangement. Provider staff were trained to use appropriate lifting equipment to support people safely and reduce the need to call emergency services.

Partners told us the local authority had a positive approach to multi-disciplinary working toward equipment and adaptations, which was supported by the Aids and Adaptations Assistance policy 2024. The Adult Care Service plan 2023 saw a 50% reduction in waiting lists for aids and adaptations due to the implementation of the ‘adaptations without delay’ guidance, introduction of direct adaptation routes, development of new assessment pathways and working with the adaptations team on a trusted assessor model. At the time of our assessment, the local authority reported a waiting list of 158 people for assistive technology, with a median wait of 24 days and a maximum wait of 56 days. The authority had recently changed provider partners and anticipated this would improve timescales for people receiving essential support. They also told us that, once an OT assessment had taken place, there was no waiting list for minor fixings. For larger equipment, the median wait was 7 days, and the maximum wait was 9 days.

Staff told us the local authority supported innovation and horizon scanning of equipment, encouraging staff to attend trade and professional events, and to ensure they had opportunities to innovate with people.

Provision of accessible information and advice

People could easily access information and advice on their rights under the Care Act and ways to meet their care and support needs. This included people who funded or arranged their own care and support. We heard from unpaid carers who felt advice and information could be available in more ways which had been fed back to the local authority. We heard

from multiple people who had experienced a robust offer and consistent contact with the local authority, which eased their journey through adult social care.

Partners told us they talked through the local authority website with people they were working with to share information with people who experienced digital poverty. Some providers told us the local authority would benefit from ensuring easy read, sensory adapted information and guides for people with neuro diversity, which would help people make greater use of the website. The local authority provided many examples of easy read leaflets as part of the assessment that ensured people who experienced challenges with digital exclusion or difficulties accessing the website had opportunities to understand the services available in ways that worked for them.

Staff told us they ensured people knew how to access assistance for their care and support needs by utilising the local authority's website, social prescribers, community networks, GP's, hospital social workers, and carers groups. They told us they met with an infrastructure voluntary organisation quarterly to share information on services and how people could be supported so this could be shared with other voluntary groups. Adult Social Care Survey (ASCS) data showed 65.67% of people who used services found it easy to find information about support which was similar to the England average of 67.88%. Survey of Adult Carers in England (SACE) data also showed 59.62% of carers found it easy to access information and advice, which was similar to the England average of 59.06%. Carers we spoke with told us the information and advice they were provided with was appropriate and suitable to their cultural needs and in a format that was accessible to them. Survey of Adult Carers in England (SACE) data found 85.11% of carers found information and advice helpful which was similar to the England average of 85.22%.

A new website had been created which included advice and guidance, including how to be safe online, and where activities and support sessions were taking place. Two digital support officers worked across Rotherham to enable partners to be digitally literate and have access to technology, this included working in care homes, assisted-living facilities, hospitals, older persons groups, groups where English was not their first language, and hearing and visually impaired groups.

Direct payments

The local authority recognised that, although direct payment use was already strong, it wanted to increase uptake further and was taking steps to support this. Refreshed guidance and enhanced staff training had been introduced to strengthen practitioners' understanding of direct payments and to ensure conversations about them consistently supported personalisation, choice and control, in line with statutory expectations. This work formed part of the local authority's wider commitment to the personalisation agenda, ensuring people and unpaid carers were empowered to shape their own support in ways that best aligned with their outcomes and preferences. Leaders were optimistic this would lead to continued improvement. Most carers we spoke with were aware of direct payments, although not all were choosing to use them. Adult Social Care Outcomes Framework (ASCOF) data showed 40.07% of people received a direct payment, which was significantly better than the England average of 24.51%, and 69.23% of carers received direct payments. This demonstrated a strong approach to person-centred and strength-based practices with the person in control of their care journey. Local authority data also showed uptake had remained consistent over the past 12 months, with around

39% of people receiving community-based support doing so via a direct payment. During the same period, 180 direct payments had ceased, largely due to people moving into residential settings or other changes that brought the arrangement to an end.

People could choose to manage their own direct payment, with 501 doing so at the time of assessment. A further 647 people chose for the local authority to manage some aspects of their direct payment on their behalf. The local authority provided comprehensive information and practical tools to ensure people employing personal assistants were fully informed and able to meet their responsibilities. Clear guidance on eligibility, employment law and best-practice principles helped people understand their role as employers, while detailed templates and step-by-step resources covering recruitment, interviews, contracts, pay, holidays and risk assessments reduced complexity and supported safe, lawful employment. Access to trusted external contacts, such as HMRC and Citizens Advice, further strengthened this offer. Having this framework in place was essential to help people use direct payments confidently, protecting both employer and personal assistants, and promote safe, well-managed care arrangements.

Staff confirmed the direct payment guidance had been refreshed to ensure it was accessible to people, to ensure staff fully understood the scheme, and to promote it when working with people. Staff told us direct payments were being used creatively to support people to access services they wanted, for example a person using it to access a British Sign Language interpreter, another example was a person with learning disabilities being able to access bespoke support, rather than support from the local authority framework of providers.

Equity in experience and outcomes

Score: 2 - Evidence shows some shortfalls

What people expect:

I have care and support that enables me to live as I want to, seeing me as a unique person with skills, strengths and goals.

The local authority commitment:

We actively seek out and listen to information about people who are most likely to experience inequality in experience or outcomes. We tailor the care, support and treatment in response to this.

Key findings for this quality statement

Understanding and reducing barriers to care and support and reducing inequalities

The local authority understood its local population profile and demographics and drew on a breadth of strategies and intelligence, though the impact of this work was not yet well established and required further embedding. Rotherham's Joint Strategic Needs Assessment (JSNA) highlighted several groups who were less likely to engage with services or have their voices heard, including people from ethnically minoritised communities, newly arrived residents, disabled people, carers, older people who are isolated, and those experiencing social exclusion such as homelessness, substance misuse, mental ill health or with offending histories. It also identified people living in deprived neighbourhoods as at greater risk of being under-represented. The 2011 census showed 22% of the population in Rotherham had a long-term health condition or were otherwise disabled. This was higher than the England average of 17.6%. Older people were the age group growing most rapidly, especially those aged 75+ who accounted for 9% of the population. Understanding these seldom-heard groups helped shape efforts to target prevention and reduce barriers to adult social care; however, the impact of this work varied and required stronger embedding to ensure people with the greatest inequalities were consistently identified and supported.

The Health and Wellbeing Strategy and Action Plan Refresh 2022-2025 was underpinned by the JSNA. This identified and quantified key health inequalities and informed the Health and Wellbeing Board's priorities, supporting targeted responses to population needs such as lower healthy life expectancy and growing long-term health conditions. The JSNA provided granular data on sub-populations such as Black and Minority Ethnic and Roma communities, which enabled local partners to tailor planning and delivery of services to match specific demographic trends, but engagement with the Roma community was still in its early stages, required further development, and had not yet demonstrated sufficient impact.

Rotherham used a Strategy Equality Analysis Form to ensure every major strategy or service change considered its impact on people with protected characteristics. It supported

the local authority to meet its duties under the Equality Act by identifying who may be disadvantaged, how barriers could be reduced and how equality could be actively promoted. Completing the analysis early in the process strengthened decision-making in adult social care by ensuring seldom-heard groups were considered, risks were understood and actions were built in to improve fairness and accessibility for all. Using this method the local authority had examined all people receiving services by gender, ethnicity, primary support reason, religion, marital status and sexual orientation. This helped shape the Adult Social Care Strategy and was driven by people with care and support needs, their families and unpaid carers. It was intended to promote inclusivity and positive outcomes for people.

The Director of Adult Social Services (DASS) told us they were aware leaders and staff must continue to be curious around the community and continue to seek opportunities to enable more people to reach out for support, but our findings indicated that further sustained and embedded action was needed to strengthen impact. The DASS told us about the way Adult Care is learning and changing its approach where officers had engaged with local communities and attended a community group for new mothers, whose first language was not English, and ensured advice and information was available in their preferred language, recognising that most communications are often in English then ensured future communications were offered in a variety of languages. The DASS encouraged staff to be present in the community. Staff told us of the groups and communities they met, such as Black and Asian communities and were keen to make in-roads into others, such as Roma and Slovak communities. The local authority had a diverse staff group who were representative of the communities they served. This helped support the cultural competence of staff working with people. Staff who spoke multiple languages did joint visits to support with assessments.

Rotherham faced a particularly complex set of challenges, including supporting people affected by group child sexual exploitation, which had a profound and lasting impact on those people and the wider community. Alongside this, the area had been shaped by significant industrial change and long-standing deprivation, contributing to deep-rooted health inequalities. These factors created a clear need to improve access to health and wellbeing support and ensure services were responsive to local circumstances. To strengthen local responses to multiple disadvantage, the Vulnerable Adults Pathway had been introduced as a multi-agency approach supporting adults experiencing intersecting risks such as mental ill health, substance misuse, homelessness and vulnerability to abuse or criminal exploitation. Although some people had needs linked to earlier exploitation, the pathway was intentionally designed to address a broad range of vulnerabilities across the community. Within this model, the local authority's Complex Lives Team provided targeted support for adults who did not meet Care Act eligibility criteria, but who experienced significant exclusion, instability or risk. Their work focused on proactive, trauma-informed engagement with people who rarely sought help and were often the hardest for services to reach, including regular outreach to known hotspots and providing harm-reduction advice and signposting. This personalised, preventative approach complemented statutory Care Act functions by addressing the needs of adults who would otherwise fall outside traditional service thresholds, strengthening multi-agency responses and improving the local system's ability to respond flexibly to the realities of multiple disadvantages.

Leaders described how they were strengthening their presence within local communities to improve understanding of services and reduce barriers to access. They attended a local

community hub used by a range of groups, including the Hong Kong Support Group, Yemeni and Kashmiri community groups, and organisations supporting Asian women with a Pakistani background. They told us by being present at the hub they were able to share information about the local authority's work and support people who may face barriers to accessing services. Leaders' presence at the community hub reflected this strategic intent and helped build trust with groups who may not otherwise engage with statutory services, leading to earlier conversations about support needs and improved awareness of how to access help. There was also a family hub worker based in the east of Rotherham who had built a good rapport with the Roma community, and they were looking to build relationships in that community also. Some early work with the Roma community had begun to improve access to primary care and strengthen relationships with local services. GP practices had been commissioned to provide tailored support through the Gateway model, enabling people who may have been excluded from traditional routes to receive the services they need. This approach had helped reduce barriers to care, increased uptake of appropriate health services, and supported a more inclusive response to the needs of the Roma community. The mental health enablement team were keen to broaden the gender of their team to ensure there was a broad range of staff to meet the needs of people approaching their service.

The local authority Equality Diversity Inclusion Strategy 2022-25 set out 4 equality objectives and key actions. The local authority recognised the need to ensure all its strategies, policies, service and functions, both current and proposed had been given proper consideration to equality and diversity. A screening process helped judge relevance and provide a record of both the process and decision.

The local authority had regard to its Public Sector Equality Duty (Equality Act 2010) in the way it delivered its Care Act functions; there were equality objectives in place and a strategy aimed at reducing inequalities and improving the experiences and outcomes for people who were more likely to have poor care. The Equality, Diversity and Inclusion Annual Report 2023-24 showed how the local authority had adopted a Social Value policy, which drove a range of outcomes through the commissioning and procurement of services. Tackling economic inequalities was an element of the Community Wealth building principles, which were embedded within the Social Value policy and a social value toolkit had been produced. The local authority told us, as the policy develops, the outcomes and measures associated with it were intended to support greater equity and were expected to bring benefits for groups with protected characteristics such as age and disability. Tenders for contracts with the council included a section to address equalities, both in terms of the service provision and in management and training of the contractor's staff. The Rotherham Digital Inclusion Strategy stated the benefits of being online and included people's views about using technology. The strategy aimed to help people with their phones, tablets and sim cards, showed people how to use the internet, increased the number of places where free Wi-Fi could be accessed, provided information about being safe online, offered flexible learning in the community and ensured schools and employers were improving digital literacy. They helped people who wanted to volunteer to support this by putting them in touch with organisations across Rotherham who were providing support in the community.

Inclusion and accessibility arrangements

There were appropriate inclusion and accessibility arrangements in place so people could engage with the local authority in ways which worked for them, for example British Sign

Language or interpreter services. Without exception, staff were aware of how to support a wide range of communication differences including language and sensory needs, with the local authority adopting AI technology to bolster interpreter services. An area of opportunity remained in supporting people with neurodiversity to access the website independently. The website did have some capabilities to provide easy read and translations of texts and staff had access to a wide range of communication tools including letters written in braille.

A person who used services told us staff had supported them to organise their goals and outcomes prior to assessments and appointments by spending time with them and writing ideas down. Staff were proud of the variety of languages across the staff resource and how staff made themselves immediately available if a person was in need and an interpreter was not available. People were encouraged to give feedback on the effectiveness of these to support the shaping of future commissioning arrangements.

The local authority was supporting a local charity to offer courses to bolster digital capability for people with learning disabilities, in an effort to promote independence online and to support employment opportunities. This charity had recently been in discussion with the learning disability team about wider regional investment to build digital skills. They described how funding allocated to Citizens Advice services across South Yorkshire could be used to provide one-to-one digital support, and how this could be promoted through local learning disability pathways to help people develop the skills they need.

Theme 2: Providing support

This theme includes these quality statements:

- Care provision, integration and continuity
- Partnerships and communities

We may not always review all quality statements during every assessment.

Care provision, integration and continuity

Score:3 - Evidence shows a good standard

What people expect:

I have care and support that is co-ordinated, and everyone works well together and with me.

The local authority commitment:

We understand the diverse health and care needs of people and our local communities, so care is joined-up, flexible and supports choice and continuity.

Key findings for this quality statement

Understanding local needs for care and support

The local authority had a detailed Joint Strategic Needs Assessment (JSNA) that was updated annually. It covered an extensive range of health and wellbeing information relating to demographics and inequalities amongst other topics. The local authority was using the JSNA along with other information sources such as internal data sets, public health, voluntary and community sector engagement and staff feedback to understand the local population and inform decision making around care and support provision. For example, staff told us consultation was completed with affiliated partners prior to any new contracts going out to tender. The key challenges highlighted by the JSNA for Rotherham included a lower than national average life expectancy for both men and women as well as a higher than national average number of alcohol dependent adults and alcohol related admission to hospital episodes. The JSNA also highlighted that 12% of residents reported a long-term mental health problem which was higher than the national average of 9.9%. Despite this we heard from the Integrated Care Board that they were working with the local authority to find opportunities to improve the provision of mental health services alongside the enablement pathway and more formal services. The local authority provided an example of the JSNA and Public Health pulling together information regarding drug and alcohol services and then working with people and families to develop a new model of support that had been in place for over 12 months at the time of our assessment.

Similarly, staff told us providers regularly engaged with the local authority to provide data submissions that helped understand local needs for care and support. This included an example of a drug and alcohol service data return which indicated fewer women were accessing services. This resulted in the local authority commissioning a piece of peer

research to investigate why this was happening. The local authority had also used similar data sets to review accessibility of emergency contraception and needle exchange services for people living in the more rural areas of Rotherham. Staff also told us there was a lack of housing provision for people with drug and alcohol abuse issues and women released from prison following the end of a recent project to support this area of housing provision. Staff had escalated these concerns to leaders as gaps in provision across the borough. However, a leader told us the local authority did commission a range of supported housing models that provided accommodation and support for people with complex needs, including those with substance misuse issues, offending histories and people leaving prison. Evidence showed services such as Housing Related Support, Housing First and the Rough Sleeper Accommodation Programme offered pathways for people with high levels of vulnerability, including a higher proportion of women, and had expanded provision in 2025 to increase capacity.

Market shaping and commissioning to meet local needs

People had access to a diverse range of local support options that were safe, effective, and high-quality to meet their care and support needs. Data from the Adult Social Care Survey (ASCS) showed 73.50% of people who used services felt they had choice over services. This was similar to the England average of 70.70%. Commissioning strategies and market shaping activity supported this. Commissioning strategies were aligned with shared directorate priorities, including those of public health. This was evident as the local authority used internal population level data and the JSNA to guide commissioning decisions and ensure services were responsive to local needs, such as domestic abuse and complex homelessness.

The local authority clearly outlined their key commissioning messages in their Market Position Statement such as promoting strength-based approaches, utilising assistive technology to support independence and offering the least restrictive option wherever possible. In addition, the local authority had developed a Market Shaping and Sustainability Plan that provided an overview of data and actions being undertaken to sustain the care and support market in Rotherham. The plan forecasted future demand on services for the population, such as an expected 7% increase in the number of people aged 65+ in Rotherham and the impact this would have on the domiciliary care market, as the local authority looked to support people to remain at home.

The local authority was proactive in reviewing data sets and analysing forecasts and then using this information to inform commissioning decisions. For example, the local authority had responded to an anticipated increase in demand for support for people with learning disabilities by developing new care models for supported living settings to increase care capacity within these services. Accelerated reform funds had also been used to employ a social worker specifically supporting the promotion and stability of Shared Lives placements.

There was specific consideration for the provision of services to meet the needs of unpaid carers. The Borough That Cares Network supported carers through in-person social prescribing and services such as parent carer support. The Survey of Adult Carers in England (SACE) data showed 18.46% of carers were accessing support or services which allowed them to take a break from caring at short notice or in an emergency. This was better than the England average of 12.08%. SACE data also showed 34.38% of carers accessed support or services which allowed them to take a break from caring for more

than 24hrs, which was much better than the England average of 16.14%. Meanwhile, 28.13% of carers accessed support or services which allowed them to take a break from caring for 1-24hrs, which was similar to the England Average of 21.73%. However, this was still a low number of carers accessing services and this was reflected in the data we received from the local authority. This detailed less than half of people receiving carers assessments (545) were going on to access services (260). Some carers told us they felt isolated and highlighted the need for better publicity and more comprehensive directories of support. However, a leader told us the local authority had funded a programme of community-based grants between July 2024 and June 2025 to reduce social isolation, with several groups delivering dedicated carer health and wellbeing activities as a result. The local authority also maintained an up-to-date carers' directory on its website, refreshed in February 2025, and distributed this through Carers Rights Day, Carers Week and partner organisations. A borough-wide network of organisations supported carers, and local events in 2025 aimed to reduce isolation and improve awareness of available support.

The Market Position Statement also highlighted an intention to support the transition of some residential homes into supported living services. Staff echoed this, explaining that the aim was to work with providers to repurpose smaller residential homes, where there was currently an oversupply, into supported living services. They explained the idea emerged when a small two-bed residential home was due to close. The local authority noted that the 2 long-term residents were already living with a good degree of independence and agreed with the provider that converting the service into supported living would better enable them to build on and further develop those independence levels. The local authority was looking to reverse the historic model of people moving from supported living into residential homes and further promote independence later in life which would help people stay healthier for longer.

The local authority was flexible in how they shaped the market to meet the needs of the population. For example, staff told us they were utilising direct payments to fill a commissioning gap following the closure of a daycare service which resulted in ex-staff setting up micro enterprises, such as gyms and sports clubs. The local authority used direct payments to allow people to access these new smaller services whilst they were waiting to be added to the framework. The result of this adaptive approach allowed people to exercise choice and access the services they wanted to.

