

Rotherham

Local Safeguarding Children Board

Annual Report

2017 - 2018

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Table of Contents

1. Foreword by the Independent Chair	4
2. Local background and context	6
<i>Rotherham demographic profile</i>	6
<i>What do children and young people think about living in Rotherham?</i>	8
3. The statutory role of Local Safeguarding Children Boards	9
4 Governance and accountability arrangements	10
<i>Local strategic partnership and accountability arrangements</i>	10
<i>Financial arrangements</i>	12
<i>Regulatory Inspections across the Partnership</i>	13
5 Effectiveness of arrangements to keep Rotherham children safe	19
<i>Early Help Services</i>	19
<i>Children in Need</i>	23
<i>Child Protection</i>	24
<i>Looked After Children</i>	27
<i>Care Leavers</i>	31
6 Learning and Improvement Framework	33
<i>Performance & Quality Assurance</i>	33
<i>Serious Case Reviews and Lessons Learned Reviews</i>	36
<i>Child Death Overview Panel</i>	38
<i>Learning and Improvement</i>	40
7 Safer Workforce	45
<i>Managing Allegations against staff, volunteers and foster carers</i>	45
8 Conclusion	48
9 Strategic Priorities for 2016-18	49
<i>Partnerships governance and communication</i>	49
<i>Neglect</i>	49
<i>Engagement with practitioners and the local community</i>	49
<i>The voice of children and their families</i>	49
<i>Effectiveness of early help</i>	50
<i>Child Sexual Exploitation and Missing</i>	50
<i>Safeguarding Looked After Children</i>	50
<i>Performance, Quality Assurance and Learning and Improvement</i>	50
10 Appendices	51

Appendix 1 – Board Member attendance 2017-1851
Appendix 2 – Financial Statement 2017-1852
Appendix 3: Contact details.....53

1. Foreword by the Independent Chair

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

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

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

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

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

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

I would like to finish by acknowledging the work across all agencies at all levels to make the improvements that have been achieved in Rotherham and the commitment shown by

partners of the LSCB to improving further the quality of the direct contact and work with children and families.

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

Christine Cassell

Independent Chair
Rotherham Local Safeguarding Children Board

2. Local background and context

Rotherham demographic profile

Rotherham is one of four metropolitan boroughs in South Yorkshire, covering an area of 110 square miles with a resident population of 263,400 (Office for National Statistics (ONS) mid-year estimate for 2017). The number of children and young people aged 0 to 17 years is 56,900 (21.6%). Growth in the older population is evident, with a 23% increase in the population aged 65 and over. Rotherham has as many people aged 63 or over as children aged 0-17.

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

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

Rotherham is a diverse borough with a mixture of people, cultures and communities. There are densely populated multi-ethnic inner urban areas, large council built housing estates, leafy private residential suburbs, industrial areas, rural villages and farms. About 70% of the Borough's land area is rural so the most notable feature of Rotherham is its extensive areas of open countryside, mainly agricultural with some parkland and woodland. Rotherham is strategically located and well connected to other areas of the region and country via the M1 and M18, both of which run through the Borough, and by the rail network which links to Sheffield, Doncaster and Leeds.

Rotherham is the 52nd most deprived district in England (In 2015, 31.5% of Rotherham's population lived in the most deprived fifth of England whilst only 8% lived in the least deprived fifth of England).

Diversity

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

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

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

National Insurance Numbers (NINo) migrants accounted for 933 in 2016 before falling again to 724 in 2017. This trend was evident amongst EU migrants from the 10 countries which joined the EU post 2004, where numbers fell by 65% from 877 in 2007 to 309 in 2012 before increasing to 585 in 2016 and falling back to 422 in 2017. People from states which joined the EU post 2004 made up 58% of all overseas migrants to Rotherham in 2017. The countries with the most migrants to Rotherham are Romania, Slovak Republic and Poland, which together accounted for 42% of NI migrants in 2017. Two thirds of NINo arrivals in Rotherham between 2007 and 2017 moved to the three central wards. A high proportion of Slovak, Czech and Romanian migrants have been from Roma communities, although not by all means all.

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

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

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

Introduction

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

The 2017 Lifestyle Survey results, undertaken by CYPS Performance & Quality Team, provide an insight into the experiences of children and young people living in the borough, and offer a series of measures to monitor the progress of the development of a child friendly Rotherham.

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

What's working well?

3515 (93%) of pupils said they visit their dentist.

More young people said they are eating the recommended 5 fruit and vegetables each day, more young people said they have breakfast in a morning and more young people said they participate in regular physical activity.

Less pupils are worried about their weight and there has been a 5% increase in the % of pupils who feel their weight is about the right size.

Increase in the number of pupils who said they regularly visit Rotherham town centre.

Far more Y7 pupils have received education about child sexual exploitation;

Reduction of 5% in the number of Y10 pupils who said they have had sexual intercourse.