The local authority was also using feedback from both providers and people who used services to help inform commissioning decisions. Providers attended regular forums and reported to the local authority on a regular basis. The local authority had also developed a homecare experience survey to get feedback and establish ongoing communication with people to inform decision making. These channels of feedback helped the local authority identify there was a gap in supported living services for people with mental health issues. As a result, the commissioning team were looking at developing new build services specified for a cohort of people with complex needs awaiting a care package.

Ensuring sufficient capacity in local services to meet demand

There was generally sufficient care and support services available to meet the demands of the population of Rotherham. However, there were instances when people with complex needs were placed out of area due to a lack of provision within the borough. Gaps were reported in working age residential services, early age dementia services and specialist Mental Health and Learning Disability provision. Mental health and learning disability

provision was a focus at the time of our assessment. Where new provision was developed, people placed out of area were considered, subject to their needs and wishes. New developments were also closely managed to ensure the provisions were prioritised for Rotherham residents and met local need.

The local authority reported as of February 2025 there were 128 people placed out of area, with 86 of these people being placed in services for people with mental health needs (33), learning disabilities (39) or memory and cognition needs (5). The local authority told us this was not always a result of a lack of provision and sometimes reflected personal choice due to the location of family and friends. Those placed out of area as a result of a lack of provision would also be prioritised and given the choice to return to Rotherham when the appropriate placement became available. The local authority recognised there was a need to ensure sufficient capacity in the provision of care and support to meet complex needs. This was evident in the innovative approach to convert residential homes into supported living where appropriate as well as introducing flexible purchasing systems for support living services for people with Mental Health issues and Learning Disabilities which had helped to improve the number of units on the framework. The brokerage team told us they were exploring the option of creating specialist provision at residential homes that were no longer in use and where there was sufficient capacity in an area for the placement of working age adults who require 24/7 support closer to home. These approaches helped to provide better options for people to remain within Rotherham should they want to.

The local authority commissioning process ensured providers were identified in a timely manner. Whenever the brokerage team were unable to source commissioned provision, the Rapid Response Team at the Hospital were able to step in and bridge gaps with rehabilitation and personal care services. Partners spoke highly of the brokerage team and their ability to source placements and alternative packages of care in the community. Care and support for more complex needs were sought by the enhanced brokerage service and as a result people were sometimes waiting for long periods to be offered placements. This reflected a very small group of people whose highly specific requirements and carefully planned transitions significantly limited the availability of suitable provision. The team told us these people were sorted into cohorts and would be offered placements suitable to their needs on a priority basis, once they became available. The cohorts would also be first consideration for placements in any new build services, and these would often be customised to suit their needs. A leader described a new integrated development in Canklow that brought together a purpose-built day centre, accessible supported living accommodation and new council homes, designed to offer person-centred support closer to home in a safe and inclusive environment, with construction nearing completion and occupation planned for Spring 2026.

Ensuring quality of local services

Rotherham had systems and procedures in place to monitor the quality of services and ensure people were safe and living fulfilled and dignified lives. There was a Contract Compliance team for regulated services who monitored quality by reviewing Care Quality Commission (CQC) reports, risk dashboards, local authority ratings and digital assessments tools. The team had implemented a points-based risk dashboard, and various points were added as a result of different factors such as Section 42 enquiries that produce actions, no Registered Manager in post, CQC enforcement etc. This provided an

overall risk score for the service which was then RAG rated and monitored by the team, ensuring a strong overview of risk amongst services in the borough.

The Contract Compliance team also carried out comprehensive assessments on site as part of their risk monitoring. These in-depth assessments lasted for 3-4 days and included speaking to people using the service, families and staff as well as reviewing care plans and governance. The team aimed to complete these assessments every 12-18 months, although they acknowledged this aim was not always met due to capacity levels.
The local authority had adopted a pro-active approach to risk management and had developed an early warning system that indicated when there were quality and/or safety issues in a service. The system alerted the contract compliance team early when events had been determined as a risk to quality or safety to allow the team to proactively address these issues before they escalated.

In addition to the early warning system the local authority also had a low level ‘eyes and ears’ form that could be completed and submitted by the public and professionals. The form would report ‘low level’ concerns such as odour in homes. The themes and trends of these concerns were then reviewed to identify any patterns or provide the appropriate support to services where applicable. The local authority’s proactive approach helped prevent any potential risk from escalating and maintain a consistent level of quality amongst services.

Rotherham Borough Council also ensured quality of local services by providing training for care staff and managers. The local authority employed a Training and Development Lead who coordinated this training. There was an additional amount of funding released for social care that was used to commission organisations to provide specialist training. A partner organisation told us the local authority provided training for the voluntary and community sector to access. However, another partner said communication relating to this training was not consistent and often training opportunities were only identified by word of mouth.

The local authority reported at the end of December 2024 there were quality concerns relating to 3 contracted care homes. The themes of these concerns relating to infection prevention and control, nutrition, medication management, falls, mental capacity assessments, risk assessments, care planning and safeguarding. Staff confirmed all 3 providers were continuing to address these issues by working towards achieving objectives on an agreed improvement plan and ensuring safe services were maintained. A voluntary suspension of admissions was agreed with one of these services and no contract defaults were issued. The local authority’s robust quality assurance systems and procedures translated into a generally well performing market.

Feedback from providers showed relationships with local social work teams were a notable strength, with many describing staff as approachable and responsive. Providers also valued opportunities to engage through forums and other partnership activities.

Ensuring local services are sustainable

The local authority acknowledged their responsibility to ensure local services were sustainable and engaged in regular provider forums to understand local trading conditions, service disruption and potential provider failure. Rotherham had an ageing population with

19.6% of the total population aged 65+ and the same age group making up 60% of all people who accessed adult social care services in the borough.

The Commissioning team highlighted an ageing population and indicated an ageing workforce. They had addressed this issue by redesigning their homecare model with a key aim of future proofing this. The aim was to support services to achieve sustainability. As a result, the services on the framework would commit to fixed hour contracts, set shifts, an agreed minimum wage and progressive development and training opportunities for care staff to help improve staff retention within the social care workforce, as well as promote social care careers for younger people.

The local authority acknowledged the difficulties this would create for services outside of the new framework; however, it was felt this was a proactive approach to take control of an increasingly fragmented market that could potentially become unsustainable. This innovative approach helped ensure the sustainability of local services by providing consistent care packages and a stable workforce.

The local authority had a workforce development plan which outlined several measures that had been implemented to try and achieve a sustainable market. This included an International Recruitment Fund to help increase capacity in a skilled and diverse workforce by recruiting team leaders, senior carers and carers from overseas. The fund could also be used to strengthen the workforce's ability to support people with more complex needs. This included access to training in positive behaviour support for dementia, advanced dementia knowledge and skills, team-leading development, effective communication, and falls awareness and prevention. The workforce development team supported provider workforce by offering training and recruitment support.

Feedback from providers suggested while there were positive elements supporting service sustainability, experiences were mixed across the market. Several providers highlighted constructive relationships with the local authority, including access to recruitment events, training opportunities and responsive social work teams. These were seen as helpful in maintaining a stable workforce and supporting day-to-day service delivery. However, other providers described gaps in routine communication and limited sharing of learning, which could make it harder to plan confidently and adapt to changing needs. Some providers also noted delays in review processes, which could affect the timely alignment of support and resources. Overall, the provider survey feedback indicated that although there were strong foundations for sustainable provision, greater consistency in communication, review activity and shared learning would help providers feel more secure and better supported in sustaining high-quality services.

Partnerships and communities

Score: 3 - Evidence shows a good standard

What people expect:

I have care and support that is coordinated, and everyone works well together and with me.

The local authority commitment:

We understand our duty to collaborate and work in partnership, so our services work seamlessly for people. We share information and learning with partners and collaborate for improvement.

Key findings for this quality statement

Partnership working to deliver shared local and national objectives

The local authority worked collaboratively with partners to agree and align strategic priorities, plans and responsibilities for people in the area. Leaders told us they recognised Rotherham had experienced unique challenges which had impacted the shaping of services and how the community were supported. One leader told us they had worked across senior roles in Rotherham for over 20 years and were proud of the culture of improvement and commitment to the community across the system. The local authority demonstrated a mature commitment to community engagement, and this was consistently reflected in the views shared by staff. Internal partnership working across teams was thriving. For example, this was demonstrated by the specialist teams supporting the community affected by group based child sexual exploitation. The local authority had prioritised a trauma informed approach to all teams' culture and specialist pockets of knowledge were evident in the safeguarding and complex lives space.

Staff told us they valued the partnership approach to learning and working together. Leaders told us about strong partnership working under a 'one team' approach where all parties shared a focus on a joint vision.

The section 75 framework agreement demonstrated a commitment to shared objectives across Adult Social Care and the Integrated Care Board. The local authority used opportunities to pool budgets and jointly fund services with partners to achieve better outcomes. For example, the Better Care Fund (BCF) had been used to fund one of the public health consultants. This role oversaw the acute and community aspects of public health. The BCF Health and Wellbeing board objectives weaved commitment and support across systems and the voluntary and community sector. Examples of system support provided a substantial funding stream to some of the key priorities within the Urgent and Community Transformation Programme and surge and winter planning was aligned to other funding streams such as Ageing Well.

Partnerships using the Better Care Fund were mature with key objectives across 2024/25 noted as prevention, supporting avoidable admissions to hospital and timely discharges,

supporting the ageing population, people with learning disabilities and autism and those struggling with mental health and reallocation of resources to provide increased capacity during seasonal pressures. The local authority provided robust governance, audit and monitoring arrangements with detailed examples of how the BCF had been used across health and social care organisations. There was a continued focus on meeting the ambitious targets system leaders set, for example increasing the number of people who remained at home 91 days after hospital discharge. Adult Social Care Outcomes Framework (ASCOF) data showed 61.72% of people aged 65+ were still at home 91 days after discharge from hospital into enablement or rehabilitation, which was similar to the England average of 60.66%.

An example of successful partnership working was the application for funding that was provided from the Additional Capacity Targeted Investment Fund. This in part was used to promote the benefits of hydration across care home providers, which in turn reduced the number of ambulance calls relating to dehydration, improving outcomes for people and reducing the pressures across the health and care system. This funding supported the training of provider staff and to look at hydration recording tools.

Budgets were pooled with the South Yorkshire Integrated Care board (ICB) to meet their plans, which included reducing the number of short term residential placements, which they noted were becoming permanent placements. This involved a culture shift among staff to note placements must only be considered if home care had been ruled out. This in turn bolstered the care at home offer, including occupational therapy and equipment services. System partners confirmed relationships were strong, with weekly system meetings in place to enable productive discussions to achieve the shared vision of improved outcomes for people being the focus.

Staff told us relationships across the Special Educational Needs (SEN) space was strong. Staff attended a recent event at a local school for young people aged 16+ to allow for networking and promote the local authority offer. The supported employment team were also closely involved with schools and visited for employment days where they conducted mock interviews. In addition to this, more schools had transition workers who were able to provide early referrals. The supported employment team had successfully supported over 60 young people to gain employment, with this early engagement seen as vital to ensure no young people were left behind. A leader described the first Futures Fair, jointly funded by the local authority and the ICB and co-produced with young people and the voluntary sector, which demonstrated a shared commitment to improving outcomes for those moving into adulthood.

The Rotherham Safeguarding Adults Board worked closely with the local authority and neighbouring authorities to focus on partnership improvements. This was accelerated by the Safeguarding peer review in 2023 with outcomes presented to the Improving Lives Select Commission in March 2024. The safeguarding awareness week hosted by a neighbouring local authority focussed on working in partnership with people, walking beside people and not walking away. Partner organisations told us they were involved in partnership working with the local authority through the Safeguarding Adults Board and vulnerable adult pathway. The Safeguarding partnership meeting was hosted and managed by the local authority. They were also involved in the Safer Rotherham partnership meetings, weekly place leadership team meetings, and monthly place board meetings, for example, the local Partnership Board for People with Learning Disabilities

and Autistic People which had a joint-funded strategic plan. Health leaders told us there were established monthly health and care place board meetings to monitor strategies. A leader provided a report from the South Yorkshire Place board which showed the Place Director had full delegation to discharge funding within Rotherham to ensure that Rotherham's agenda was heard in terms of other local authorities within the Integrated Care Board. Weekly meetings were in place to oversee operational delivery of strategy and bolster system relationships. Health leaders told us Adult Social Care leaders had a can-do attitude and prioritised attending these forums which had resulted in plans moving forward. For example: urgent care, discharge and waiting times for Mental Health, Learning Disability and Autism services. The systems were working together to broaden their place-based services, for example the plans for a health hub in the city centre, was in phase 1 of development to bring prevention, screening and treatment closer and more central to people.

Partners described having constructive and collaborative relationships with the local authority, noting joint work supported progress on local and national priorities such as carers' support, learning disability strategy delivery, health inequalities and community wellbeing. Organisations reported positive engagement with strategic leads and commissioners, alongside practical examples of coordinated work to support people with complex needs. While some voluntary sector services experienced pressure due to rising demand, partners generally felt communication with the local authority had been open and responsive, and shared initiatives, such as social prescribing and strategic planning groups had helped strengthen collective efforts to improve outcomes for local people.

Arrangements to support effective partnership working

The partnership between the local authority and health colleagues operated effectively, with clear governance, shared accountability and well-established arrangements for joint planning. Strategic plans, such as the joint health and care plan, were co-produced and jointly managed, reflecting a shared approach to meeting local and national priorities. Senior leaders met monthly to review spend and address emerging issues, which enabled timely decision-making and joint problem-solving. This was demonstrated through the jointly funded equipment service contract, where an identified overspend led to a collaborative audit and renegotiation to ensure the service remained sustainable for local people. Jointly funded posts also supported integrated working, with staff describing the benefits of working holistically across health and social care to improve outcomes. Staff told us there was an inclusion lead located in emergency care at the acute hospital; they engaged with clinics and met people waiting to be seen to talk about the local authority offer. This role also involved training and supported acute staff to advise patients and their families on the services available to reduce and prevent admission and inform staff of services to meet needs on discharge. The acute trust added further support by enabling local authority messages to be shared through the communications team. Staff told us they had been able to engage with people who had not identified as a carer to share their rights to a Care Act assessment and subsequent available support. This partnership working was central to a positive, whole system approach.

The local authority provided many examples of arrangements in place across organisational boundaries to promote closer working, this included arrangements to ensure decision making with the Integrated Care Board was timely for people who may be eligible for continuing healthcare funding. The local authority ensured staff were able to share and access information to support a smooth transition for people across their social

care journeys, examples were seen in the Rotherham Health Care Record (with health colleagues), Preparing for Adulthood data portal (with education and children's services), vulnerable people's household index, the quality monitoring provider portal and the provider risk matrix.

Partners also described well-established arrangements which supported effective joint working across organisational boundaries. They highlighted strong communication, shared leadership and regular multi-agency forums that enabled issues to be identified and resolved quickly. For example, weekly meetings between adult social care, the hospital, community services and health partners helped maintain smooth system flow, and co-location at a shared site strengthened day-to-day collaboration. Partners also noted that integrated teams, such as those supporting hospital discharge, enabled more coordinated decision-making and improved people’s experience of moving between services. These arrangements were viewed as fostering trust, transparency and a shared commitment to improving outcomes for local people.

Impact of partnership working

The local authority monitored and evaluated the impact of its partnership working on the costs of social care and the outcomes for people. This informed ongoing development and continuous improvement. Rotherham's unique approach to delivering aspects of the prevention and early intervention support ensured equity and person-centred support, this in turn aimed to reduce demand across crisis services to support a smooth journey for people using services. Without exception, partners described positive impacts from working with Rotherham.

Co-production advocates told us the local authority had found creative and flexible ways to involve communities in shaping services, such as working with the long-standing parent carer forum to design accessible consultation questions for the Learning Disability Strategy. Other organisations shared examples where their input directly influenced decisions, including changes to major roadworks following engagement with people with visual impairments. Partners also highlighted joint work to review commissioning models and develop specialist support, demonstrating a shared commitment to ensuring that people’s experiences informed local priorities and service design. They also described strong system relationships, supported by regular multi-agency forums, co-location and shared leadership arrangements, which helped maintain clear communication, joint problem-solving and a consistent focus on improving outcomes for local people.

Although specialist mental health and learning disability provision was an area of development, the local authority and health services worked closely together to provide coordinated and timely support for adults with mental health needs. Partners described clear joint arrangements for managing pressures on mental health beds under Section 140 of the Mental Health Act, supported by active data-sharing and close collaboration with Approved Mental Health Professionals (AMHP). This was reinforced by wider system structures, including weekly multi-agency meetings involving adult social care, community mental health teams, the hospital and the Integrated Care Board, which helped maintain oversight of demand, discharge pathways and referral activity. Rotherham had established integrated mental health teams and was developing a Mental Health Partnership Board to strengthen shared governance and ensure people’s experiences shaped service design. Together, these arrangements supported joint problem-solving, improved flow through the system and helped ensure people received appropriate care in the least restrictive setting.

The mental health service had established a joint Section 117 (S117) of the Mental Health Act 1983, policy, pathway and register with the local authority to support reviews and aftercare. The AMHP service supported the Trust in S117 review clinics which focused on people discharged from services with little or no recent contact. Health partners said in the last 12 months the collaboration with the local authority had been highly successful, we heard how the S117 process now operated much more smoothly with people receiving regular reviews. Staff told us strong working relationships had been built with health colleagues through the S117 panel where efforts continued to better understand processes and address barriers to recovery.

Working with voluntary and charity sector groups

The local authority worked collaboratively with voluntary and community organisations to understand and meet local social care needs. The local authority had community connectors who were active in understanding what was available in the community and linking people up. When people needed support to attend a group or attend an appointment, the Supporting Independence Team (SIT) attended appointments with people until they were comfortable to attend alone, or with the support of a local organisation to offer peer support.

The local authority provided funding and other support opportunities to encourage growth and innovation by funding a 3-year service level agreement from 2024. Partners told us the local authority supported the sector to apply for grants and explored external funding avenues. A local voluntary sector infrastructure organisation was recognised as a key enabler, supported by both the local authority and health partners, helping over a thousand organisations contribute to local priorities.

Partners consistently described strong and supportive relationships between the local authority and the voluntary and community sector (VCS). Organisations told us the local authority was proactive in building connections, facilitating networking and ensuring VCS voices were included early in planning and strategy development. Several groups highlighted practical support through grants and commissioning, including funding for lived-experience-led services, British Sign Language support, and community-based projects tackling loneliness, welfare advice and emotional wellbeing. Partners also gave examples of collaborative work that strengthened local provision, such as joint development of recovery services for people affected by substance use, and VCS involvement in shaping the carers' strategy. Across the sector, partners described open communication, transparent contract management and a shared commitment to improving outcomes for communities.

One partner told us the mental health services understood the advantage of people being part of peer support opportunities among the voluntary sector, with examples of people who historically relied on intensive mental health support now supporting others, the purpose of volunteering had helped to keep people well. Innovation in partnerships was seen with the local authority and a voluntary sector partner joint leading a drug and alcohol recovery program. Based on feedback from people, this partnership had become a community based lived experience program where people had access to support outside of a clinical setting. Another partner told us access to public health support enabled them to tailor their service delivery to areas of most need.

Theme 3: How the local authority ensures safety within the system

This theme includes these quality statements:

- *Safe pathways, systems and transitions*
- *Safeguarding*

We may not always review all quality statements during every assessment.

Safe pathways, systems and transitions

Score: 3 - Evidence shows a good standard

What people expect:

When I move between services, settings or areas, there is a plan for what happens next and who will do what, and all the practical arrangements are in place. I feel safe and am supported to understand and manage any risks.

I feel safe and am supported to understand and manage any risks.

The local authority commitment:

We work with people and our partners to establish and maintain safe systems of care, in which safety is managed, monitored and assured. We ensure continuity of care, including when people move between different services.

Key findings for this quality statement

Safety management

Safety was a priority for everyone. The local authority understood the risks to people across their care journeys; risks were identified and managed proactively; the effectiveness of these processes in keeping people safe was routinely monitored. The views of people who used services, partners and staff were listened to and considered. The local authority had a good understanding of the risks to people across their care journey and worked proactively with health partners and other organisations to ensure systems to keep people safe during transitions were effective.

The Vulnerable Adults Pathway supported people to receive a longer-term multi-agency approach to support with the Vulnerable Adults Risk Management Meeting (VARMM) which were held fortnightly. The Complex Lives team attended Multi-Agency Risk Assessment Conferences (MARAC) and Multi-Agency Public Protection Arrangements (MAPPA) meetings whilst supporting people.

There were clear cross service protocols in place in relation to ensuring that when people moved from one service to another this was done in a safe way, including an escalation process where risks or problems were identified. In addition to this there were partnership agreements in place for specific situations. For example, a clear policy in relation to Continuing Healthcare funding and an agreement in place with the mental health trust

regarding the transition of young people with mental health needs to adult services. Relevant policies and agreements included risk management and information sharing arrangements.

The local authority had clear guidance in place for staff with regard to the sharing of personal information in ways that protected people's rights and privacy. The local authority and health partners had safe shared IT access to people's care records, which supported accurate information sharing and shared risk management. However, staff told us not all systems were fully available to different organisational staff, with read only access in place.

The arrangement had not resulted in any safety issues and whilst full access would enable staff to update records as intelligence was available this measure provided safe access allowing staff to see essential information while ensuring updates were made by those authorised to do so.

Hospital leaders told us discharge into enablement services was smooth, and feedback from people who had experienced this pathway was positive, with examples of smooth transitions between services.

Safety during transitions

Care and support were planned and organised with people, together with partners and communities in ways that improved their safety across their care journeys and ensured continuity in care. This included referrals, admissions and discharge, and where people were moving between services. The Health and Wellbeing Strategy and Action Plan Refresh 2022-2025 emphasised the importance of safety during transitions in its 4 strategic aims with a focus on no-one being left behind.

Arrangements for hospital discharge were largely safe, coordinated and supported by clear pathways, with people generally experiencing timely assessment and continuity of care. Documented processes, including the discharge-to-assess pathways and continuity-of-care procedures for people moving across local authority boundaries, set out structured, time-bound arrangements that ensured people were assessed promptly and risks were escalated when progress was not made. A partner organisation told us the people they supported had experienced timely discharge and enablement arrangements with no gaps in support, demonstrating safe and seamless transitions home. Other partners, including acute and mental health trusts and voluntary sector organisations, described effective joint working, smoother handovers into local authority-commissioned provision, and improvements in responsiveness following targeted recruitment. This showed the local authority had safe systems in place to support hospital discharge, with recognised pressures around capacity and information-sharing being actively managed.

Leaders demonstrated passion and commitment to examining the Transitions pathway with a view to providing best practice service delivery within a multi-disciplinary system. The leadership team emphasised the importance of preparing services to meet the needs of the growing number of people with neurodiversity, in terms of service provision, assessment and employment opportunities.

The local authority demonstrated a clear and shared commitment to supporting young people as they moved into adulthood. Adult Social Care worked closely with Children and

Young People's Services and health partners to deliver a coordinated Transitions Pathway. External assurance supported this progress: the Written Statement of Action visit in June 2023 reported improved outcomes for young people preparing for adulthood, and the Special Educational Needs and Disabilities (SEND) inspection in October 2024 further evidenced strengthened practice. Oversight of preparation for adulthood was provided through an annually refreshed Preparing for Adulthood (PfA) Work Programme and a PfA Strategic Board, jointly chaired across adults and children's services. The Board's fifth theme, voice, ensured young people influenced the programme's priorities.

Young people were involved in case management ahead of their legal transition to adulthood so support could be arranged without gaps. Local authority data showed 88.7% of young people referred to transitions had an assessment completed by 17.5 years. One person told us they had been supported by the same social worker for over 3 years, which had enabled a trusting relationship and contributed to positive outcomes. Young people without an Education, Health and Care Plan were not excluded from support; instead, they were offered help through the Supporting Independence Team and the Supported Employment Team, reflecting an approach based on need rather than eligibility status.

Transitions were safe and coordinated, with clear pathways, timely adult assessments and examples of seamless support once adult services became involved. People and carers described positive experiences, and partners highlighted effective joint working, improved responsiveness following recruitment, and proactive initiatives such as transitions events. One partner described a poor transition experience from children's services that was improved by the intervention of the adult transition team via prompt assessment and support. Staff reported that most referrals continued to arrive post-16 despite a desire to engage from age 14, and partners noted previous responsiveness issues linked to capacity. However, there was a clear desire and plan to continue to reduce the age at which allocations were assigned by the senior leadership team and new pathways being introduced to give earlier access to information and services. Overall, adult services delivered safe and person-centred support with strong communication systems in place with partners and other key agencies.

Specific consideration was given to protecting the safety and well-being of people who were using services which were located away from their local area, and when people moved from one local authority area to another. The local authority guidance provided detail information and principles to support people to live well, this included safeguarding practices, Deprivation of Liberty and equipment arrangements. Neighbouring authorities provided updates for staff to share how people were thriving in their settings to support staff to hear peoples journey through adult social care.

When people were placed out of area the local authority had robust measures in place to monitor the quality of the service. The local authority would complete checks prior to any out of area placements to ensure the service was not rated inadequate, under any warning notices or any ongoing quality and safeguarding concerns. The local authority also told us if any concerns were raised either by the Care Quality Commission or the host local authority then they would be informed immediately and an urgent review of the person would be undertaken. This ensured people remained safe when placed out of borough.

Contingency planning

The local authority undertook contingency planning to ensure preparedness for possible interruptions in the provision of care and support. The local authority knew how it would respond to different scenarios, such as IT failures, fires and floods. Plans and information sharing arrangements were set up in advance with partner agencies and neighbouring authorities to minimise the risks to people's safety and wellbeing. We saw robust plans in the event of residential and domiciliary provider failures and responses to significant safeguarding concerns. Business continuity plans were embedded in all commissioned services to reduce the risk of service disruption.

The local authority provided 24/7 services to people across Rotherham enabling people to seek advice and support to help problem solve and develop contingency plans with or without services outside of usual working hours. People told us they felt assured by contingency planning with the local authority, this included both emergency planning for unpaid carers who could not provide support in an emergency but also recognising the local authority could provide respite services if required. We heard from families of the importance of contingency planning to help people feel reassured, this was heard across domiciliary and residential arrangements. One family told us knowing that a placement could be arranged quickly reassured them to continue caring for their relative until such time as this was no longer achievable. Another person told us respite was factored into their care plan, again reducing the risk of family feeling overwhelmed by the caring role. Staff told us it was important to encourage families to try respite as it enabled people to feel assured there are contingency plans that can provide secure care in the event of an emergency.

Safeguarding

Score: 3 - Evidence shows a good standard

What people expect:

I feel safe and am supported to understand and manage any risks.

The local authority commitment:

We work with people to understand what being safe means to them and work with our partners to develop the best way to achieve this. We concentrate on improving people's lives while protecting their right to live in safety, free from bullying, harassment, abuse, discrimination, avoidable harm and neglect. We make sure we share concerns quickly and appropriately.

Key findings for this quality statement

Safeguarding systems, processes and practices

There were effective systems, processes and practices in place to make sure people were protected from abuse and neglect. The local authority managed all safeguarding concerns through a central hub, triaging the concern with management oversight to agree the triage outcomes. Timely responses were undertaken with multi agency partners, for example the police or environmental health, with team manager oversight and ensuring the 3-point test had been recorded. The local authority applied the statutory three-point test to determine whether a safeguarding concern met the threshold for a Section 42 (S42) enquiry. This required practitioners to establish that the adult had care and support needs, that they were experiencing or at risk of abuse or neglect, and that, because of their care and support needs, they were unable to protect themselves from that harm. Using this test ensured that decisions were consistent, lawful and proportionate, and that safeguarding enquiries focused on adults who required statutory intervention to remain safe. Local authority processes ensured all concerns were screened by dedicated workers within the safeguarding hub which ensured consistent application of the S42 criteria. Support was available from staff to ensure people's safety while concerns were screened. If the S42 criteria was met, the hub ensured safe transfer of the enquiry to locality teams with management oversight in place.

The local authority worked with the Rotherham Safeguarding Adults Board (RSAB) and partners to deliver a co-ordinated approach to safeguarding adults in the area. The board included housing, health partners, mental health teams, emergency services and the voluntary community sector. The board actively sought views from people to ensure strategy aligned with people's wishes and feelings, with the Rotherham Adult Social Care Always Listening (RASCAL) Board and co-production events regularly providing opportunities for shared learning. The board received twice-yearly updates from the ongoing police investigation into historic child sexual exploitation in Rotherham and learning from this was shared across partner organisations. The board noted improvements in access to safeguarding support and the clarity of local pathways.

Without exception, staff told us the safeguarding hub had improved outcomes for people, this was due to clear roles and timeframes for work to be undertaken. Staff told us people had fed back the benefits of having the same worker support the initial process, it allowed for a relationship to build and continuity to develop. Adult Social Care Survey (ASCS) data showed 65.94% of people who used services felt safe, which was similar to the England average of 70.16%. The ASCS data also showed 88.28% of people who used services said those services made them feel safe. This was also similar to the England average of 87.81%. However, the Survey of Adult Carers in England (SACE) data showed only 74.24% of carers felt safe, which was worse than the England average of 80.93%, demonstrating an opportunity to understand more about what might help carers feel safe.

There was a strong multi-agency safeguarding partnership, and the roles and responsibilities for identifying and responding to concerns were clear. Information sharing arrangements were in place, so concerns were raised quickly and investigated without delay. All staff involved in safeguarding work were suitably skilled and supported to undertake safeguarding duties effectively with the local authority's training data showing a focus on training and development had been successful. Safeguarding practitioners also played a central role in proactive multi-disciplinary meetings, bringing together professionals from health, social care, housing, mental health and the voluntary sector to identify people at risk earlier, share intelligence and coordinate support. This preventative, relational approach helped prevent escalation of need, strengthened risk management and ensured safeguarding was personalised and responsive to the complexities of people's lives.

Responding to local safeguarding risks and issues

There was a clear understanding of the safeguarding risks and issues in the area. The local authority worked with safeguarding partners to reduce risks and to prevent abuse and neglect from occurring. Data provided by the local authority regarding a recent external audit of repeat safeguarding concerns showed of 36 enquiries, 86.11 % were medication errors, 80.5% were organisational abuse and 66.66% were neglect/acts of omission. This audit examined people's journeys to identify practice elements with a focus on improvement. Rotherham had responded to the recommendations with new or improved guidance for staff and partner organisations.

Staff told us of the unique challenges across the borough. We heard about consistent, close and flexible work with vulnerable adults to minimise risks and to support people through the criminal justice system. Staff told us the local authority had a positive and encouraging approach to learning about the needs of people to support safety, including good quality housing and preventative support options.

The local authority worked in partnership with providers to ensure there was a common language regarding concerns and enquiries, particularly around self-neglect. Providers and the Safeguarding Adults Board (SAB) chair told us the commissioned training delivered by a specialist provider had supporting language in this complex area.

The local authority learned lessons from Serious Adult Reviews (SAR's). The SAB chair highlighted the priority of supporting staff to underpin their practice in Making Safeguarding Personal as this learning had been identified as an area for improvement. Multi agency guidance demonstrated how reviews were undertaken and how learning across partners was disseminated, with the Principal Social Worker taking a lead role for the local authority

staff. Data provided by the local authority showed how SARs had been completed and actions to improve communication and processes had been embedded.

Responding to concerns and undertaking Section 42 enquiries

There was clarity on what constituted a Section 42 (S42) safeguarding concern and when S42 safeguarding enquiries were required. This was applied consistently. There was a clear rationale and outcome from initial enquiries, including those which did not progress to a S42 enquiry. There were clear processes in place starting with contacts made to the local authority that may have some safeguarding element. These were screened for eligibility and where eligibility was identified they become a safeguarding concern. Local timeframes for this were 2 working days. Although some safeguarding concerns waited longer than 2 working days for initial review, staff took active steps to manage risk during this period. All contacts were screened on receipt to determine whether they met the threshold to progress to a safeguarding concern, and staff told us they would immediately put protective measures in place where there was any indication of harm. This included developing a protection plan, contacting relevant agencies, and escalating concerns to a duty manager when required. These actions ensured people were not left without oversight while awaiting formal screening. Despite a median wait of 4 days and some cases waiting longer, the approach taken by frontline staff meant emerging risks were identified early and mitigated, helping to maintain people's safety until a full safeguarding decision could be made. During the screening process senior staff were contacted to support staff to determine the outcome at that stage and determination to progress to a section 42 enquiry.

The local authority's standard time frame for completing a S42 enquiry was 80 working days from the receipt of contact. This target had been under review since 2022, with a proposal to increase it to 100 days, to align with neighbouring areas. The local authority had an opportunity to consult with people to determine the direction of these considerations with reference to neighbouring authorities. Local authority data showed out of the 123 open S42 enquiries, 88 were concluded within 80 working days and 35 continued to be open after 80 working days. In the previous 12 months, data showed the median working days an enquiry took was 45 days, the maximum was 372 working days, with 75.6% being completed within the 80 working day timeframe. To maintain oversight, the longest-running cases were reviewed weekly, with managers examining the reasons for delay and working with system partners to address any barriers. This approach helped reduce unnecessary drift and supported more timely progression of enquiries in future. Social work leaders were undertaking a review of safeguarding referrals for people which have a repetitive theme, to address root causes to support people to reduce this pattern.

The local authority retained overall responsibility for safeguarding enquiries, even when operational tasks were delegated to a partner agency, such as a health partner or care provider. The Rotherham Adults Safeguarding Procedures and the Rotherham Safeguarding Adults Board framework set out clear expectations for the scope, timescales and outcomes of the enquiry, to ensure the adult's views and desired outcomes shaped the approach. The processes stated the local authority should maintain oversight through regular monitoring of progress, scrutiny of the quality and sufficiency of the enquiry work, and timely escalation where practice does not meet required standards. Staff were responsible for evaluating the findings, determining the outcome, and ensuring protection planning and learning actions were completed.

Providers described a generally supportive relationship with the local authority when they were asked to undertake their own safeguarding enquiries. They said the local authority's policies were clear and safeguarding staff were accessible, responsive and willing to talk them through the process, including offering advice, guidance and sense-checking recommendations. Some providers, particularly care homes, reported they were frequently asked to investigate concerns they had raised themselves. This was in line with the local authority's policy on 'causing' elements of section 42 enquiries where providers may be asked to supply information or carry out initial fact-finding to support the safeguarding enquiry. Providers also noted that outcomes were not always shared back with them. Domiciliary care providers highlighted the local authority offered safeguarding training for managers, though they felt the experience and quality of safeguarding staff could vary. Overall, providers' experiences reflected both strengths in local authority staff availability and guidance, and some inconsistencies in feedback and practice.

Deprivation of Liberty Safeguards (DoLS) were a priority for the local authority, which continued to manage a significant volume of applications. As of February 2025, there were 827 open DoLS cases, including 280 awaiting risk screening and 346 awaiting allocation. The local authority reported allocation was based on a scoring system designed to prioritise people with the highest level of need. Between April 2024 and February 2025, 1105 DoLS assessments were completed. During this period, people had a median wait of 28 working days, with a maximum of 2233 working days for an assessment. The local authority told us they screened all new referrals on duty 3 times a week, with a maximum wait of 48 hours. All screenings included a full risk matrix and application of a Red, Amber, Green (RAG) rating. Recently the local authority began screening all first time and subsequent referrals in the same way. Work had gone into recruitment, and they had now fully recruited the team, which had led to a significant reduction of the waiting list from 280 to 41 referrals waiting to be triaged by September 2025.

Staff worked in partnership closely with external partners to ensure people's safety. For example, the fire service who provided fire retardant bedding, metal bins and smoke alarms to improve people's safety in their own homes. There were positive links and collaborative working with GP surgeries through regular community partnership meetings and staff told us they were proud of the partnership working with health services, community development workers and adult learning providers to ensure holistic and multi-disciplinary safeguarding support.

Making safeguarding personal

Making Safeguarding Personal (MSP) is a national approach that ensures safeguarding was done with people rather than to them. It focuses on understanding what matters to the person, involving them in decisions, and shaping safeguarding enquiries around their desired outcomes, wellbeing, and sense of safety. Leaders and staff told us; safeguarding was everyone's business. This commitment was further demonstrated within organisational priorities, with MSP outcomes identified as a key success measure within the Council Plan.

The Rotherham Safeguarding Adults Board (RSAB) monitored MSP principles and RSAB performance data showed 66% of people who were asked their desired outcomes from safeguarding enquiries had a response recorded, a further 8% did not give a response. Data provided by the local authority in February 2026 showed there had been some increase in the recording of outcomes on the previous year and the RSAB had a drive to

improve this further. In 2024/2025, of the 66% who gave a response, 95% of people felt their personal outcomes had been fully or partially achieved.

Safeguarding enquiries were carried out sensitively and without delay, keeping the wishes and best interests of the person concerned at the centre. People could participate in the safeguarding process as much as they wanted to. Staff told us people could exit the safeguarding process at any stage, recognising people's choices and wishes to participate. Staff told us they advocated people's choice to be part of the process. People had the information they needed to understand safeguarding, what being safe meant to them, and how to raise concerns when they did not feel safe or they had concerns about the safety of other people.

People could get support from an advocate if they wished to do so, this included family, friends and formal advocacy from the local authority provider. People were supported to understand their rights, including their human rights, rights under the Mental Capacity Act 2005 and their rights under the Equality Act 2010 and they were supported to make choices that balanced risks with positive choice and control in their lives. Advocacy across safeguarding and Care Act activities was strong across Rotherham. Data from the Safeguarding Adults Collection showed 93.33% of people lacking capacity were supported by an advocate, family or friend, which was much better than the England average of 83.38%. These ambitions reflected the RSAB's commitment to person-centred practice and supporting people to make decisions that balance independence and safety.

Theme 4: Leadership

This theme includes these quality statements:

- *Governance, management and sustainability*
- *Learning, improvement and innovation*

We may not always review all quality statements during every assessment.

Governance, management and sustainability

Score: 3 - Evidence shows a good standard

The local authority commitment:

We have clear responsibilities, roles, systems of accountability and good governance to manage and deliver good quality, sustainable care, treatment and support. We act on the best information about risk, performance and outcomes, and we share this securely with others when appropriate.