Bullying

The pupils who said they have been bullied told us what form of bullying they have been subject to:

- Verbal bullying 64.3% (72.4% in 2016)
- Physical bullying 16.4% (10.5% in 2016)
- Being ignored 10% (5.2% in 2016)
- Cyber bullying 6.6% (8.2% in 2016)
- Sexual bullying (inappropriate touching/actions or comments) 2.6% (3.7% in 2016)

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

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

Feeling Safe

There has been a decline in the % overall of pupils who said they always feel safe in Rotherham town centre. 18% (683) of pupils said they always feel safe, compared to 24.6% in 2016. More pupils said they sometimes feel safe 50% (1900) compared to 45.4% in 2016, there has been a decrease in the % of pupils who said they never feel safe 18.5% (697) compared to 19.3% in 2016. 13.5% (501) of pupils said they have never visited Rotherham town centre.

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

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

What are we worried about?

Increase of 3% in the number of pupils saying they consume 2 or more high **sugar drinks** each day and also an increase of 2% of the number of pupils saying they consume **high energy drinks**, (in particular boys).

A 3% reduction in the number of pupils who aspire to go to **university**. Overall 42% (1592) said they aspire to go to university in 2017 results from 45% in 2016.

A 6.6% reduction in the number of pupils who said they always **feel safe** in Rotherham town centre. Overall 18% (683) pupils said they always feel safe, compared to 24.6% in 2016.

An increase of 3% of pupils saying they have been **bullied** out of school time. More pupils of those who have been bullied said they have been bullied out of school time, 12.8% (124) said this in 2017, compared to 9.3% in 2016

Decrease of 6.7% of young people who have identified themselves as a **young carer** who have heard of the Rotherham Young Carers service. 37.3% (267) said they had heard of this service in 2017, compared to 44% in 2016.

Decrease of 4.7% of homes identified as **smoke-free** homes. In 2017 59.3% (2243) said their home was smoke-free, compared to 64% in 2016.

Decrease of 3.5% of Y7 pupils who said they have never tried an **alcohol drink**. This has decreased to 76.3% (1643) from 79.8% in 2016.

An increase in the % of pupils in Y10 who said they did not use **contraception** when having sexual intercourse, this has increased to 27.5% from 20%, and the increase is more prevalent with boys.

3. The statutory role of Local Safeguarding Children Boards

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

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

Statutory objectives and functions of LSCBs are:

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

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

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

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

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

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

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

(e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

Regulation 5 provides that an LSCB may also engage in any other activity that facilitates, or is conducive to, the achievement of its objectives.

LSCBs do not commission or deliver direct frontline services though they may provide training. While LSCBs do not have the power to direct other organisations they do have a role in

making clear where improvement is needed. Each Board partner retains its own existing line of accountability for safeguarding.

4 Governance and accountability arrangements

Local strategic partnership and accountability arrangements

Improvement in this area was identified as a Board priority

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

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

The LSCB independent chair meets regularly with:

- Council Chief Executive
- Council's Strategic Director for Children and Young People's Services
- Government appointed commissioners for the Council
- Independent Chair of the Rotherham Safeguarding Adults Board
- Chair of the Health and Well Being Board
- Chair of the Safer Rotherham Partnership Board