Key findings for this quality statement

Governance, accountability and risk management

There were clear and effective governance, management and accountability arrangements in place across the local authority. Decision-making was structured and aligned to agreed strategic priorities, with people's experiences and outcomes remaining central to the authority's approach. This was reflected in the Borough that Cares Strategic Framework 2022–25 and the key objectives set for April 2024 to March 2025, which provided a transparent basis for planning and oversight. Governance arrangements ensured carers' voices informed strategic direction, supported by the Community Empowerment Plan, which aimed to involve carers in decisions affecting their lives. People with lived experience formed part of the local authority's Learning Disability Partnership Board and Autism Partnership Board both of which had co-chairs with lived experience. The local authority have also formed a new coproduction group, Rotherham Adult Social Care Always Listening (RASCAL), that further strengthened the voice of people with lived experience in influencing decision making. People are also able to regularly feedback on experiences via an SMS survey and 'How Did We Do?' cards that were also used to inform strategic decisions. Measures of success were defined, including strengthening caring communities, increasing connection and resilience, and embedding prevention-led approaches across services. Leaders monitored progress through analysis of online engagement metrics and tracking carer representation at strategic meetings, demonstrating an ongoing commitment to accountability and continuous improvement.

There was a stable adult social care leadership team with clear roles, responsibilities and accountabilities. Leaders were visible, capable and compassionate which was reflected in feedback from staff and community members who valued opportunities to meet them during local events. Governance arrangements were supported by the Package of Care Assurance Guidance dated May 2024, which set out the escalation responsibilities across the local authority, from frontline staff through to assistant directors. This ensured staff

understood their accountability within the system and their role in maintaining safe and effective care provision.

There were clear risk management and escalation arrangements. These included defined internal and external escalation routes to ensure risks were identified and acted on promptly. The Performance Management Framework 2022-2025 set out how the local authority monitored and audited key performance metrics and how findings were reported to leaders and elected members. This provided mechanisms for leaders to adjust priorities and deploy resources when required. Audit activity was graded as excellent, good, requires improvement or inadequate. Across 2024/25, 68 of the 73 completed audits met the local authority's 'excellent' standard. The same audit cycle also identified areas where practice required strengthening, particularly around contingency planning, the use of advocacy, and decision-making and recording in relation to the Mental Capacity Act. These findings informed targeted support for practitioners and reinforced accountability across the system demonstrating that learning from assurance activity was systematically used to improve practice and maintain high standards.

The local authority's political and executive leaders were well informed about the potential risks facing adult social care. These were reflected in the corporate risk register and considered when decision-making across the wider council. The elected members felt assured by regular updates with involvement in projects and focused tasks as required. For example, the local authority had a robust commissioning risk register which outlined all the medium and high risks, with mitigations and management actions. The highest risk identified was that the local authority was commissioning care without the correct delegations in place. The consequence being risk to the person in need of support not being able to access the right type of care and support. Commissioning staff were actively working with the Integrated Care Board (ICB) to agree a delegated framework for joint packages of care. The local authority also had a comprehensive risk register in place for Adult Care and Integration. Risks were rated high, medium or low and outlined the risk, consequences, mitigations and management actions. All risks were reviewed monthly. These included the increased demand for Continuing Health Care (CHC) Decision Support Tool (DST) completions by local authority staff, which had a significant impact on the adult social care budget and on assessment and support-planning times. Mitigations included monitoring priority DSTs to ensure adult social care attendance, tracking outcomes to alert senior managers to any emerging impact, and overseeing ICB CHC packages before transfer to adult care services. Risk mitigation forums were in place to monitor local authority concerns. At the time of our assessment these included, spiralling homelessness demand, provider fees, gaps in service provision, and increasing complexity and acuity of people with care and support needs.

An elected member told us the local authority continued to operationalise scrutiny forums recommended by previous independent reviews into local governance and safeguarding practice. This encouraged the continuation of transparent and regular oversight across the local authority and system partnerships. Further updates regarding outcomes for people were provided by twice-yearly briefings from the police relating to an ongoing national investigation. These updates ensured system partners continued to learn from the experiences of people.

Most partners told us the local authority had clear and effective governance arrangements that enabled leaders to respond quickly to changes in system demand. Issues such as

capacity, demand and infection risks were routinely monitored through established forums, including weekly operational meetings and the place escalation wheel, which provided live oversight of pressures and the ability to flex services. The local authority used these structures to coordinate timely action, for example deploying community teams to support care homes during infection outbreaks and addressing recurring winter challenges around risk tolerance. Performance and impact were reviewed through the Health and Care Board and the Health and Place Board, which monitored targets and outcomes. These arrangements supported accountable decision-making and ensured the local authority could mobilise support, including through voluntary sector services, to maintain flow and manage seasonal pressures. There were mixed views from partners about communication following some recent restructures. Some partners described transparent communication and felt able to raise issues, reporting a positive and responsive relationship with the local authority. Others told us frequent staff changes and limited availability of allocated workers made it difficult to contact the right person, although the duty system provided timely responses when this occurred. These experiences showed that while communication mechanisms were valued, the consistency of staffing and clarity about team changes required further strengthening to support accountability across the system.

Strategic planning

The local authority's self-assessment set out a clear vision for 2024–2027 to enable every person with care and support needs to live their best lives, close to home, and with access to the right support at the right time. The Adult Social Care Strategy was focused on strengths-based approaches and early intervention. This was co-produced with people, carers, and community partners. A suite of supporting strategies, including the Learning Disability Strategy and the All-Age Autism Strategy, underpinned delivery of the vision.

The local authority used information about risks, performance, inequalities and outcomes to plan workforce challenges, for example, the Workforce plan 2022-25 had an established annual Performance Development Review process which was supportive of individual wellbeing and development and provided direction and feedback on performance. The outcome measures of the strategy were core stability rate of the workforce (both inhouse and in the independent sector); number of vacant posts and posts successfully recruited; feedback from the workforce, reduction in waiting times for assessments and reviews and capacity within the sector to respond to assessed needs and commissioned care packages. These metrics were essential to ensure the local authority could assure itself it had a clear line of sight on commissioning and market shaping to meet the needs of the community. The local authority produced a detailed plan for the whole council services through its Council Plan 2022-2025. The document evidenced good outcomes and strategic planning to deliver actions to improve care and support outcomes. The Adult Social Care Strategy 2024-2027 focussed on implementing and delivering a successful Transfer of Care Hub (TOCH) as one aim. The system leaders we spoke with welcomed this move to streamline discharge processes.

Staff told us the monitoring of demographic data over the past 5 years had fed into strategic planning, for example areas across the borough with higher numbers of older people who may have different needs to other pockets of demographics. Staff said their leaders had a clear line of sight on emerging themes, for example working age adults with needs relating to neurodivergence.

Partners told us leaders created opportunities to hear a range of perspectives across the system to inform strategic planning. This included working with partners to reach people using services who were not already known to the local authority; helping to identify unmet needs. The local authority valued these insights and used them to shape and refine services.

Information security

The local authority had arrangements to maintain the security, availability, integrity and confidentiality of data, records and data management systems. These arrangements were aligned with legislative requirements and supported compliance with the General Data Protection Regulation (GDPR). Staff demonstrated an understanding of information security protocols, including password protection and access controls. Access to systems was
restricted to trained personnel, with tiered permissions ensuring only authorised staff could view or edit specific data. Mandatory training and regular reminders reinforced a culture of accountability and risk mitigation in relation to data handling.

In line with the Managing Allegations Against Persons in Positions of Trust guidance (May 2023), the local authority's policy for managing allegations included an information-sharing protocol. This allowed for the proportional and justifiable sharing of information with employers, where appropriate.

The local authority also produced the Adult Social Care Need to Know Guidance, a document intended to inform senior managers and/or elected members of specific issues that could pose reputational or other significant risks to the council. Information was shared strictly on a need-to-know basis, in a timely and secure manner, and in accordance with GDPR requirements. Written communication played a central role in the process, providing a clear governance structure for the sharing of information relating to risk and associated outcomes. Examples of situations in which this guidance was applied included incidents likely to attract media interest; the death or serious injury of a vulnerable adult; or cases where a vulnerable adult had died or suffered serious harm and abuse or neglect was suspected.

Learning, improvement and innovation

Score: 3 - Evidence shows a good standard

The local authority commitment:

We focus on continuous learning, innovation and improvement across our organisation and the local system. We encourage creative ways of delivering equality of experience, outcome and quality of life for people. We actively contribute to safe, effective practice and research.

Key findings for this quality statement

Continuous learning, improvement and professional development

The local authority demonstrated a culture of continuous learning and improvement. Staff across adult social care had regular access to learning opportunities, reflective spaces and structured supervision, which supported the safe and effective delivery of Care Act duties. Profession-specific leadership for social work and occupational therapy ensured staff had access to guidance aligned to their roles. The Supervision Framework introduced in May 2024 set clear expectations for reflective practice and accountability. Annual sampling of supervision records, supported by a structured audit tool, enabled leaders to monitor quality and provide feedback, reinforcing consistent standards across teams.

Leaders described a range of workforce initiatives designed to strengthen capability and support career progression. These included development of a workforce strategy, recruitment to the Assisted and Supported Year in Employment (ASYE) programme, and the introduction of Advanced Practitioner roles to enhance quality assurance and increase capacity to support students, apprentices and newly qualified workers. Staff told us these opportunities helped them grow in confidence and competence.

Audit activity further supported continuous improvement. The Audit Analysis Tool 2024/25 enabled leaders to monitor compliance with the Care Act, ensure people's wishes were central to decision-making, promote access to advocacy and oversee risk management. Findings were used within supervision and team forums to support reflective practice. Equality impact assessments were routinely completed, demonstrating a commitment to understanding community impact and embedding co-production in planning.

Staff told us leaders listened to feedback and acted on it. Recent examples included the introduction of speech-to-text technology to reduce administrative burden and changes to referral RAG-rating and out-of-hours processes to improve workflow. Staff described this as evidence of a listening and learning culture with a clear focus on improving people's experiences.

There was a wide range of training available, including domestic abuse, hoarding, homelessness and addiction. Staff undertaking Deprivation of Liberty Safeguards (DoLS) assessments accessed regional and national learning events. Lunch-and-learn sessions were used to share learning from Safeguarding Adult Reviews. Staff consistently told us supervision and support were readily available, and they valued direct access to senior leaders which included, a range of regular reflective practice and leadership sessions that

supported professional development, strengthened practice oversight and created space to discuss complex issues.

Leaders promoted connection with frontline teams through reverse mentoring and ‘walking in your shoes’ opportunities, enabling them to understand how policies and processes affected day-to-day practice. Staff described an inclusive culture where peer case reflection was embedded and helped teams learn from each other to improve outcomes for the community.

Social value requirements in contracting had reinforced equality, diversity and inclusion (EDI) principles, and leaders told us EDI was routinely discussed at senior management level. The strengths-based approach, completed by around 1,400 staff, influenced how practitioners understood communities and supported people to articulate their strengths and goals. A leader reported this had contributed to more equitable opportunities and helped reduce inequalities.

Innovation was encouraged. For example, the Mental Health Enablement Service offered short-term, preventative and person-centred support for adults experiencing mental ill health who were not eligible for Care Act support. The model had been shaped through engagement with people with lived experience and public consultation, and the revised service had been operating since June 2024. It also provided a dedicated offer for carers and worked with a broad range of people, including those leaving prison and people from travelling and LGBTQ+ communities. Evidence showed the service delivered bespoke, targeted support aimed at reducing the likelihood of future need, demonstrating an innovative approach to early intervention and community-based mental health support.

Occupational Therapy (OT) staff described being supported to explore new technology and equipment, attend professional events and share learning with colleagues. They provided examples of bespoke equipment that had significantly improved people’s independence and quality of life.

Leaders also used opportunities to learn directly from practice. During a shadowing visit, an OT leader identified gaps in equipment availability and the impact on people being encouraged to purchase items themselves. This led to a review of processes, including increasing the reuse of returned equipment and widening the options available to people. People with lived experience and carers told us they could access approachable leaders, which they valued. Leaders were visible in the community, including at events where people could learn about pathways such as preparing for adulthood.

Overall, the local authority fostered a strong culture of learning, reflection and innovation, with clear evidence that staff development and continuous improvement were embedded in everyday practice.

Learning from feedback

The local authority learned from people’s feedback about their experiences of care and support, and from staff and partners. This informed strategy, improvement activity and decision-making at all levels. There were established processes to ensure learning happened when things went wrong, and leaders encouraged reflection and collective problem-solving across the organisation and wider system.

Co-production was in its early stages in terms of a single dedicated co-production board, however other areas were more mature including the Borough that Cares Board, the Learning Disability Partnership Board and the Autism Partnership Board, all of which were led by people with lived experience. Several groups and areas of co-production were represented including neurodiversity support services, Preparing for Adulthood and unpaid carers. At the time of our assessment, unpaid carers were actively involved in the co-production of the new Carer's Strategy 2026 - 2031 and had co-produced community events as part of carers rights week. The local authority had also begun to develop structures to support people's voices to influence adult social care. The Rotherham Adult Social Care Always Listening (RASCAL) co-production board brought together people with lived experience, carers, providers and senior leaders to shape priorities and test ideas. Co-production activity had also been supported through academic research, which introduced innovative elements to the model. People valued having a regular space to meet, but some told us the arrangements did not always enable meaningful involvement. They wanted more time to understand how their views influenced strategic plans, practical support to enable carers to attend, and a wider range of communication methods. Autistic people described particular challenges engaging with co-production activities, which limited their participation.

Partners told us they felt valued in co-production work, particularly in the development of the learning disability strategy and autism strategy. They described how the local authority used their close links with communities to reach people who would not usually engage, ensuring a broader range of voices were heard. The local authority also enabled partners to participate in academic research on delegated health tasks and workforce development, and staff benefitted from university-led best practice training, including work on hoarding behaviours. This demonstrated a commitment to drawing on external expertise to strengthen practice.

People shared their experiences through a range of routes, including surveys, meetings, questionnaires and online forms. Feedback highlighted both positive experiences and areas where improvements were needed. A partner organisation told us carers found online complaints processes were difficult to use and that delays in phone responses created frustration. This insight informed wider work to improve accessibility and communication.

Staff across adult social care contributed actively to learning and improvement. Themes from safeguarding audits, such as incomplete history-gathering, were fed into thematic learning groups and led to improvements in assessment quality. Staff highlighted the impact of resourcing pressures and the need for earlier collaboration, which informed the redesign of the Deprivation of Liberty Safeguards pathway. Frontline teams routinely gathered feedback through surveys, reflections, enablement reviews and meetings. Staff told us leaders acted on suggestions, including changes to referral RAG-rating and out-of-hours processes to improve workflow. Following staff feedback, the local authority revised the safeguarding pathway to improve clarity, reduce duplication and align timescales to risk, supporting more consistent recording and safer, more efficient decision-making.

The local authority listened to its workforce through a range of staff engagement mechanisms, including leadership sessions, the annual health check and the employee opinion survey, and used this feedback to inform clear action plans that strengthened

wellbeing support, improved communication about change and increased opportunities for staff to connect and share learning. This included the introduction of Speak Up Champions, who provided an additional route for staff to raise concerns and be supported to decide how best to take them forward.

Partners described constructive relationships that supported shared learning. Provider representatives told us the local authority was keen to learn from other areas, including visiting neighbouring authorities to understand different models of supported living. Learning from safeguarding investigations was shared with providers through the quality assurance process and at the end of enquiries. Voluntary sector partners also contributed insight; for example, organisations supporting neurodiverse people shared data to inform the All-age Autism Strategy, and equality, diversity and inclusion leads used flexible engagement methods to reach people who might not participate in formal consultations.

The local authority had clear processes for analysing complaints and identifying themes. The Adult Social Care Complaints Dashboard showed communication was a recurring issue, including the need for timely updates, clearer written information and accurate contact details. Learning was shared with teams to prevent recurrence. In 2024–25 Quarter 1, 20.8% of complaints were upheld and 45.8% partially upheld. The local authority also received 323 compliments in the year to date, with the highest number recorded in Access and Prevention services. Local Government and Social Care Ombudsman (LGSCO) data showed 3 detailed investigations, a 66.67% uphold rate (below the average for similar local authorities), 100% compliance with recommendations and no late remedies. Leaders provided evidence of acting on LGSCO recommendations, including emails showing how improvements were implemented.

The local authority also demonstrated a commitment to external scrutiny. Peer reviews, safeguarding self-assessments and Special Educational Needs and Disabilities (SEND) inspections were used to identify strengths and areas for improvement. Action plans showed how findings were incorporated into ongoing improvement work, including strengthening communication, improving pathways and enhancing the use of data. Leaders used this insight to refine practice, strengthen governance and ensure learning informed service development.

Overall, the local authority fostered a culture of learning, reflection and improvement. Feedback from people, staff and partners was routinely sought and used to shape services, and there were clear mechanisms to ensure learning from complaints, audits and external reviews translated into meaningful change.

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Overall Scores

Our challenge during factual accuracy has led to increased scores for assessing needs and safeguarding.

Now both rated ‘Good’ when they were previously ‘Requires Improvement’.

Quality Statements	Assessing needs	Supporting People to live healthier lives	Equity in experience and outcomes	Care Provision, integration and continuity	Partnerships and communities	Safe systems, pathways and Transitions	Safeguarding	Governance, management and sustainability	Learning, improvement and innovation
Evidence Categories									
Peoples experience	2	3	2	2	3	3	3	3	3
Feedback from staff and leaders	3	3	2	3	3	3	3	3	3
Processes	3	3	3	3	3	3	3	3	3
Feedback from Partners	2	3	2	2	3	3	2	3	3
Rating	3	3	2	3	3	3	3	3	3
Overall % QS Score	63%	75%	57%	63%	75%	75%	69%	75%	75%

Overall score: 73%

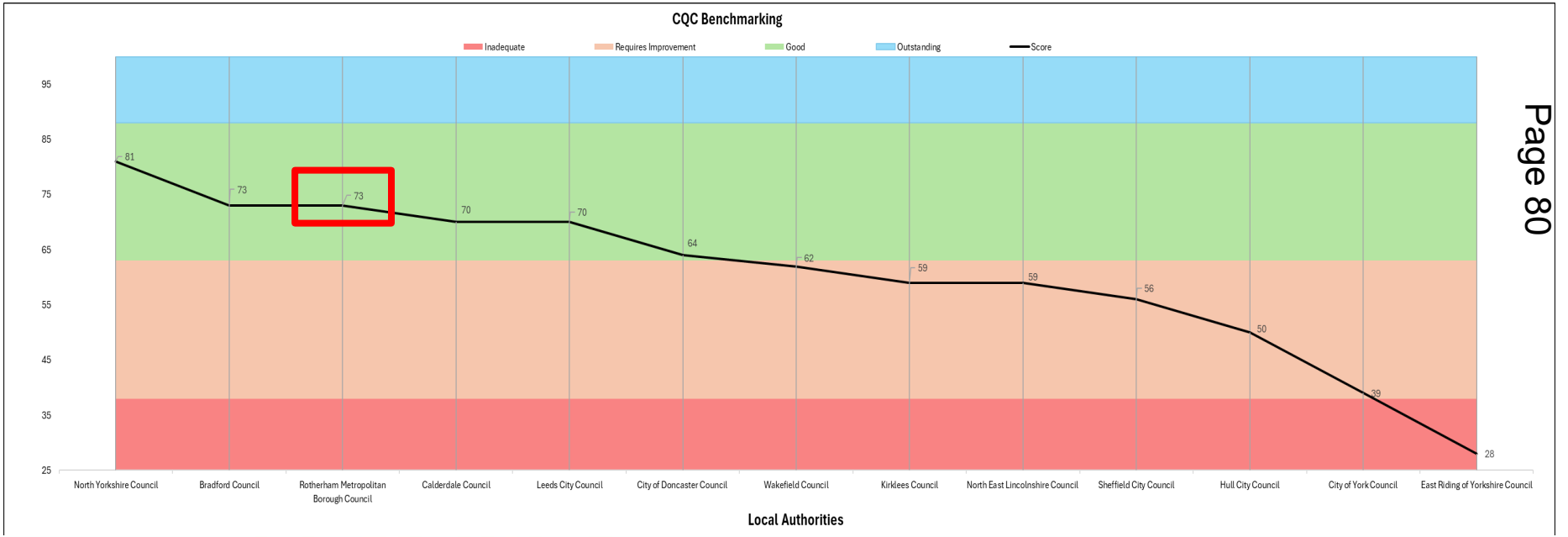
Overall rating: Good

The percentages in relation to the ratings are: 23-38% = inadequate, 39-62% = requires improvement, 63-87% = good, 88% and above = outstanding.

Overall Grade

‘Good’ with a total score of 73%.

This ranks Rotherham as the **highest scoring Local Authority in South Yorkshire*** and **joint second across Yorkshire and the Humber** (out of 13).



Care Quality Commission (CQC) Assessment of Rotherham Adult Social Care

May 2026

Governance relating to CQC outcome

Event	Date
Report governance: SMT	01/04/2026
Report governance: DLT	14/04/2026
Report governance: SLT	21/04/2026
Health Select Commission	14/05/2026
Cabinet	08/06/2026

Background

From April 2023, The Health and Care Act 2022 gave CQC new regulatory powers to undertake independent assessment of local authorities' delivery of regulated care functions as set out in Part 1 of the Care Act 2014. Local authorities are assessed against four domains:

i.) Working with people

ii.) Proving support

iii.) How the local authority ensures safety

iv.) Leadership

Adult Social Care (ASC) began work to ensure preparedness for the regulatory assessment. This assurance work included two peer reviews – one December 2023 by the Local Government Association (LGA) and a second January 2025 by the Association of Directors of Adult Social Services (ADASS). Both peer reviews supported ASC's improvement journey as well as its readiness for assessment by the CQC.

Key assessment dates

CQC assurance visit notice – 10 February 2025

CQC onsite assessment – 14-17 July 2025

CQC draft report received – 3 February 2026

CQC final report received – 4 March 2026

CQC outcome report published – 20 March 2026

Overall Scores

Our challenge during factual accuracy has led to increased scores for assessing needs and safeguarding.

Now both rated ‘Good’ when they were previously ‘Requires Improvement’.

Quality Statements	Assessing needs	Supporting People to live healthier lives	Equity in experience and outcomes	Care Provision, integration and continuity	Partnerships and communities	Safe systems, pathways and Transitions	Safeguarding	Governance, management and sustainability	Learning, improvement and innovation
Evidence Categories									
Peoples experience	2	3	2	2	3	3	3	3	3
Feedback from staff and leaders	3	3	2	3	3	3	3	3	3
Processes	3	3	3	3	3	3	3	3	3
Feedback from Partners	2	3	2	2	3	3	2	3	3
Rating	3	3	2	3	3	3	3	3	3
Overall % QS Score	63%	75%	57%	63%	75%	75%	69%	75%	75%

Overall score: 73%

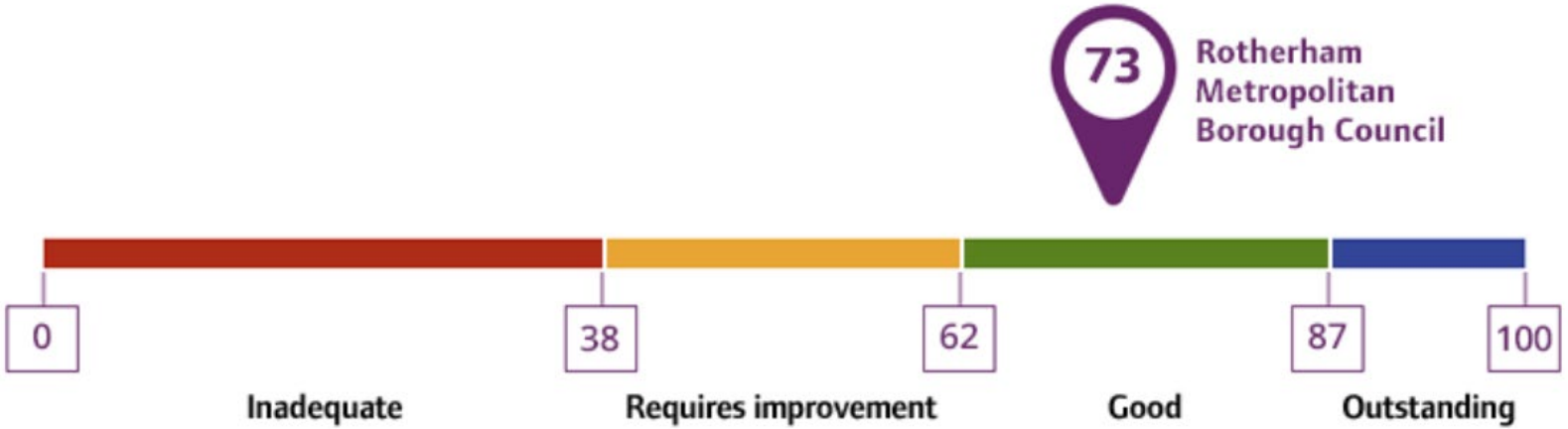
Overall rating: Good

The percentages in relation to the ratings are: 23-38% = inadequate, 39-62% = requires improvement, 63-87% = good, 88% and above = outstanding.

Overall Grade

Rotherham Metropolitan Borough Council

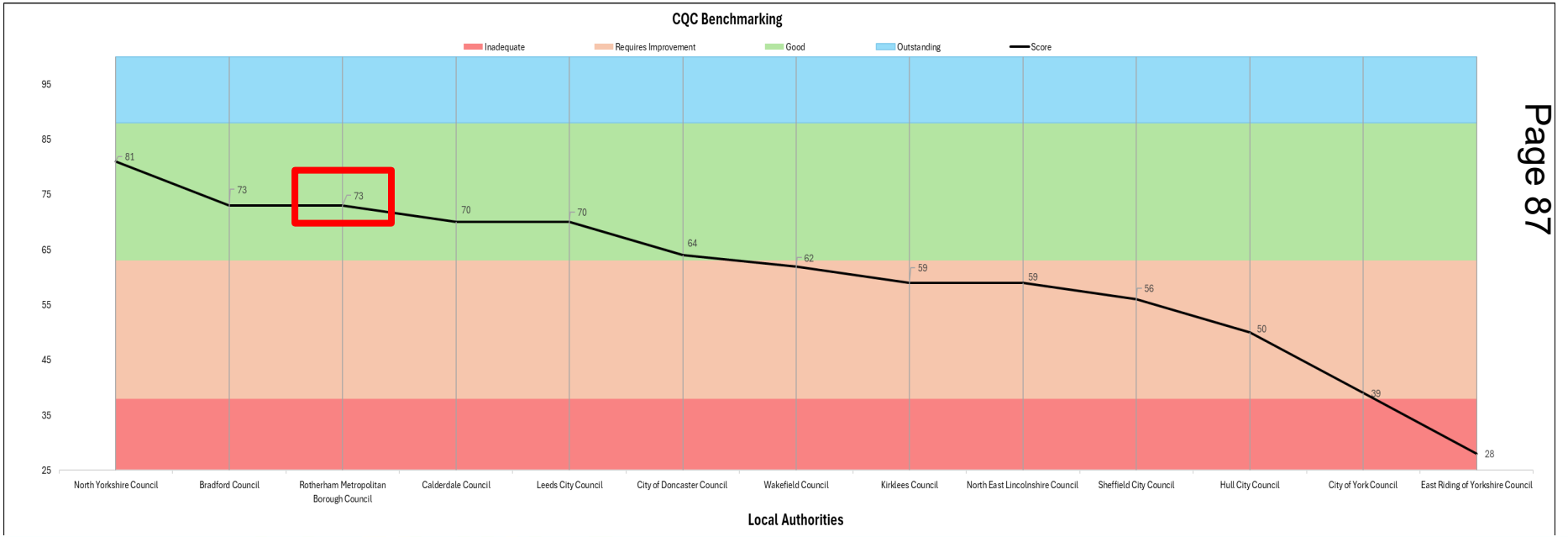
Good



Overall Grade

‘Good’ with a total score of 73%.

This ranks Rotherham as **highest scoring Local Authority in South Yorkshire*** and **joint second across Yorkshire and the Humber** (out of 13).



Summary of Peoples Experiences

- Overall, we heard **positive** feedback from people about their **experiences** of contact with and receiving support from the local authority. However, we did hear that some people had **waited** considerable time for **assessments**.

- There were a variety of ways in which **information** about the services available could be **accessed**, including talking directly with a wellbeing advisor who provided initial contact and assessment. The website included signposting people to other organisations for support which some people told us was helpful for them.

- People were **communicated with** whilst they **waited** for an **assessment**, with a letter explaining the process and guiding people to contact alternative sources and emergency services should their needs change. The Supporting Independence Team could visit people whilst they were waiting.

- **Assessments** were **person centred**, with a focus on **working with** people, not 'doing to' people and a good use of **advocacy** and person-centred safeguarding practices ensured people retained control.

- **Carers** told us their **needs** were **assessed** in their own right as a carer and that there was **good support** provided through Carers support in Rotherham. However, some carers had found it **difficult** to find out about the support **available** to them and found the amount of information overwhelming at times whilst others told us that they had found it really helpful.

Summary of Strengths and Areas for Development

- There was a broad range of **early intervention** services in place, with practical support to improve people's wellbeing, offered through the Supporting Independence Team. This early intervention sought to direct people to draw on community resources and maintain independence for longer.

- The Complex Lives Team offered **trauma informed support** for people who needed preventative and risk management support. This team provided a **holistic, person-centred** service for people experiencing multiple challenges including histories of trauma, homelessness, drug and alcohol misuse and offending behaviour. Support was available to people who did not meet the eligibility criteria for support under the Care Act.

Summary of Strengths and Areas for Development

- Assessments were **strength based**, and **person centred**, considering a **whole family approach**, however there were some **waits** for people to receive an **assessment**. Unplanned and annual reviews showed waits for people, which meant the local authority were not fully appraised of a service meeting needs in a strength-based person-centred way. However, people were **prioritised** on **risk** to ensure those most in need received timely support.

- The local authority had opportunities to **strengthen** its approach to **co-production** to create meaningful partnerships with people and communities. **Outcomes** for unpaid **carers** had the **opportunity to improve** with closer partnership working. **Section 75 agreements** and the use of the **Better Care Fund** provided opportunities for **joined up, system working**. There was a **strong** use of **enablement**, equipment and telecare to maximise **independence**.

Summary of Strengths and Areas for Development

- **Safeguarding** was everyone's business, with a strong emphasis on the **Making Safeguarding Personal** principles. Support was available 24/7 and there was a strong focus on **partnership** working to keep people **safe**. **People** were **supported** to grow and thrive through the employment service which was redesigned with people through co production activities.

- People experienced **safe transitions between services**, for example between Children's to Adults services and through hospital discharge activity. Staff were **co-located** to reduce the number of teams people were referred to, **improving communication** and **outcomes**.

Summary of Strengths and Areas for Development

- Rotherham **staff** and **leaders** knew its **community well**. Staff felt **connected** to the **leadership team**. They were encouraged to share ideas and innovation as systems changed to **improve processes** and **outcomes for people**. Staff were nurtured to **thrive** in a positive and encouraging culture with opportunities to develop careers led by **compassionate** and available leaders. The local authority sought to **improve** by gaining **feedback** from **peer reviews** and **audits** of performance.

MOST AGREEMENT ✓	% POSITIVE
Q1.2 In my job I make good use of my skills and abilities	95%
Q1.5 I look for ways to do my job more efficiently	95%
Q9.1 My line manager trusts me to do my job properly	94%

Key strengths

Theme One – Working with People

OT and AT accessible at Front Door.

Timely and effective advocacy.

Transparent decisions. No appeals made in the prior 12 months to CQC being onsite.

Complex Lives team delivers rapid and flexible trauma-informed support.

Person-centred and strength-based ethos, competent assessment teams, and responsive OOH arrangements.

Key strengths

Theme One – Working with People

Inclusion tools and feedback loops to shape services.

Clear strategies including EDI and Digital Inclusion.

Supported Employment team provides person-centred, bespoke support.

Diverse workforce that aids cultural competence.

Key strengths

Theme Two – Providing Support

Understanding of local need to align supply.

Quality oversight of services.

Effective brokerage which supports provision.

Work on sustainability of the market, including a redesigned homecare model.

Key strengths

Theme Two – Providing Support

Mature and aligned system partnership.

VCS relationships are strong.

A one-team ethos approach.

Key strengths

Theme Three – Ensuring Safety

Safety is prioritised with clear escalation, shared records and robust guidance.

Contingency planning is strong and out-of-area placements are tightly risk-managed.

Transitions and pathways are timely and work well.

Timeliness around DoLS referrals which are screened based on risk.

Making Safeguarding Personal is embedded and advocacy use is high.

A central safeguarding hub with triage, clear application of 3-point test, and strong multi-agency board oversight.

Key strengths

Theme Four – Leadership

Strategic planning that is data driven and co-produced.

A culture of learning and improvement.

Clear governance and accountability with stable leadership.

Areas for development

Theme One – Working with People

Assessment delays, particularly relating to annual reviews.

No agreed local standard for financial assessment decision timescales.

Some moderate waits for assessment relating to equipment.

Strength-based approaches not always evident in unpaid carer assessments. Mixed outcomes.

Sustained action is needed to reduce inequalities across seldom-heard groups.

Proportion of 65+ year olds receiving enablement/rehab after discharge from hospital is below national average.

Accessibility to be strengthened.

Areas for development

Theme Two – Providing Support

Gaps in provision for working-age residential, early age dementia and specialist MH/LD provision. Some waits for complex cohorts.

Quality team capacity means assessments can be less frequent than intended.

Low number of carers accessing services.

Areas for development

Theme Three – Ensuring Safety

Carers reporting that they feel safe is below England average.

Not all S42 enquiries are complete within 80 working days.

Initial screening can exceed 2 working days in some cases.

Some read-only constraints limit cross-agency updating.

Areas for development

Theme Four – Leadership

Audits highlighted practice improvements needed around contingency planning, advocacy use, and MCA decision recording.

Partner feedback indicates a need for strengthening of communication.

Co-production arrangements do not always enable meaningful involvement.

Next Steps

Reflection sessions and a celebration event are taking place to acknowledge areas of strength and inform development actions to be progressed.

- Senior Management Team CQC away day – 25 March 2026
- Operational managers, team managers and service leads CQC planning session – 22 April 2026
- Celebration event – 22 May 2026
- Development plan finalised and progressed

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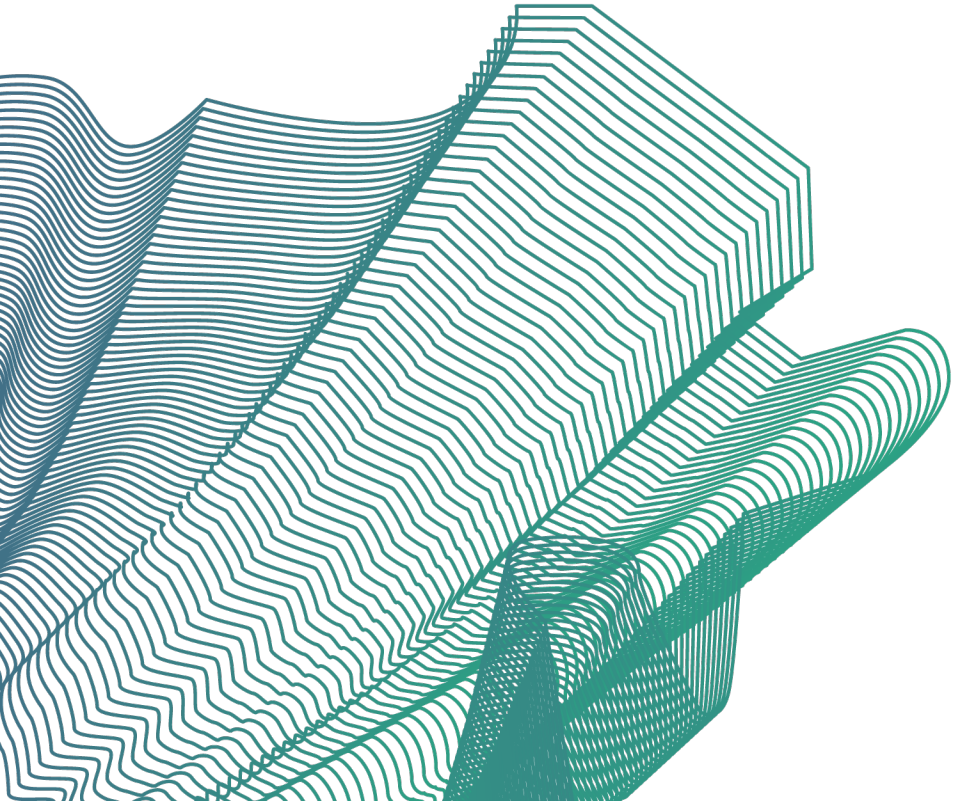
ROTHERHAM
PLACE PARTNERSHIP | HEALTH AND CARE

Rotherham Place Board

Neighbourhood Health Framework Overview



ROTHERHAM INTEGRATED CARE PARTNER
Connect Healthcare Rotherham C
NHS Rotherham Clinical Commissioning Gro
Rotherham Doncaster and South Humber NHS Foundation Tru
Rotherham Metropolitan Borough Council
The Rotherham NHS Foundation Trust
Voluntary Action Rotherham

yourhealthrotherham.co.uk

What is the Neighbourhood Health Framework?