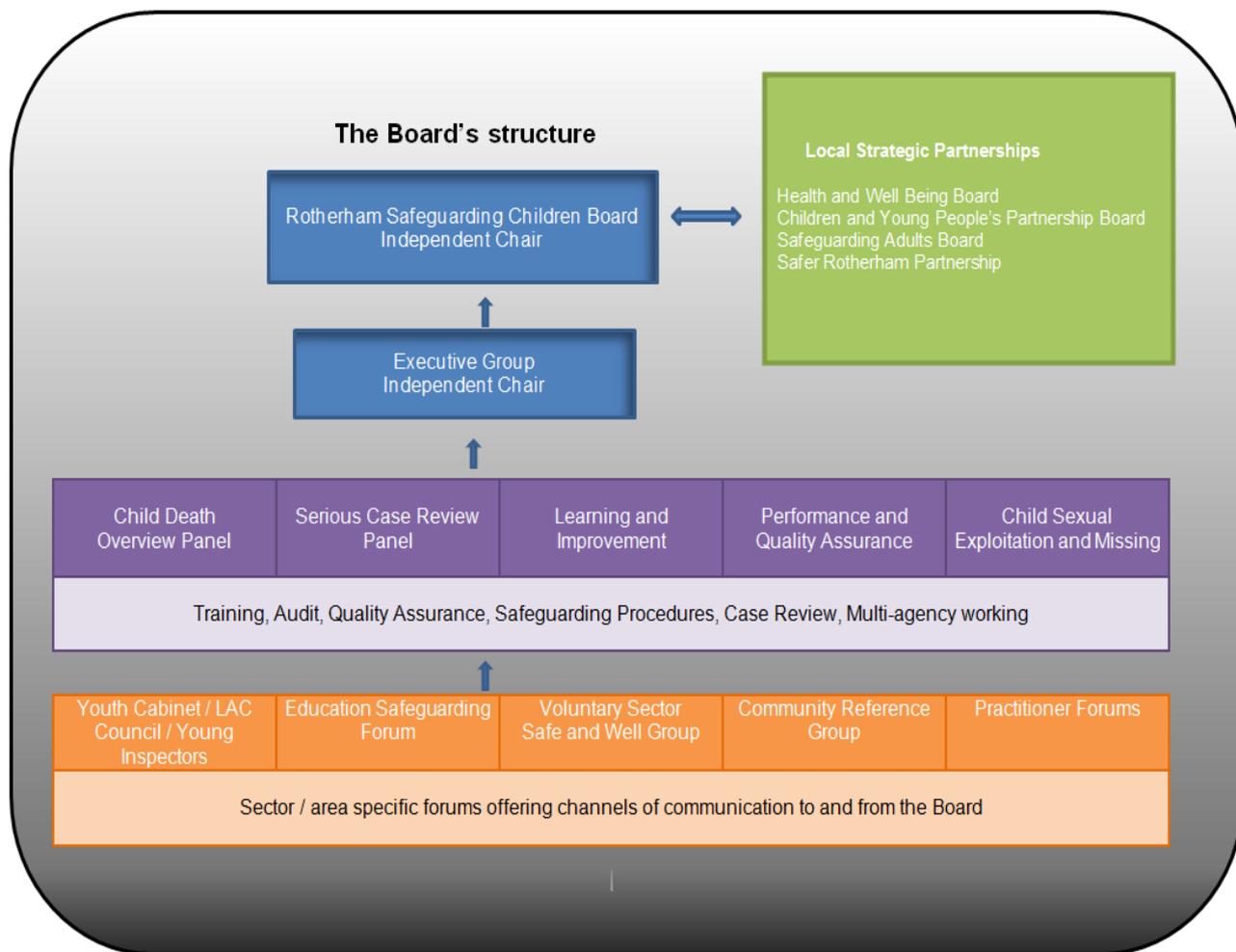
Members of an LSCB should be people with a strategic role in relation to safeguarding and promoting the welfare of children in their organisation and should be able to speak for their organisation with authority; commit their organisation on policy and practice matters; and hold their own organisation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

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

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

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

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



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

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

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

Inspection Feedback

Ofsted Inspection Report (February 2018)

Strategic partnerships are much strengthened, improving the way in which children are helped and protected. This includes resourcing of the MASH, engaging in early help assessments and a commitment to tackling child sexual exploitation. Rotherham has effective governance and multi-agency procedures that help to identify and protect children from child sexual exploitation.

Financial arrangements

The Board's budget is based on partner organisations contributions to an agreed formula. The funding formula and 2017-18 budget statement can be found at **Appendix 2**.

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

Budget – 2017-18 Outturn

Income:	Budget	£ 339,149	Actual:	£ 331,950
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Expenditure:	Budget	£ 339,149	Actual:	£ 343,600
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Overall expenditure for 2017/18 was £11,650 over budget. This is due to a number of budget pressures and remedial action has been taken within the 2018/19 budget to recover this overspend.

Regulatory Inspections across the Partnership

Inspections of local agencies are routinely reported to Rotherham Local Safeguarding Children Board. This section summarises key findings from inspections of safeguarding board partners.

Inspection Findings:

NB: The Trust also provides services to other areas.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST CARE QUALITY COMMISSION (11 January 2018)

Summary of the key findings

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

However:

- We rated safe as requires improvement in four of the 14 core services. The overall rating for acute wards for adults of working age and psychiatric intensive care wards had gone down to requires improvement.
- Although the trust had improved its overall mandatory training compliance, staff in some wards and teams were not up to date with their mandatory training requirements. Training for prevention and management of violence and aggression, a key component of enabling safe care was below 75% in acute wards for adults of working age and psychiatric intensive care units.

- There were medicines management issues in three core services at this inspection. At our last inspection we found that patients allergy status was not completed on some prescription charts in the community based mental health services for adults of working age. At this inspection we found that this had not been rectified across all teams.
- Patients in some services had limited access to psychological therapies and occupational therapy.

Inspection Findings:

Metropolitan Borough of Rotherham

CHILDREN'S SERVICE INSPECTION (6-November – 30 November 2017)

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

Summary of the key findings

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

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

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

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

Children become looked after when they need to be. The number of children becoming looked after has risen because of the improved identification of risk and the focused work on complex abuse. This increase has impacted on placement capacity and matching children who have more complex needs with permanent foster carers.

A previously unstable workforce, both in the fostering service and the locality social work service, meant that some children did not achieve permanence quickly enough. The development of a more stable workforce and the systematic review of children with a plan for long-term fostering who have not yet been formally matched are supporting improvements in the achievement of permanence for children. The quality of court work is improving. Decisions to return children home to their parents are informed by good-quality assessments. Children benefit from early consideration of placement with their extended families. Although management oversight is evident and supervision is regular, management challenge of the quality of practice and planning for children looked after is not consistently good.

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

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

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

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

Inspection Findings:

Quality & Impact inspection The effectiveness of probation work in South Yorkshire An inspection by HM Inspectorate of Probation (June 2017)

Summary of the key findings

Community Rehabilitation Company (CRC) – effectiveness

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

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

National Probation Service (NPS) – effectiveness

The quality of work to protect the public was generally good. We found the NPS had a good grip on complex cases with work undertaken to engage those in denial and resistant to change. There was an effective victims' team who worked closely with the police and partner agencies to respond to the needs of victims of child sexual exploitation. We were pleased that following a review of Multi-Agency Public Protection Arrangements, a county probation coordinator had been introduced. Reviews were completed in over two-thirds of cases but officers did not always adjust their planning to take account of changing circumstances.

Some probation officers found working primarily with high risk of harm and complex cases challenging. Some were reluctant to move less demanding cases to probation service officers, as they doubted their skills and experience. Others resisted, knowing that it would further increase the concentration of high risk of harm cases in their caseload.

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

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

Inspection Findings:

HM Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS). PEEL: Police effectiveness, efficiency and legitimacy programme (2017)

Summary of the key findings

Effectiveness

South Yorkshire Police is good at keeping people safe and reducing crime. Since HMICFRS' 2016 effectiveness report, the force has made progress in several areas. HMICFRS is pleased to see the positive effect recent improvements have had across the force, particularly in neighbourhood policing and investigations. Further action is needed to ensure the force is providing all vulnerable people with an effective service.

South Yorkshire Police is good at keeping people safe and reducing crime.

Since HMICFRS' 2016 effectiveness report, the force has made progress in several areas. South Yorkshire Police is effective in its approach to reducing crime, tackling anti-social behaviour and keeping people safe. The force must improve its ability to protect people who are vulnerable through their age, disability, or because they have been subjected to repeated offences, or are at high risk of abuse, for example. South Yorkshire Police is generally good at investigating crimes. The force effectively investigates some crimes over the telephone, through its new crime support hub and its dedicated investigation teams.

Efficiency

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

Legitimacy

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

Inspection Findings:

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

Summary of the key findings

The overall judgement is outstanding Cafcass leads effective services that meet the requirements for outstanding.

The quality and effectiveness of Cafcass private law practice with families – Good

The quality and effectiveness of Cafcass public law practice with families - Good

The leadership and governance of the national organisation – Outstanding

The leadership and management of local services - Outstanding

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

Since the last inspection, the chief executive, together with the national service director and supported by an effective and active board, have worked diligently to develop and support a culture of continuous learning and improvement. Stability of leadership and strong aspirations to 'get it right' for vulnerable children are key factors in their success. The vast majority of Cafcass staff at all levels consistently provide excellent quality services for children, their families and the family courts.

Cafcass's highly evolved and mature strategic relationships with its key family justice partners (Her Majesty's Courts and Tribunal Services (HMCTS), the Judiciary and the Association of Directors of Children's Services (ADCS) have led to creative and innovative services nationally and locally. The chief executive and the national service director are held in high regard. They work tirelessly, driving much needed development and reform to meet the increasing levels of demand.

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

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

Performance management is a key priority. A rigorous, strength-based performance framework supports the delivery of good and outstanding services nationally and locally. Key strengths and areas for development, identified accurately in Cafcass's self-assessment, are used to inform both management understanding of the quality of practice and individual staff development. Senior managers have clear plans in place to help staff improve the consistency of 3 performance learning reviews (PLRs)¹ and case planning, and to ensure that relevant diversity issues are fully considered.

Strong governance arrangements are firmly in place, augmented by a culture of professional accountability and respectful challenge at every level across the organisation. Cafcass has successfully implemented a model of proportionate² working to address demand on services. Despite having high workloads, staff who spoke to inspectors felt extremely positive about working for an organisation in which they are treated well, as professional adults, and their views and needs are important and highly valued.

The national business centre (NBC) is exceptionally well-managed, effective and efficient. This means that Cafcass's services for children benefit from the support of a coherent and expertly coordinated range of centralised systems. Business services and social work staff are skilled and committed.

5 Effectiveness of arrangements to keep Rotherham children safe

Early Help Services

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

Improvement in this area was identified as a Board priority

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

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

Inspection Feedback

Ofsted Inspection Report (February 2018)

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

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

Early Help Assessments (EHA's). Overall, during the year, 47.2% (518/1097) of EHA's were completed in timescales, with a further 29.8% (327/1097) being completed outside of local timescales. There was a total annual completion rate for assessments at 77% (845/1097).

The Triage Team within the MASH is increasing the numbers of requests to partner organisations to complete an Early Help Assessment. This will have a positive impact on the time for locality Early Help teams to spend supporting families.

Early Help Assessments:

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

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

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

Education Health and Care Plans (EHCP)

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

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

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

In relation to 'conversions' from SEN to EHCPs, there were a total of 998 to convert. 98% of all conversions were completed by the target date (April 2018) the remaining 2% (24 cases) were delayed due to the complexity of the individual cases.