The Neighbourhood Health Framework sets out the government's approach to establishing a neighbourhood health service across England, shifting care:

- From hospitals to communities
- From reactive treatment to prevention
- From fragmented services to integrated neighbourhood teams

It provides a national framework that defines:

- What "neighbourhood health" means at neighbourhood, place and system level
- The minimum national goals and metrics
- The roles of ICBs, local authorities, Place-based partnerships and Health and Wellbeing Boards
- A phased implementation approach between 2026–2029
- The expectation that financial arrangements support neighbourhood delivery
- General practice and Primary Care Networks (PCNs) are core to neighbourhood teams

Core Purpose of Neighbourhood Health

Neighbourhood health aims to ensure that most people's health and care needs are met within their local neighbourhood, through:

- Multi-disciplinary teams (MDTs) working at neighbourhood level – footprints of 30 – 50k populations
- A strong focus on prevention, early intervention and proactive care
- Integration of NHS, social care, VCSE and community services
- Addressing wider determinants of health (housing, employment, social connection)
- Builds on existing Better Care Fund principles, including integration, prevention and reducing avoidable hospital use

This is a core delivery pillar of the 10-Year Health Plan and is intended to be the default way services are designed and delivered supported by aligned funding and commissioning arrangements at Place

National Minimum Goals (What the Rotherham System Must Deliver)

The framework establishes five national minimum goals, each with defined objectives and metrics. These must be delivered locally alongside locally-set priorities:

1. Improved health outcomes
2. Improved access to general practice
3. Better experience of planned care
4. Improved urgent and emergency care (UEC) outcomes
5. Improved patient and staff experience

These goals are expected to be delivered through neighbourhood models, with:

- Place-level leadership
- Aligned financial and commissioning arrangements
- System-level assurance

Required Areas of Reform
(What Must Change on the Ground)

Over the next three years, systems are required to deliver a minimum set of neighbourhood interventions across three reform priorities

1. ***Improving services for people with routine care needs***
    - Easier, faster access to general practice and community services
    - Better navigation and digital access (including NHS App)
    - Delivery through modern general practice and PCNs, with improved access and navigation
2. ***Strengthening proactive and preventative care***
    - Population health management and risk stratification
    - Targeted support for people with complex needs
    - Early intervention to prevent escalation
3. ***Creating better alternatives to hospital care***
    - Expanded community-based services
    - More care delivered at home or close to home
    - Reduced avoidable admissions

All three require neighbourhood delivery, coordinated at Place and enabled by aligned resources

Implementation Expectations and Timeline

Neighbourhood health builds on modern general practice and the Better Care Fund, delivered through neighbourhoods aligned to PCNs and led at Place

The framework sets out two implementation stages:

Stage 1 – 2026/27

- Immediate improvements building on existing neighbourhood and PCN arrangements
- Early use of population health data
- Initial alignment of resources to support prevention and access
- Alignment with existing Better Care Fund plans and priorities

Stage 2 – April 2027 to March 2029

- More formalised neighbourhood models
- Commissioning reform and greater financial flexibility
- Increasing ability to shift investment from hospital to community settings
- National support will be provided through the National Neighbourhood Health Programme

Defined Roles/Geographies

The framework is clear about who does what, and how those roles work together across the system.

Integrated Care Boards (ICBs)

- Set overall direction and assure delivery
- Commission neighbourhood health models
- Define metrics and monitor outcomes

Local Authorities

- Co-lead neighbourhood health alongside ICBs
- Align prevention, public health and wider determinants
- Support place-based integration

Health and Wellbeing Boards

- Provide strategic leadership
- Ensure alignment with JSNA and Joint Health and Wellbeing Strategy
- Hold the system to account for reducing inequalities
- Act as the forum for democratic and community oversight

Defined Neighbourhoods

- Typically serve 30,000–50,000 population
- Often aligned to Primary Care Networks
- Designed to be
  - Locally meaningful
  - Operationally viable for MDTs

What This Means for SYICB

Key shift: From operational oversight and activity management to strategic commissioners for defined populations

Implications	In practice, ICBs will need to:

• ICBs are responsible for setting direction, not running services
 	
• Commissioning is organised around:
  • neighbourhood populations (30–50k)
  • larger aggregated populations
 	
• Increased use of:
  • population-based contracts
  • outcomes-based accountability
 	
• Providers take on greater responsibility for delivery, integration and performance
 	
• Stronger use of population health management to address inequalities
 	
• Prevention becomes a core commissioning expectation, not an add-on
	• Focus on:
	  • defining outcomes for neighbourhoods
	  • commissioning for impact rather than volume
	
	• Shifting investment upstream into:
	  • neighbourhood teams
	  • community services
	  • alternatives to hospital care
	
	• Supporting providers to:
	  • operate across neighbourhoods
	  • hold outcomes-based contracts
	
	• Using place-level governance to:
	  • track neighbourhood outcomes
	  • address unwarranted variation and inequalities
	  • success to be measured by population outcomes in Rotherham, not organisational throughput.

What This Means for RMBC

Key shift: From service specific roles to place based system leadership for neighbourhood health

Implications	In practice, Councils will need to:
Councils are central to neighbourhood health, not peripheral Prevention and the wider determinants of health become: • core system priorities • shared NHS–council responsibility Health & Wellbeing Boards have an enhanced role in: • setting neighbourhood priorities • agreeing outcomes • holding the system to account • Council services must align more explicitly to neighbourhood footprints	The council jointly defines neighbourhoods with the ICB and NHS partners Council services actively support Integrated Neighbourhood Teams, particularly through: • adult social care • housing • public health • community and VCSE links • The Health & Wellbeing Board: owns the neighbourhood health plan • Ensures alignment with the JSNA and Health & Wellbeing Strategy • Focuses scrutiny on inequalities and prevention anchoring neighbourhood health in communities, prevention and place.

What This Means for Provider Organisations

Key shift: From delivering isolated services to being accountable for outcomes for defined populations
Providers succeed by acting as system leaders for neighbourhood health, not standalone organisations

Implications

Providers are expected to:
- Work as part of Integrated Neighbourhood Teams (INTs)
- Take shared responsibility for population outcomes

Greater expectation to:
- collaborate formally with other providers (including councils and VCSE)
- operate across organisational and sector boundaries

Increased use of:
- population-based and outcomes-based contracts
- lead provider or alliance models

More responsibility sits with providers to:
- manage resources flexibly
- redesign pathways
- reduce reliance on hospital care

Performance is judged on:
- outcomes, experience and equity - not just activity levels

In practice, providers will need to

Providers operate as part of defined neighbourhood footprints, aligned to:
- GP practices / PCNs
- community services
- social care and VCSE partners

Neighbourhood teams become the default frontline delivery model, particularly for:
- long-term conditions
- frailty
- complex and high-need patients

Providers are expected to:
- contribute to joint neighbourhood health plans
- share workforce, data and decision-making

More delivery happens:
- in people's homes
- digitally
- in community settings

Provider leaders focus on:
- integrating services end-to-end
- improving population outcomes
- reducing inequalities across neighbourhoods

What This Means for the Rotherham Place Board

Key shift: From coordination to clear neighbourhood delivery ownership

Implications:

- Stronger accountability for delivering neighbourhood services, not just planning them
- Oversight of multi-disciplinary neighbourhood teams
- Clear links between neighbourhood delivery and:
  - Primary care
  - Community and mental health services
  - VCSE partners
- Use of population health data to target resources and reduce inequalities
- Ensure Better Care Fund plans support neighbourhood priorities

In practice, the Place Board will need to:

- Agree neighbourhood footprints that balance local identity with delivery viability
- Ensure neighbourhood models align with national minimum goals
- Track place-level outcomes and performance
- Resolve delivery barriers across organisations
- Support cultural change towards integrated working
- Align better care fund to neighbourhoods

What This Means for the Rotherham Health and Wellbeing Board

Key shift: From broad strategic oversight to explicit stewardship of neighbourhood health

Implications:

- Neighbourhood health becomes a core delivery route for the Joint Health and Wellbeing Strategy
- Stronger focus on:
  - Prevention
  - Inequalities
  - Wider determinants of health
- Increased expectation to hold the system to account for neighbourhood outcomes, not just plans
- Neighbourhood health builds on BCF and GP reforms, not alongside them

In practice, the HWB will need to:

- Ensure the Joint Strategic Needs Assessment (JSNA) and strategy clearly drive neighbourhood priorities
- Monitor whether neighbourhood models reduce inequalities
- Provide visible leadership across partners and communities
- Strengthen links with place-based and community leadership

Key Differences Between the Boards

Rotherham Place Board	Health & Wellbeing Board
Delivery-focused	Strategy and assurance-focused
Oversees neighbourhood teams and services	Oversees inequalities, prevention and system outcomes
Resolves operational and financial barriers	Holds system leaders to account
Focus on “how” services work	Focus on “why” and “for whom”

Required Areas of Reform: Suggested Approach for Rotherham

Strengthening Routine & Preventative Care

What changes nationally?

- Improve access to routine care, especially general practice and community services
- Begin consistent use of population health management
- Start shifting from reactive to proactive care models

What this means for Rotherham

- Agree our Neighbourhoods and test in shadow form
- Build on existing partnership working such as proactive care
- Improve access and navigation across GP, community and VCSE services
- Use Rotherham population health data to identify people at risk of deterioration and Communities experiencing the poorest outcomes
- Identify pooling financial resources to gain economies of scale
- Place Board to oversee delivery progress and resolve system barriers

Embedding Proactive Neighbourhood Care

What changes nationally

- Proactive, preventative care becomes standard practice
- Neighbourhood MDTs operate consistently across places
- Better coordination for people with complex needs

What this means for Rotherham

- Neighbourhood teams increasingly work as “one team” across organisations
- Stronger alignment between:
  - Primary care
  - Community and mental health services
  - Adult social care and VCSE
- Health and Wellbeing Board to assess whether neighbourhood approaches are reducing inequalities and improving outcome

Shifting Care Away from Hospital

What changes nationally

- Clear alternatives to hospital admission
- More care delivered at home or close to home
- Reduced avoidable A&E attendances and admissions

What this means for Rotherham

- Expanded community-based services supporting people outside hospital
- Stronger links between neighbourhood teams and urgent care pathways
- Clear evidence of impact on:
  - Hospital activity
  - Patient experience
  - Health inequalities
- Joint assurance through Place Board delivery oversight and HWB strategic accountability

Closing Summary

Neighbourhood health is now a national requirement, not optional

Delivery is organised by clear geographies:

- Neighbourhoods deliver care (typically aligned to PCNs)
- Place leads integration and delivery oversight
- System assures overall performance

Neighbourhood health builds on existing programmes, particularly:

- The Better Care Fund, as a key enabler of integration and prevention
- Modern general practice and PCN reform, as foundational to neighbourhood models

Financial success depends on alignment, not mandatory pooling:

- Place-based leadership is required to remove financial barriers
- Resources must increasingly support prevention and care closer to home

Neighbourhoods must be:

- Small enough to be locally meaningful
- Large enough to support sustainable multi-disciplinary teams

The Place Board and Health & Wellbeing Board have distinct but interdependent roles in ensuring neighbourhood health improves outcomes and reduces inequalities in Rotherham

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National Neighbourhood Health Implementation Pilot

Progress Update – April 2026

Joanne Martin, Programme Lead – Transformation and Delivery

NNHIP Overarching Summary

Representatives from Rotherham attended the second NNHIP event, providing a valuable opportunity to connect with peers, reflected on progress, and shared learning across systems.

A key highlight for was hearing from Minal Bakhai, who shared her seven principles for neighbourhood working, developed through direct engagement with local sites. These principles offer a clear and practical framework to further strengthen Rotherham's neighbourhood approach:

1. **Empower people** – Enable staff and system partners to take ownership and act
2. **Build trust** – Foster credible, meaningful partnerships across organisations
3. **Think system-wide** – Develop a clear neighbourhood model with strong, shared decision-making on priorities and roles
4. **Lead collectively** – Bring leaders together to address shared challenges
5. **Strengthen place** – Ensure the right local structures are in place to support delivery
6. **Commission for impact** – Create commissioning routes that support prevention and a shift towards earlier intervention
7. **Align nationally** – Embed neighbourhood working as business as usual across the system

The event also provided valuable time to pause and recognise progress. Over the past six months, Rotherham has made significant strides in a relatively short period—an achievement that reflects the commitment and collaboration of partners across the system.

Rotherham continues to make strong progress across the programme. Baseline data has been successfully submitted, and data sharing and processing agreements are now in place across partners. This provides a solid foundation for extracting and reporting outcomes to the national team. Partnership working remains a key strength, with continued engagement across system stakeholders to support delivery.

Data Sharing and Processing Agreements
Rotherham Place Summary

Place summary - Rotherham	Number of practices	Population Covered
Practices with a completed DSA	24	238,870
Practices with a DSA currently in progress	4	32,734
Practices who have declined sign up	0	-
Practices with no response	0	-
Total	28	271,604

YORK ROAD SURGERY
WOODSTOCK BOWER GROUP PRACTICE
WICKERSLEY HEALTH CENTRE
VILLAGE SURGERY
TREETON MEDICAL CENTRE
THORPE HESLEY SURGERY
SWALLOWNEST HEALTH CENTRE
STAG MEDICAL CENTRE
ST ANN'S MEDICAL CENTRE
SHAKESPEARE ROAD SURGERY
RAWMARSH HEALTH CENTRE
PARKGATE MEDICAL CENTRE
MORTHEN ROAD GROUP PRACTICE
MARKET SURGERY
MANOR FIELD SURGERY

KIVETON PARK MEDICAL PRACTICE
GREENSIDE SURGERY
GREASBROUGH MEDICAL CENTRE
GATEWAY PRIMARY CARE
DINNINGTON GROUP PRACTICE
CROWN STREET SURGERY
CLIFTON MEDICAL CENTRE
BROOM LANE MEDICAL CENTRE (DR PATEL & PARTNERS)
BRINSWORTH MEDICAL CENTRE

THE MAGNA GROUP PRACTICE
HIGH STREET SURGERY
DR RAOLU'S PRACTICE
BLYTH ROAD MEDICAL CENTRE

Cohort 1: Prevention – Over 40s Health Check

Progress within the prevention cohort is well underway, supported by the establishment of a dedicated task and finish group.

This group has been instrumental in:

- Identifying and refining the patient cohort
- Securing system-wide agreement on the approach
- Agreeing baseline and outcome measures (including NNHIP and local priorities)
- Establishing data flows and confirming SNOMED coding for cohort identification
- Developing patient pathways and updating Health Check templates

Delivery elements are also progressing:

- Contracts with Connect Healthcare are being finalised
- Targeted outreach is being enabled through non-attender lists
- Workforce micro-training on behaviour change conversations is underway
- Mobile, workplace, and community Health Check delivery has launched
- Recruitment for a dedicated Health Check role is in progress
- VCSE engagement has commenced, with a focus on IMD1 populations
- Resident focus groups are being undertaken to better understand barriers and motivators

In addition, communications and engagement plans are being implemented, including structured messaging to improve uptake. A directory of services has been updated to support prevention pathways, and a clear patient pathway has been developed.

Evaluation activity is embedded, with early evaluation and a mid-year report planned. PDSA cycles will be used to iteratively refine the approach where required. Overall, work is progressing well, and all partners are aligned and supportive of the delivery plans.

Cohort 2: Rising Risk (18–39 years with 1 physical LTC and Anxiety/Depression)

A task and finish group has also been established for this cohort, with significant progress made against key milestones. The programme is now live across practices from **1 April 2026**.

Cohort Definition & Data

- Patient cohort identified and refined (Nov–Dec 2025)
- System agreement secured via Place Board (Dec 2025)
- Outcome and baseline measures agreed (Feb 2026)
- Data collection methods and SNOMED coding confirmed (March 2026)
- All practices signed up to data sharing agreements (March 2026)
- NNHIP data submitted (March 2026)

Pathway Development

- Patient pathway developed, including risk stratification approach
- Clinical templates revised to support data capture
- Data queries and user guidance developed for practices
- Self-care resources identified and social prescribing offer agreed
- Stakeholder mapping completed, with named leads across PCNs
- Directory of services updated and communicated to practices

Communications & Engagement

- Stakeholder mapping completed
- Briefing documentation developed and disseminated
- Briefings delivered across PCNs, VCSE (VAR), social care, and community services

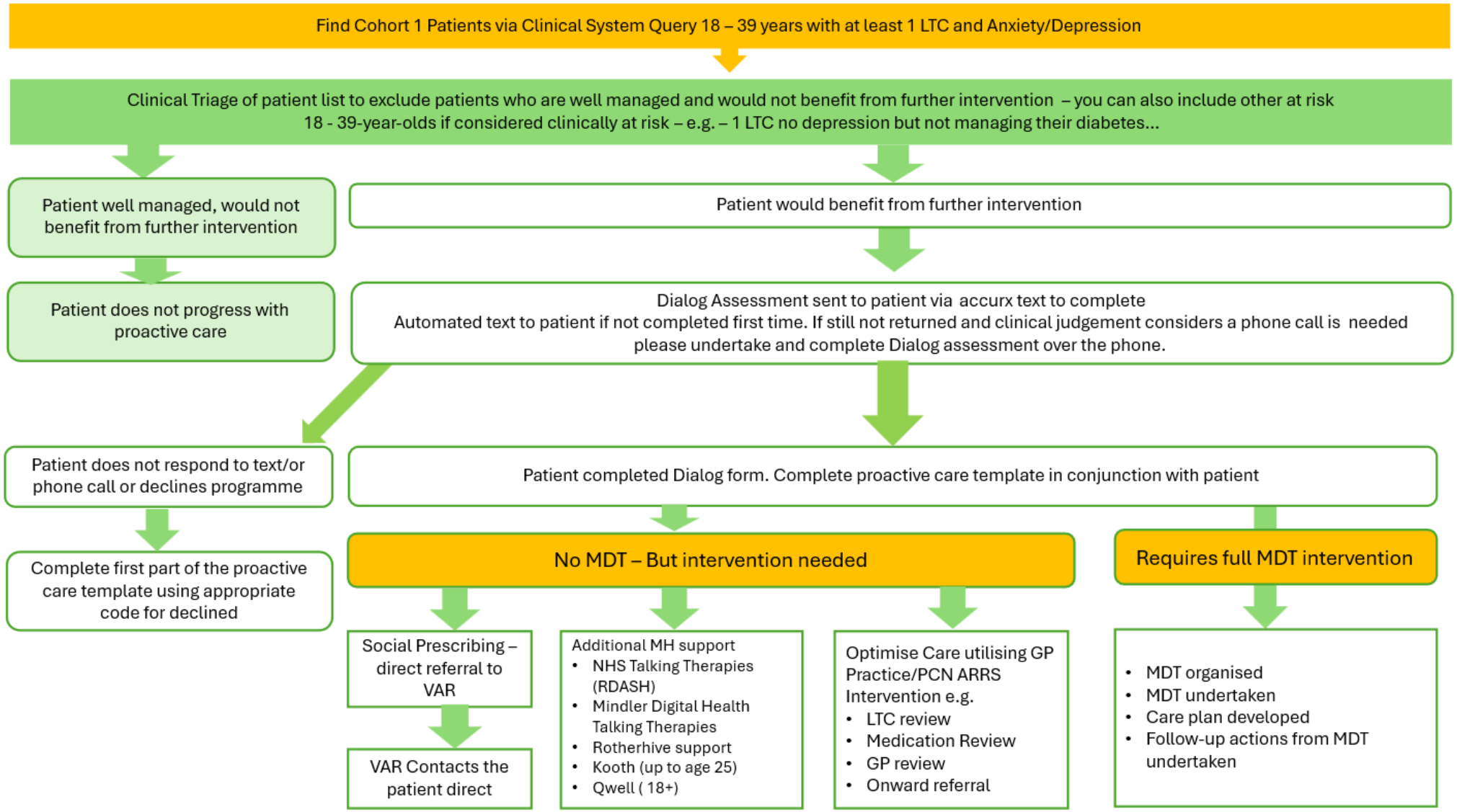
Pathway Development
Pathway Development

- Training for dialogue-based interventions scheduled
- Go-live readiness confirmed, with all practices prepared to commence from 1 April

Evaluation

- Evaluation plan in development, with completion expected by 30 April 2026

Rising Risk Patient Pathway



Cohort 3: Complex Frailty (4+ LTCs and 1 unplanned attendance/admission in 12mths