Children’s Centres. Overall Children's Centres fell slightly short of their registration rates during 2017/18 at 91% against the 95% target. However, performance in the 30% most deprived Super Output Area (SOA) neighbourhoods was better with 96% of children registered against the 95% target overall. Good performance was found in the South and North localities of the borough achieving 101% and 97% respectively. Engagement rates saw a similar trend with the 30% most deprived SOA's achieving overall performance of 68% against a 66% target. Overall performance across the borough was 58% against the 66% target, however this was an increase when compared with 2016/2017 when performance reached 52%.

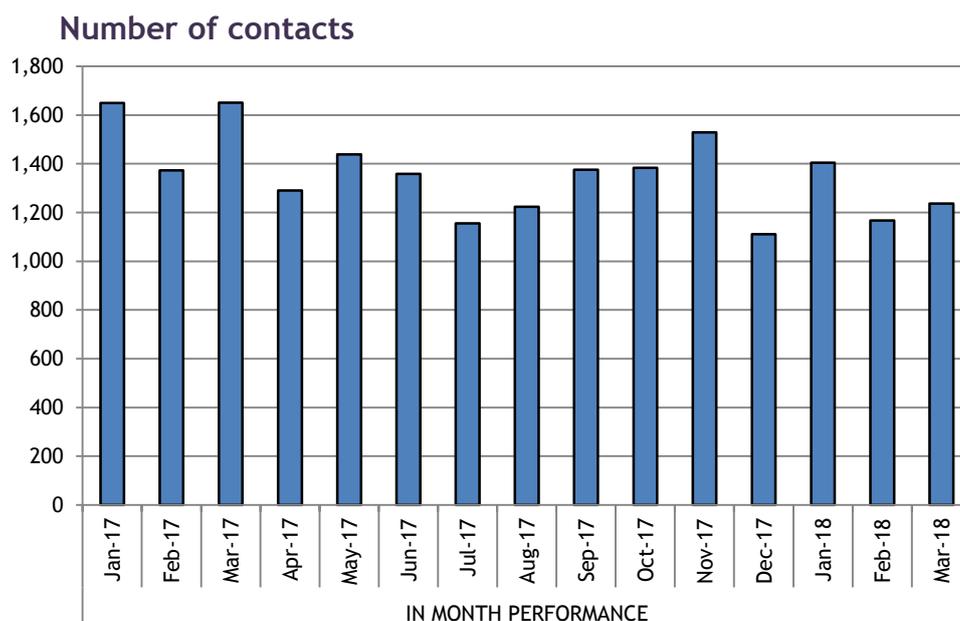
Contacts and Referrals

A “Contact” is a request for help when a child is thought to have support needs or to be at risk of harm. If there are concerns which cannot be managed through the provision of early help services, a referral is made for a multi-agency assessment to be undertaken, led by a social worker.

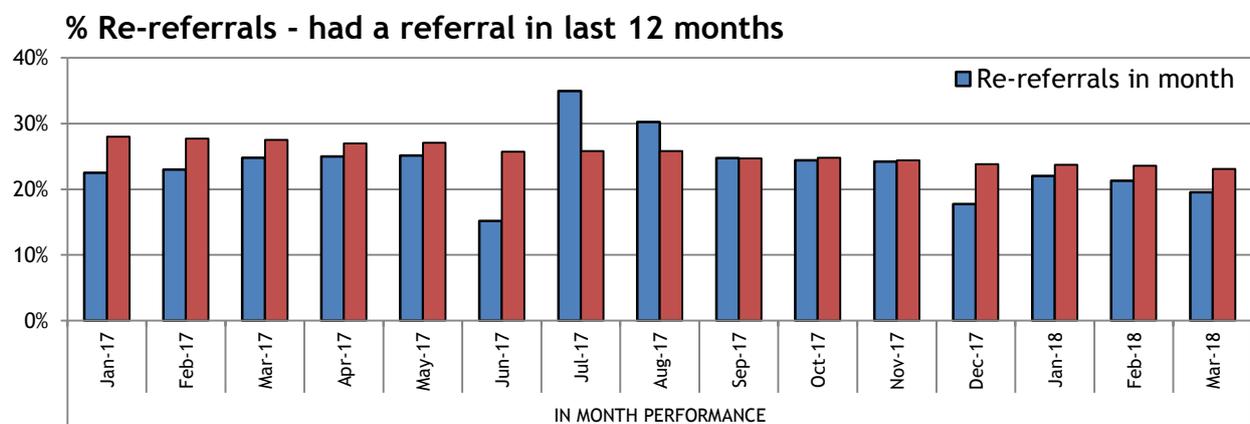
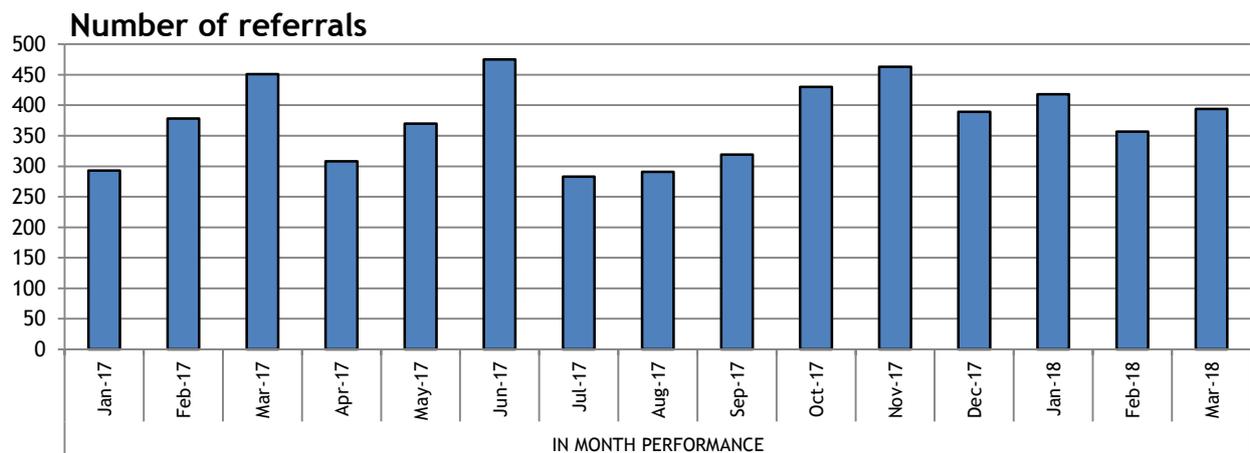
In total 15,684 contacts were been received over the year compared to 16,609 in 2016/17, which equates to a 5.6% decrease. However, in the same period the proportion progressing to referral has increased by 2% to 28.6% with a trajectory towards 30%. Similarly progression from referrals to assessment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

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

Volume of contacts per month:



Referral rates by month:



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

Improvement in information sharing between partners:

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

Inspection Feedback

Ofsted Inspection Report (February 2018)

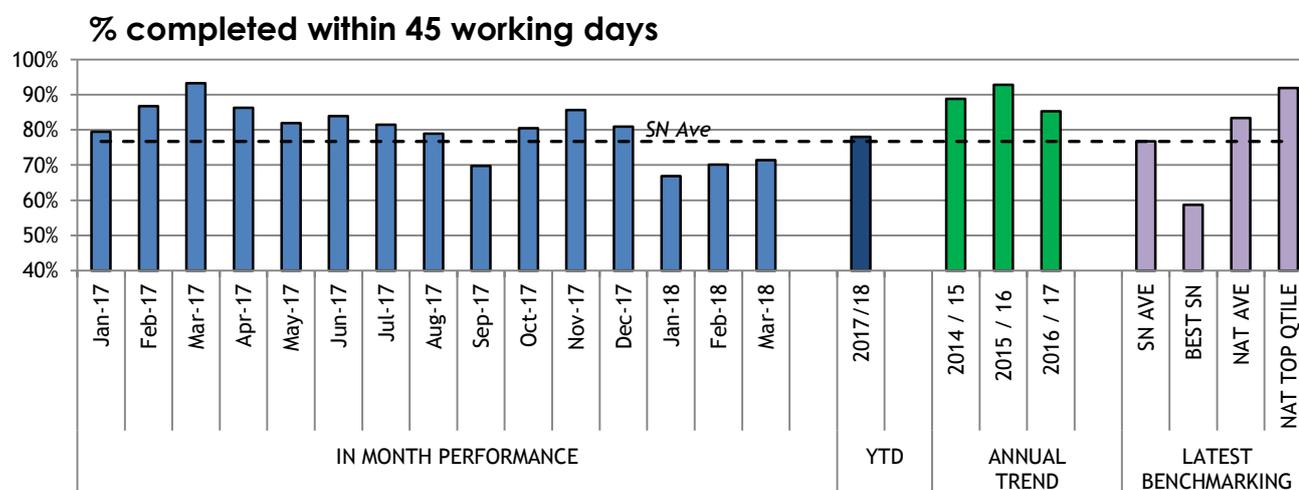
Children in need of help and protection are protected through effective multi-agency working in the MASH. Confident, experienced social workers, and co-located multi-agency partners who understand thresholds and issues of consent, effectively screen and triage in the MASH. There are timely responses to contacts and referrals, as well as effective information sharing and decision-making by managers.

Assessments

The timeliness of an assessment for a child is important because it means that their needs or the risks to them are identified quickly and support put in place. The upper time limit for assessments to be completed is 45 working days.