Work for the complex frailty cohort is progressing well, with the programme now live across practices from **1 April 2026**. A task and finish group has led delivery across the following areas:

Cohort Definition & Data

- Patient cohort identified and refined
- System agreement secured via Place Board
- Outcome and baseline measures agreed
- Data collection methods and SNOMED coding confirmed Logic model refreshed for the national team Clinical templates revised to support data capture
- NNHIP data submitted

Pathway Development

- Patient pathway developed, including approach to risk stratification
- “My Personal Wishes” embedded within clinical systems
- Data queries developed to support cohort identification and monitoring
- Social prescribing offer agreed for this cohort
- Stakeholder mapping completed across the patient journey
- Named leads identified across Place and PCNs
- Directory of services updated and communicated to practices

Communications & Engagement

- Stakeholder mapping completed
- Briefing documentation developed and shared
- Webinars delivered across PCNs, VCSE (VAR), social care, and planned community services

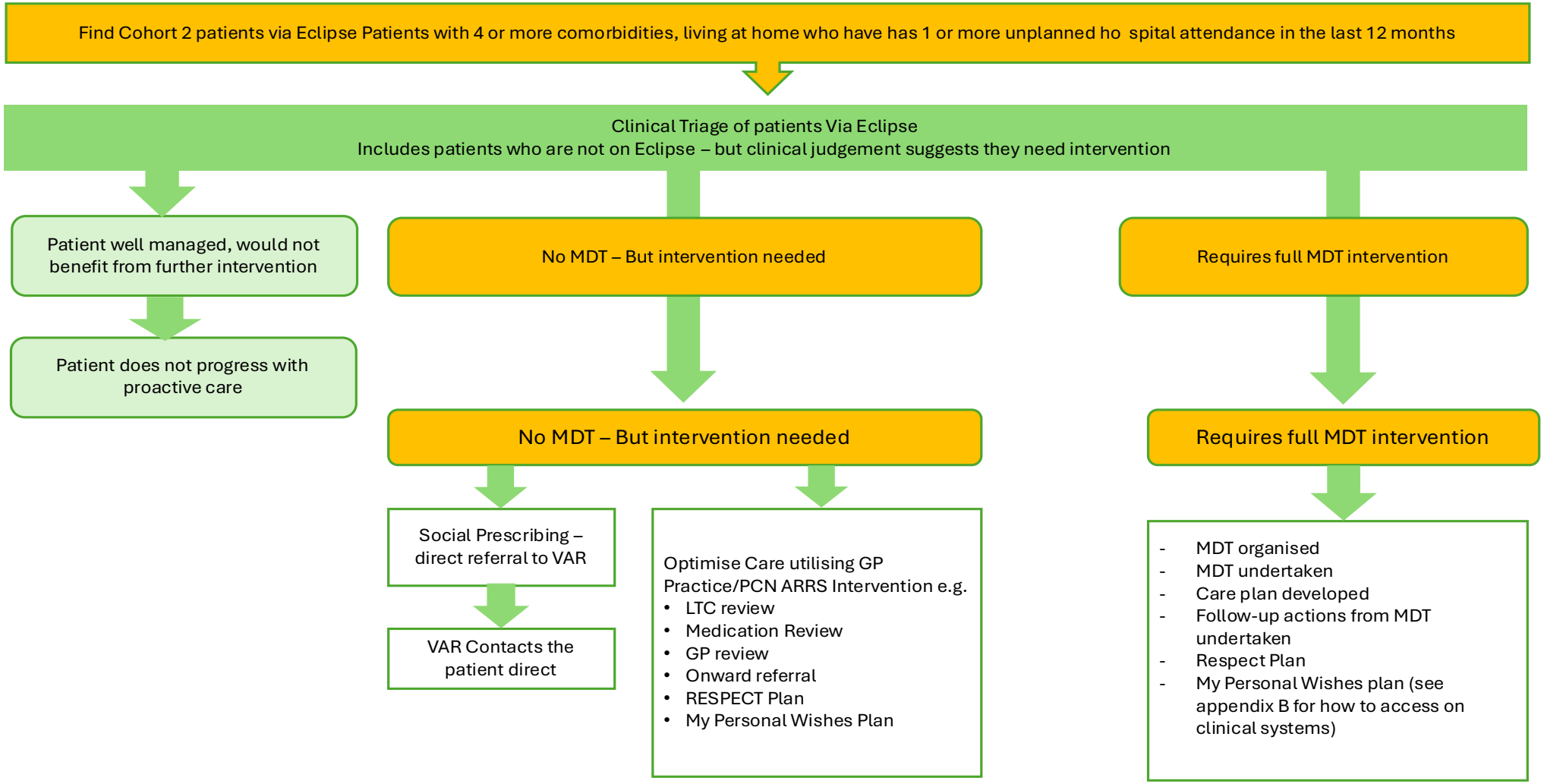
Training & Readiness

- Training for Eclipse system agreed and scheduled
- Training requirements reviewed for My Personal Wishes and RESPECT processes
- Go-live readiness confirmed, with all practices prepared to commence from 1 April

Cohort Definition & Data

- Evaluation plan in development, with completion expected by 30 April 2026

Complex Frailty Patient Pathway



Conclusion and Next Steps

All three cohorts are progressing in line with planned timelines, with Cohorts 2 and 3 now live across practices.

Strong system collaboration, robust data infrastructure, and clear governance arrangements continue to support delivery.

The programme remains on track, with a continued focus on demonstrating measurable outcomes, embedding delivery, and sharing learning with the national team.

Next steps are to build on the 3 cohorts to develop a wider neighbourhood plan in line with national guidance and Rotherham priority areas

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Rotherham Metropolitan Borough Council

Public Report
Health Select Commission

Committee Name and Date of Committee Meeting
Health Select Commission – 14 May 2026

Report Title
Menopause Review

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

Executive Director Approving Submission of the Report
Chris Paddock, Interim Director of Policy Strategy and Engagement

Report Author(s)
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Ward(s) Affected
Borough-Wide

Report Summary
This report summarises the findings and recommendations of the Health Select Commission Spotlight Review into the Menopause. According to the NHS website 'Perimenopause is when you have symptoms of menopause but your periods have not stopped. Perimenopause ends and you reach menopause when you have not had a period for 12 months'.

Originally, this piece of work was progressed as a Health Select Commission Workshop arising from its 2025/26 work programme, however, immediately following completion of the workshop it became clear that the quality and engagement in the workshop was such that it was clear that there was a strong desire from all participants to see progress made in relation to the recommendations developed during the session. As such, through subsequent consideration by the Health Select Commission Chair in conjunction with the Governance Manager and Head of Democratic Services, it was agreed that it was appropriate to re-frame the work undertaken as a Spotlight Review in order to deliver the progress and impact sought by those who participated.

This report sets out the evidence heard during the Spotlight Review, reflecting the experiences of Rotherham residents and the current system infrastructure surrounding Menopause advice, guidance and treatment options available within the borough and the recommendations made arising from that work.

Recommendations
That the Health Select Commission endorse the following recommendations:

1. Public Awareness and Information, Including Engaging Men and Young People
   a) That the Council seeks to improve public awareness of perimenopause and menopause through:
      i) The establishment of a single, well-promoted online menopause resource on the RotherHive or another appropriate online medium, supported by printed information that can be accessed via relevant community settings accessible to the digitally excluded.
      ii) That bespoke targeted content aimed at men, young people and employers is included in that resource to ensure a holistic and borough wide approach to raising awareness.
      iii) That the Council works with education providers including schools and colleges to ensure that young people receive age appropriate advice and guidance regarding the effects of the menopause and how to seek support if they or their loved ones are affected.

2) Primary Care Improvement
   a) That the Council seeks to support Primary Care Improvement in relation to perimenopause and menopause through:
      i) Encouraging the adoption of a 'Menopause Champion' in every GP Practice in Rotherham, and sharing information regarding GPs Menopause Champions once achieved.
      ii) Encouraging, via the 'Menopause Champion' GP network and in conjunction with the NHS Healthcare in the Community Agenda, Development of the Town Centre Health Hub and through collaborative work with TRFT, RDaSH and South Yorkshire ICB, the establishment of a clear and consistent menopause pathway, including consistent assessment tools and referral guidance.
      iii) Encouraging, through the 'Menopause Champion' GP network and collaborative work with TRFT, RDaSH and South Yorkshire ICB, the expansion of GP and practice staff training through Protected Learning Time and online modules to further support service delivery, consistency and capability to provide perimenopause and menopause care in Primary Care settings.

3) Mental Health Support
   a) That the Council seeks to improve Mental Health Support during perimenopause and menopause by:
      i) Encouraging health partners, including GPs to embed menopause screening questions within Talking Therapies and other mental health pathways.

ii) Increase the visibility of mental health support options within all menopause information, advice and guidance materials.

4) Community Support and Engagement
   a) That the Council seeks to improve Community Support and Engagement during perimenopause and menopause by:
      i) Working with relevant Council Services, Health Partners and the Voluntary and Community Sector to expand menopause cafés and community information sessions across more venues.
      ii) Working with relevant Council Services, Health Partners and the Voluntary and Community Sector to further develop outreach support to minority ethnic communities, faith groups and groups with language barriers.

5) Workplace Health
   a) That the Council seeks to improve Workplace Health in the context of perimenopause and menopause by:
      i) Producing and promoting a bespoke 'Rotherham Menopause Workplace Toolkit' setting out best practice, reasonable adjustments and support options for adoption by the Council and which can in be shared with employers across the borough to support 'menopause positivity', creating space for open conversations and contributing to reducing the number of women affected by perimenopause and menopause who leave the workforce.
      ii) Promoting workplace 'Menopause Champions' in local organisations and businesses, starting with RMBC as an exemplar employer

6) System Leadership
   a) That the Council seeks to improve System Leadership in the context of perimenopause and menopause by:
      i) Utilising the connectivity of the Rotherham Women's Health Network to support the drive for better perimenopause and menopause awareness and care across the borough.
      ii) Inviting partners who work with the Council as part of the Health and Wellbeing Board and Safer Rotherham partners, who comprise of some of the borough's largest employers, to adopt workplace 'Menopause Champions' and to support a broader agenda of working towards making Rotherham a 'Menopause Friendly Borough'.
      iii) Developing a shared muti-agency action plan with measurable outcomes in support of that aim, including considering inclusion of improvements in menopause information, advice and support in the Council's Health and Wellbeing Strategy.

iv) Working with relevant Council Services, Health Partners and the Voluntary and Community Sector to explore opportunities to secure sustainable long-term funding for menopause initiatives across Rotherham Place.

List of Appendices Included
None

Background Papers
BBC News article outlining the inclusion of Menopause questions in NHS Health Checks
Department of Health and Social Care, Baroness Merron and Rt Hon MP Wes Streeting Press Release
Women's Health Concern - A Woman's Relationship with the Menopause Infographic
Women's Health Concern - Menopause National Survey Results Infographic
Women's Health Concern - Understanding the Risks of Breast Cancer Infographic
Women's Health Concern - Emotional Wellness in Menopause
British Menopause Society - What is the Menopause Fact Sheet
British Menopause Society - Menopause Practice Standards Fact Sheet
British Menopause Society - Menopause identification and management: from NICE guidelines to practice
British Menopause Society - Top Ten Tips
British Menopause Society HRT Guide
British Menopause Society - HRT and Breast Cancer Risks Fast Facts
British Menopause Society - CBT for Menopausal Symptoms
British Menopause Society - Managing Sleep Disturbances
British Menopause Society - Nutrition and Weight Gain Top Ten Tips
British Menopause Society - Menopause in Ethnic Minority Women
British Menopause Society - Menopause and the Workplace Guidance
Menopause Support - Understanding Menopause Essential Guide
Healthwatch Rotherham - Menopause Report
South Asian Women's Experience of Menopause Report
Rotherham United Community Trust Health and Wellbeing Guide (Including Menopause Support Fitness and Chat Sessions)
RDaSH Talking Therapies – Rotherham's Menopause Support Offer Presentation
Official Census and Labour Market Statistics for Rotherham

Consideration by any other Council Committee, Scrutiny or Advisory Panel
None.

Council Approval Required
No.

Exempt from the Press and Public
No

Menopause Review

1. Background

1.1 The Health Select Commission convened a multi-agency menopause Workshop to explore the lived experience of Rotherham residents, to understand challenges within current service pathways, and identify opportunities to strengthen support across health, community and workplace settings.

1.2 The session brought together GPs and Clinicians, the Council's Public Health, Adult Commissioning and Libraries Services, Healthwatch Rotherham and Voluntary and Community Sector providers such as Rotherham United Community Trust with Elected Members representing the Health Select Commission. Discussions revealed some consistent themes, identified some areas of strength and others where more could be done to support Rotherham's residents through their experience of the Menopause.

1.3 During those discussions, Members and participants were encouraged to keep three key questions in mind:

- Did evidence and experiences presented reflect sufficient awareness and understanding of perimenopause and menopause issues across the borough?
- Were Rotherham's pathways and services truly aligned with the level of need around perimenopause and menopause?
- Crucially, where were the gaps. What areas of need in relation to perimenopause and menopause were not yet addressed or supported as effectively as necessary?

1.4 The recommendations produced during the session have direct links to the Council Plan 2025-2030 in the context of the 'Residents Live Well', 'Children and Young People Achieve' and 'An Economy That Works For Everyone' Strategic Outcomes, which in conjunction with participants' expressed wishes and expectations, led to the ultimate determination to re-frame the Workshop as a Spotlight Review and prepare this report to formalise those recommendations.

2. Key Issues

2.1 In terms of the Spotlight Review's alignment with the Council Plan, it was felt that there was the potential for the findings to directly and/or indirectly impact three Strategic Outcomes as follows:

2.1.1 <u>Residents Live Well:</u>

The Council Plan reflects that 'Improving the health of Rotherham residents is a key priority. Our new Health and Wellbeing Strategy 2025-2030, provides the framework for wide-ranging action, with local partners, to enable Rotherham people to live happy, healthy, independent lives within

thriving communities, regardless of their background or circumstances' and that 'We will also support people to maintain and improve their physical and mental health'. Members recognised that the effects of Menopause posed significant physical and mental health challenges for Rotherham people and improved advice, guidance, support and treatment for those affected in the Borough would positively contribute to the achievement of the Council's stated aims in relation to this Strategic Outcome.

2.1.2 Children and Young People Achieve:

The Council Plan states that 'In Rotherham, we want our children and young people to start well, grow with support, and feel safe and heard. We aim to create a place where they can dream big, knowing that no matter their background or challenges, they have the opportunity to achieve their aspirations and reach their full potential. Providing stability, skills and opportunity for our children and young people will inevitably benefit Rotherham as a whole. By ensuring our young people have the best possible start in life, by empowering them and enabling them to flourish, we can make them feel like they have a stake in our town and encourage them to be part of its successful future'. Members recognised that often, young people experienced disruptions in family dynamics and the stability and consistency of their home environment attributable, at least in part, to the impact of Menopause on their loved ones, which had the potential to adversely affect their own mental health and wellbeing, their academic performance and in turn their long-term aspirations and quality of life. Better understanding of and response to those experiencing perimenopause and menopause had the potential to minimise or mitigate those potential adverse impacts.

2.1.3 An Economy That Works for Everyone:

The Council plan refers to 'equipping people with the core skills that provide the bedrock for securing employment, as well as offering holistic support to overcome any barriers that are preventing them from finding and maintaining Employment' and Members recognised that experiencing Menopause, or the wider familial impacts of the Menopause, could significantly increase barriers to securing or maintaining employment. Work on this area could support the achievement of one of the long term measures of success for this Strategic Outcome, 'An increase in the proportion of the working age population who are in work (or actively looking for work) in Rotherham'.

2.2 **Review Methodology**

2.2.1 A working group was convened which included the following Health Select Commission Members:

- Councillor Keenan (Chair)
- Councillor Clarke
- Councillor Thorp
- Councillor Duncan

- Councillor Brent
- Councillor Garnett
- Councillor Harper

2.2.2 A number of Council Officers, Health Partners and other relevant Voluntary and Community Sector (VCS) organisations were also invited to participate, with representation during the session from:

- Amanda Smith, Libraries and Neighbourhood Hubs Team Leader, RMBC
- Colin Ellis, Public Health Practitioner. RMBC
- Ruth Fletcher-Brown, Public Health Specialist, RMBC
- Dr Linda Strettle, GP Partner, The Village Surgery
- Andrea McCann, Community Project Officer, Rotherham Healthwatch
- Kym Gleeson, Manger, Healthwatch Rotherham
- Jodie Goodall, Health and Wellbeing Manager, Rotherham United Community Trust (RUCT)
- Radhika Gosakan, Consultant Obstetrician and Gynaecologist, The Rotherham NHS Foundation Trust (TRFT)
- Jemma Hall, Communications and Engagement Officer, Rotherham, Doncaster and South Himber NHS Trust (RDaSH) Talking Therapies

Unfortunately, the ICB were unable to send representation to participate in the session on this occasion, as were the Women's Health Network.

2.2.3 Evidence gathering, round-table discussions and the development of agreed recommendations was undertaken during a three hour, in person session conducted under a workshop format.

2.3 **Discussion themes and key insights**

2.3.1 Discussions centred around the following themes:

2.4 <u>Public Awareness and Information, Including Engaging Men and Young People:</u>

2.4.1 Members benefited from a professional explanation and technical definition of perimenopause and menopause, including the varied presentation of symptoms experienced by women at different stages of their menopause journey, and noted that research reflected that 70-80% of women experienced some menopause symptoms, with as many as 25% of women experiencing severe symptoms that had significant adverse impacts on their daily lives. In the context of Rotherham's population based on 2024 Census data, that represented a number in the region of 98,000 to 113,000 women expected to experience some menopause symptoms, and up to 35,000 women expected to experience severe symptoms during their lifetime. Members felt this represented a significant health challenge.

2.4.2 They heard that women often struggled to recognise perimenopause and menopause symptoms and did not know where to seek support. Current

information was fragmented, lengthy, or too clinical in nature to be easily understood and translated into tangible actions that could be taken by affected individuals. Many were unaware of what constituted a menopause-related symptom, leading to fear, misattribution and delayed help being sought.

2.4.3 Members were advised about the role of Oestrogen and Progesterone in perimenopause and menopause, and given information in relation to the various types of HRT (Hormone Replacement Therapy) available to treat symptoms. Information was also shared regarding the risks of HRT including the risk of cancer, balanced against other behaviours such as the effect of diet, exercise, alcohol consumption and smoking on cancer risks. Members noted that whilst there had at one time been reticence in some quarters around HRT due to perceived risks, there had been increased uptake following a highly publicised TV documentary which challenged perceptions. Members noted the role of providing access to reliable and accurate information at scale in driving societal behavioural change.

2.4.4 RMBC Libraries, Healthwatch Rotherham and Rotherham United Community Trust (RUCT) were already providing well-attended menopause cafés and information sessions. However, it was acknowledged that:

- Coverage remained uneven across the borough.
- Sessions were not as widely publicised as they could be.
- Many women, especially those not engaged with healthcare services, were not aware that support existed.

2.4.5 Participants stressed the importance of peer support, particularly for those who felt isolated or misunderstood, as an effective tool for lessening the wider impacts of menopause symptoms.