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

Assessments completed:



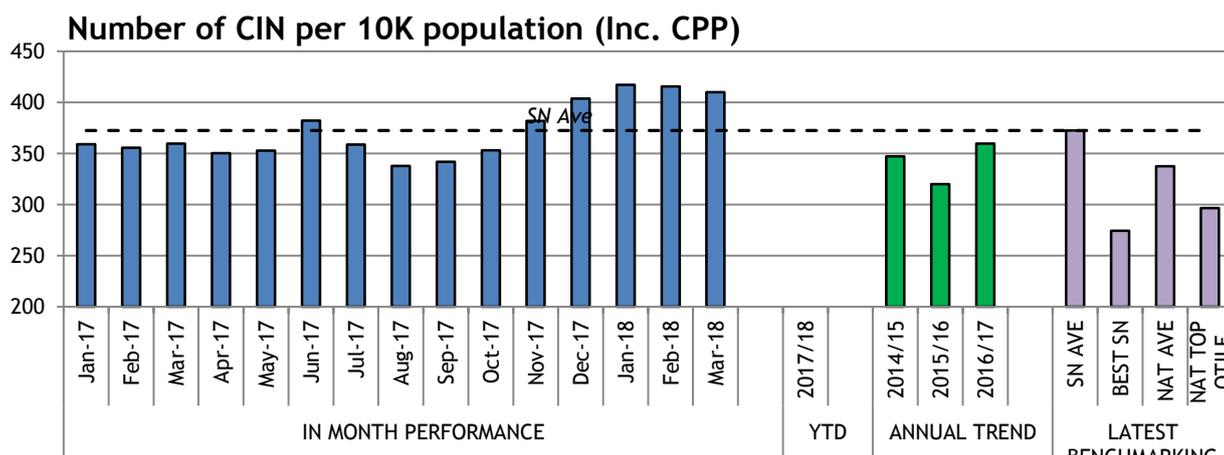
Children in Need

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

There is no good or bad performance in relation to the number of Children in Need (CIN), although it is important to monitor against statistical neighbour and national averages as numbers considerably higher or lower than average can be an indicator of other performance issues. The

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

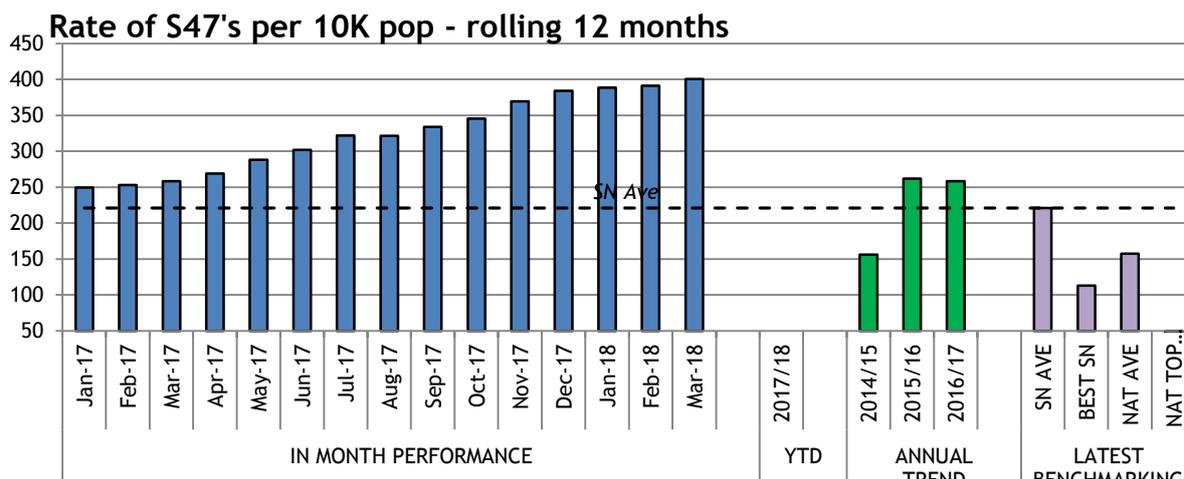
At the end of March 2018 there were 1686 CIN, when combined with those subject to child protection plans (CPP) this equates to a rate of 413.8 per 10k population; positioning Rotherham above both the statistical neighbour average (372.7), and the national average (337.7).



Child Protection

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

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



Inspection Feedback

Ofsted Inspection Report (February 2018)