2.4.6 Members were made aware of a report produce by South Yorkshire ICB (Integrated Care Board) in 2023 concerning Women's Health, including menopause, arising from the 2022 National Strategy for Women's health which reflected the following experiences of Rotherham women during perimenopause and menopause including women:

- Avoiding going out.
- Carrying spare clothing.
- Feeling disregarded by family members in terms of the symptoms they were experiencing.
- Feeling unsure of where to get help for anxiety and depression.
- Feeling the need to leave work as a result of the impact of symptoms.
- Being unwilling to admit to being perimenopausal or menopausal due to societal expectations and perceptions.
- Wanting greater awareness, advice, guidance and support to reduce embarrassment and stigma and to encourage more open conversations about perimenopause and menopause.

2.4.7 Members heard that perimenopause and menopause experienced women described a lack of understanding and awareness amongst partners and their children, which raised the potential of contributing to escalating family tensions and mental health pressures for both them and their loved ones. It was noted that in some cases, changes during menopause had driven or contributed to the failure of relationships and the breakdown of family units.

2.4.8 Members also considered the natural timeline of perimenopause and menopause often coinciding with women experiencing increased demands being placed upon them. In particular, it was noted that in England and Wales in 2024, the average age of mothers at childbirth was 31.0 years (Office for National Statistics Data) meaning that the pattern of parents increasingly having families later in life in turn increased the number of women experiencing perimenopause and menopause whilst also raising adolescent children addressing their own physical, hormonal and mental health challenges associated with puberty and pivotal educational milestones such as GCSEs, A-levels and University as they move toward and into adulthood.

2.4.9 It was likewise noted that through extended continuation of those patterns over time, increasingly many women were also simultaneously experiencing perimenopause and menopause whilst not only addressing those challenges, but whilst also seeing increased reliance from elderly relatives such as parents due to age-related general health issues and declining independence.

2.4.10 Members heard that the compounding nature of those competing demands and challenges exacerbated and intensified the adverse effects of perimenopause and menopause at time where the need for energy, emotional strength and personal resilience was arguably at its greatest for those women.

2.4.11 Members heard of the potential for the physical and mental health effects to contribute to difficulties in personal relationships, most notably within an individual's own household, and considered this in the context of the limitations to accessibility of information, support advice and guidance. Participants reflected that for many men, their first awareness or any level of understanding of the menopause is through experiencing the perimenopause stage when a woman is actively experiencing symptoms, whether as a son, partner, brother, friend, colleague or manager. It was noted that men had no personal experiences to draw on to aid their understanding and were not routinely educated in relation to the impacts of perimenopause and menopause and how to best respond to and support women around them experiencing symptoms, which affected their ability to do so. Members heard that within both personal and professional relationships, this was further compounded by reluctance to openly discuss highly sensitive and personal issues connected to Women's Health for fear of embarrassment or insensitivity, or responding inappropriately due to lack of experience, awareness or understanding. It was likewise noted that women who were not perimenopause or menopause experienced, predominantly those in younger age groups, were in that same position.

2.4.12 Members and participants agreed that there was merit in increasing awareness and understanding of perimenopause and menopause amongst the following groups, with the intention of reducing stigma and achieving improved family dynamics:

- Men (partners, carers, family members).
- Younger people including secondary school-age children.
- Employers.

2.4.13 Both Members and other participants emphasised the need for:

- Concise, clear and plain-English guidance.
- Clear symptom explanations.
- Simple instructions on what to discuss with a GP.
- Improved visibility of resources, support, advice and guidance in community settings.

2.4.14 They noted that this would not only be likely to deliver health and wellbeing benefits for those experiencing perimenopause and menopause, but also to those with whom they lived and their dependants by contributing to:

- Maintaining emotional stability in the home environment and family unit by increasing awareness and understanding.
- Supporting young people to achieve their full potential, particularly during key developmental and educational milestones, by supporting emotional health, wellbeing and stability within the home environment.

2.4.15 Similarly, they considered that this would also support maintaining financial stability and a thriving local economy by contributing to:

- Supporting financial stability through maintaining an environment in which women were supported to remain economically active during perimenopause and menopause.
- Creating workplace environments better prepared to respond positively to the needs of women experiencing perimenopause and menopause and increasing the proportion of the overall population that was economically active.

2.5 <u>Primary Care Improvement:</u>

2.5.1 GPs were represented in the discussion by Dr Strettle, who in addition to bringing their own opinion and professional expertise in relation to perimenopause and menopause through particular interest in Women's Health in their role as GP Partner which included teaching across Rotherham for GPs in relation hormone replacement therapy and menopause, had also gathered the views of GPs and patients across Rotherham through surveys conducted in the GP practice to provide a broader and more representative overview.

2.5.2 Members heard that women reported variable experiences when approaching their GP, including dismissal, lack of recognition of perimenopause, and mixed messages around treatment options. Whilst some practices had highly trained and knowledgeable clinicians, others lacked a designated lead, resulting in inequalities in care across the borough.

2.5.3 Participants reflected that it was encouraging to see a focus on Primary Care interventions and improvement as all too often, when individuals presented at Hospital Clinics and Secondary Care settings in relation to perimenopause and menopause issues, the depth or duration the issue or issues experienced had already caused significant harm, and broader health impacts than would have been seen if need had been identified and addressed at the earlier stage. Members welcomed that view and endorsed the importance of early stage identification and intervention to improve outcomes.

2.5.4 Members heard that there was a Menopause Clinic in operation at Rotherham Hospital with the ability to provide specialist advice, guidance and support to Primary Care as required and which also served as a referral point for more complex cases which could not be resolved within the Primary Care setting. A description outlining the types of complex cases that would necessitate referrals into the Menopause Clinic at the Hospital setting from Primary Care was provided. Members were also advised of the proportion of patients seen by the Menopause clinic who had sought Menopause care privately at great cost, and in some cases without having had face to face contact with a Clinician prior to prescriptions for HRT being issued, potentially exposing those with complex care needs to additional risks.

2.5.5 Dr Strettle shared that as part of their preparations for participation in the session, they had contacted all Rotherham GP surgeries and requested details of a GP willing to act as the menopause point of contact for their clinic. Whilst they were unable to confirm whether every practice had responded, a significant proportion had and there was therefore a defined list of GPs within the Rotherham footprint willing to lead on those issues. Members welcomed that as encouraging progress towards improved delivery and intention to achieve greater consistency in the services offered to Rotherham residents.

2.5.6 Discussions acknowledged pressures around Primary Care. Members were advised that as a result of financial pressures arising from squeezed funding streams and the implications of pay increases and National Insurance contributions, there was an increasing need for GP Practices to focus on delivering services that generated income such as immunisations, diabetes and blood pressure control, particularly in the context of maintaining CQC standards and meeting targets. Members were advised that there was no specific funding for perimenopause or menopause care which limited the ability to make significant progress in those areas of delivery whilst carefully managing the need to maintain financially viable GP Practices. Likewise, the role of South Yorkshire ICB in setting funding rates,

identifying regional priorities and commissioning, particularly in the context of the ongoing restructure of the organisation was considered along with the need to encourage direction of travel that supports issued identified locally.

2.5.7 Discussions acknowledged that in relation to Primary Care:

- GPs wanted more structured training in relation to perimenopause and menopause.
- There was appetite to nominate suitably trained practice-level champions, despite challenges around funding, financial feasibility and competing health priorities.
- A standardised perimenopause and menopause pathway could improve consistency and address service, experience and treatment inequalities that existed across the borough.
- A Community Clinician that worked across Primary and Secondary Care to streamline service delivery and reduce waiting times from referrals would be a 'gold standard' ambition.

2.6 Mental Health Support:

2.6.1 Members and other participants considered increased rates of incidence of anxiety, depression and suicidal ideation among midlife women, typically largely in the perimenopause and menopause window, and especially when racial variations relating to average onset of symptoms were taken into account.

2.6.2 Members heard that whilst clearly not all mental health issues affecting women in the relevant age ranges were attributable to perimenopause or menopause symptoms, there was clear evidence of correlation. Members hear that many women within the relevant age ranges did not recognise or consider the potential for mental ill health to be hormonally driven and potentially connected to perimenopause or menopause, including those that were indirectly driven by other menopause symptoms such as altered sleep, weight gain, loss of libido etc.

2.6.3 Members were advised that due to a lack of broad understanding around perimenopause and menopause, including the racial variations around symptom presentation and onset, GPs, Health Care Practitioners and Mental Health Professionals may not routinely ask about questions about perimenopause or menopause, and women attending their local surgeries or Talking Therapies due to mental health concerns may either not be aware of or volunteer the connection themselves.

2.6.4 Members heard about support available via Talking Therapies through RDaSH (Rotherham, Doncaster and South Humber NHS Trust).

2.6.5 Members heard that whilst male suicide rates were higher in Rotherham, a trend of increasing rates of suicide amongst women, particularly in certain age groups had been a source of concern for some time. Whilst there had been pockets of small scale regional research, in places such as Manchester and Liverpool, there had been no national research around the

drivers of suicide in women and ways in which perimenopause and perimenopause experience might contribute to deaths by suicide in women.

2.7 Community Support, Engagement and Outreach:

2.7.1 Members heard that menopause sessions were delivered in some Rotherham Libraries, with support and involvement from Connect Healthcare Rotherham CIC (Community Interest Company), Healthwatch Rotherham, Places Leisure and RUCT. It was also noted that support for broader community outreach had been offered and delivered by TRFT's Obstetrics and Gynaecology Department on order to provide information, advice and guidance to specific communities that were harder to engage. Members noted that the menopause café and information and chat sessions were predominantly funded by RUCT. Most sessions delivered by RUCT were free of charge, whilst some attracted a small fee in order to allow sessions to continue to be viable. Members were keen that to maintain free provision wherever possible.

2.7.2 Members were advised that TRFT had also recently established a Women's Health Network, whose aim was to drive the kind of systemic improvements that were being considered. Whilst the Women's Health Network Chair was unable to attend the session, they were keen to explore how they could support any work to improve the experiences of perimenopausal and menopausal women in Rotherham.

2.8 Workplace Health:

2.8.1 Members and other participants heard that women shared examples of struggling at work due to perimenopause and menopause symptoms, and of experiencing embarrassment or fear of stigma. It was noted that a proportion of perimenopause and menopause aged women left employment entirely because of poor support, whether directly in the workplace or indirectly due to insufficient advice, guidance, and practical treatment options being offered to effectively manage symptoms.

2.8.2 Participants reflected that normalising workplace conversations about perimenopause and menopause was critical to breaking down broader cultural barriers and stigma, and moving awareness and responsiveness in both professional and personal lives into a more open and comfortable space.

2.8.3 Members were advised that the Council's Public Health team had previously delivered some sessions on the menopause to Rotherham employers. It was noted that delivering training, information, advice and guidance through workplaces was an effective method of delivering information at scale and maximising reach.

2.8.4 Whilst members were advised that Public Health had delivered workplace menopause sessions, they heard that a borough-wide workplace health approach was needed, including:

- Practical adjustments guidance.
- Employee and Manager training and 'toolkits'.
- Workplace champion networks.

2.8.5 Members heard that the Council's Public Health Team did not have a Women's Health Lead, but that rather different Public Health Specialists whose roles comprised various elements of Women's Health.

2.8.6 Members heard that as significant employers in the region, the Local Authority and NHS infrastructures do not yet fully embody the behaviours discussions idealised around normalisation of and responsiveness to perimenopause and menopause in the workplace. Members welcomed a move towards those organisations becoming ambassadors for 'menopause friendliness' and embedding policies and procedures that aligned with the behaviours they wanted to see reflected across the borough as a whole under a broader ambition of being a 'Menopause Friendly Borough'.

2.9 <u>System Leadership:</u>

2.9.1 The Women's Health Network was identified as a potentially appropriate forum to co-ordinate borough-wide menopause work across Health Partners, Council Services and the Voluntary and Community Sector.

2.9.2 Participants reflected on the potential of 'RotherHive' as an online space for housing menopause, advice, guidance and resources for individuals and groups such as schools and employers under its 'Life Stages' area. Members welcomed the general idea of readily accessible and impactful information, resources and tools to support broader understanding and normalisation or perimenopause and menopause.

2.9.3 Members were advised that some Pharmacies in Rotherham were able to prescribe certain types of HRT in certain circumstances. However, what was not clear was which Pharmacies had that ability, whether there was any centra record of that or if that information what shared widely with Rotherham residents whom it might benefit. Members were keen to see that information shared to address some of the systemic pressures affecting both Primary Care, and potentially partly driving the incidence of private menopause care being sought.

2.9.4 Members heard participants highlight that previous national funding for Women's Health had been short-term and non-recurrent, which created challenges in long-term planning and supporting improvements in service provision. Views were shared that previous approaches to Women's Health and in particular perimenopause and menopause could be considered tokenistic and did not generate an environment that facilitated broad cultural change or significant progress on the issue.

3. Options considered and recommended proposal

3.1 Option A: Do nothing. (Not recommended)

This option would result in no proactive changes and the maintenance of the status quo. The body of this report describes why Members felt that this would not sufficiently address the needs of Rotherham residents or contribute to the vision and Strategic Outcomes identified in the Council Plan.

3.2 Option B: Support the recommendations outlined in this report. (Preferred Option)

Members felt that tangible and sustained improvements for Rotherham residents could be achieved through the recommendations outlined within this report. They acknowledged that progress in this area was not in the Council's gift to deliver alone, and accepted that this would only be possible through effective collaboration with health partners over time. However, they were clear that there was the opportunity to realise meaningful collaborative systemic change when there was commitment to delivery of the identified recommendations. It was likewise felt that these recommendations supported multiple Strategic Outcomes described in the Council Plan.

4. Consultation on proposal

4.1 Members have regard to the expressed views of their constituents in their formulation of scrutiny priorities and lines of inquiry. Recommendations from scrutiny are produced as outcomes from consultation by Members in their role as elected representatives of Rotherham residents.

4.2 In its review, the working group considered evidence from the officers and key partners. Those who participated are outlined in paragraph 2.2.2.

5. Timetable and Accountability for Implementing this Decision

5.1 The accountability for implementing recommendations arising from this report will sit with Cabinet and relevant officers.

5.2 The Overview and Scrutiny Procedure Rules require Cabinet to consider and respond to recommendations from Overview and Scrutiny Management Board and the Select Commissions in no more two months from the date that Cabinet receives this report.

6. Financial and Procurement Advice and Implications

6.1 No financial implications arise directly from this report, although the response to the review will need to take account of any such implications arising from consideration of the scrutiny recommendations.

7. Legal Advice and Implications

7.1 There are no legal implications directly arising from this report.

8. Human Resources Advice and Implications

8.1 There are no human resources implications directly arising from this report.

9. Implications for Children and Young People and Vulnerable Adults

9.1 Implications for Children, Young People, and Vulnerable Adults are set out in the main body of the report.

10. Equalities and Human Rights Advice and Implications

10.1 Furthering equalities and human rights are scrutiny objectives; therefore, Members considered equalities in the development of scrutiny work programmes, lines of inquiry and in their derivation of recommendations designed to improve the delivery of council services for residents.

11. Implications for CO_2 Emissions and Climate Change

11.1 There are no climate or emissions implications directly associated with this report.

12. Implications for Partners

12.1 Implications for partners are set out in the main section of the report outlining the Commission's findings. Cabinet will need to consider the implications for partners in its response to the recommendations from scrutiny.

13. Risks and Mitigation

13.1 Members have regard to the risks and mitigation factors associated with the services under scrutiny and have made recommendations accordingly.

Accountable Officer(s)
Emma Hill, Head of Democratic Services and Statutory Scrutiny Officer
Kerry Grinsill-Clinton, Governance Advisor

Approvals obtained on behalf of:

	Name	Date
Service Director of Legal Services (Monitoring Officer)	Phillip Horsfield	22/04/26
The Executive Director with responsibility for this report	Chris Paddock, Interim Director of Policy, Strategy and Engagement	22/04/26

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This report is published on the Council's website.

Health Select Commission – Work Programme 2026-2027

Chair: Cllr Keenan **Vice-Chair: Cllr Yasseer**
Governance Advisor: Kerry Grinsill-Clinton **Link Officer: Emily Parry-Harries**

The following principles were endorsed by OSMB at its meeting of 5 July 2023 as criteria to long/short list each of the commission's respective priorities:

Establish as a starting point:
- What are the key issues?
- What is the desired outcome?

Agree principles for longlisting:
- Can scrutiny add value or influence?
- Is this being looked at elsewhere?
- Is this a priority for the council or community?

Developing a consistent shortlisting criteria e.g.
- T: Time: is it the tight time, enough resources?
- O: Others: is this duplicating the work of another body?
- P: Performance: can scrutiny make a difference
- I: Interest: what is the interest to the public?
- C: Contribution to the corporate plan

Meeting Date	Responsible Officer	Agenda Item
18-Jun-26	Cllr Baker-Rogers, Kirsty Littlewood/Rebecca Wilson Nasreen Iqbal, Dr Linda Strettle Governance Advisor	Castle View Transition Plan Rotherham Women's Health Network Introduction and Overview Nominate Representative to Health, Safety and Welfare Panel
23-Jul-26	Denise Littlewood Simon Langmead	Immunisation Programme Commissioning Changes Primary Care Network (PCN) Development
24-Sep-26	Cllr Baker-Rogers, Gilly Brenner, Carole Foster Cllr Williams, Simon Moss, Cllr Baker-Rogers, Gilly Brenner	Physical Activity for Health (Sport England Main Bid and progress update) Health Hub Development Phase 2
19-Nov-26	Steph Watt, Emily Parry-Harries, Bob Kirton Jackie Scantlebury, Moira Wilson, Sally Morris- Shaw and Cllr Baker-Rogers Cllr Baker-Rogers	Place Partners Winter Plan 26/27 Rotherham Safeguarding Adults Board Annual Report and 2025-2028 Strategic Plan Delivery Updat Health and Wellbeing Board Annual Report (For Information Only)
21-Jan-27	Bob Kirton, Helen Dobson, Jodie Roberts Cllr Baker-Rogers, Kirsty Littlewood, Dania Pritchard Emily Parry-Harries	TRFT Annual Report Adult Social Care Strategy 2027-2032 (Pre-Decision Scrutiny)?? Director of Public Health's Annual Report (For Information Only)
18-Mar-27	Garry Parvin Cllr Baker-Rogers, Kirsty Littlewood	All Age Autism Strategy Pre-Decision Scrutiny Castle View 6 Month Post Implementation Update
13-May-27	Vacant Slot Vacant Slot	Vacant Slot Vacant Slot

Substantive Items for Scheduling

Summer 2026	Cllr Williams, Simon Moss, Cllr Baker-Rogers, Gilly Brenner	Health Hub Development Phase 2
June/July 2026	Simon Langmead	Primary Care Network (PCN) Development

Reviews for Scheduling

2026/27 municipal year		Access to NHS Dentistry Review

Items to be Considered by Other Means (e.g. off-agenda briefing, workshop etc)

Sep-26	Garry Parvin	Consultation/Co-production enagagement with HSC re All Age Autism Strategy Refresh
April/May 2027	Kerry Grinsill-Clinton, Cllr Keenan	Quality Accounts

Items for Future Consideration

TBC	Bob Kirton	ERCP Reintroduction at TRFT
Mid-Late 2027	Cllr Baker-Rogers, Holly Smith, Scott Matthewman	Adult Social Care Mental Health Strategy - Mid point review of delivery