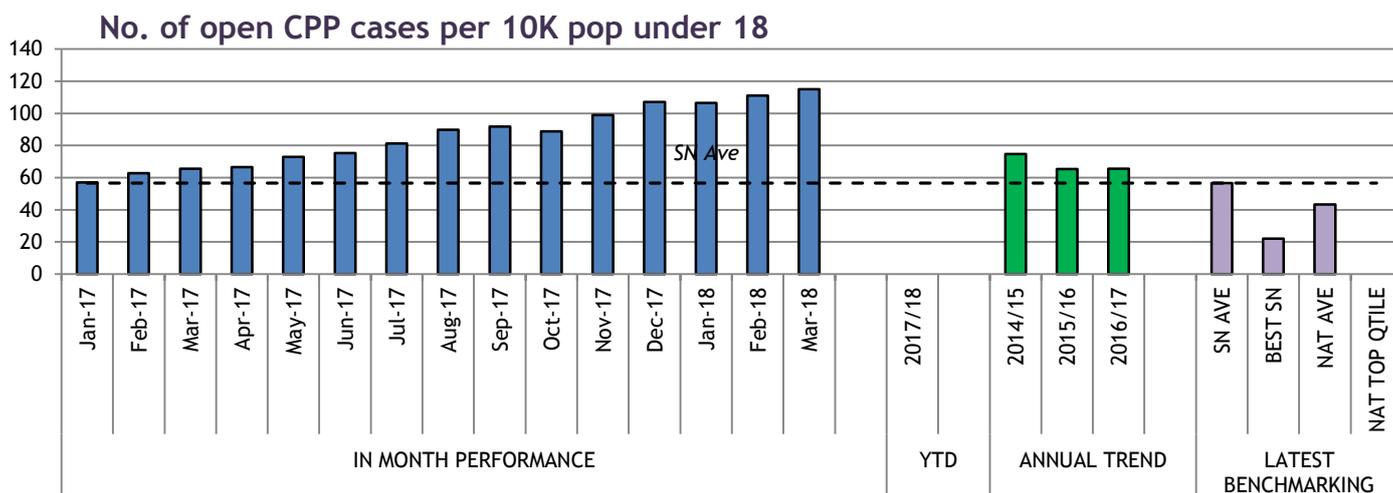
Child protection enquiries and strategy meetings involve appropriate multi-agency representation that informs robust decision-making in order to protect children. Work with South Yorkshire Police on the conduct of Achieving Best Evidence interviews is beginning to improve the quality of joint social work and police interviews.

Child Protection Plans

Children who are at risk of significant harm through abuse or neglect have a Children Protection Plan to help make sure that they are supported and kept safe. Using the number of children per 10,000 child population is a standard way to compare and measure how well we are doing against other authorities.

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

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



Inspection Finding:
Ofsted Inspection Report (February 2018)
 Children do not stay on protection plans for longer than necessary as a result of the effective monitoring by child protection chairs. When change has not been achieved, appropriate assertive action is taken through escalation into pre-proceedings.

Performance in the timeliness of Review Child Protection Conferences for the year as a whole was 94.6% which is a decline when compared to the previous year's 98.6% but still places Rotherham above the national average of 92.2%.

Child Protection Visits

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

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

Child Protection Advocacy Service (Barnardo's)

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

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

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

The Advocacy Safe booklet and activity sheets are good'

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

The Advocacy Safe booklet is very good'

The advocate service was friendly and helpful

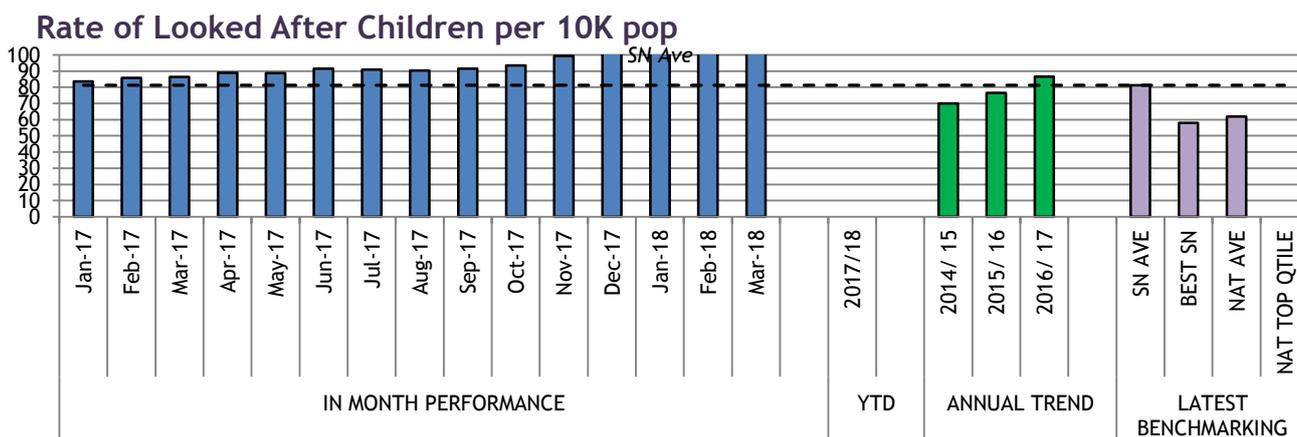
The advocate explained to me what happens at a conference

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

Looked After Children

A Looked After Child is one who is in the care of the local authority and is sometimes called a "child in care" or "LAC". Safeguarding children in care was identified as a Board priority

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



Inspection Finding:

Ofsted Inspection Report (February 2018)

Decisions to look after children are now made in the children’s best interests and are timely and planned in most cases. This has resulted in increasing numbers of children entering care appropriately. Children are beginning to benefit from early consideration of placement with their extended families. Permanence is not yet achieved for all children soon enough. Assessments are not sufficiently robust or up to date to inform decisions about placement choice or identify broader needs. Brothers and sisters are often placed together in foster care, but children’s relationships, in terms of placement and contact needs, are not fully considered. Plans are not as sharply focused as they could be.

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

Positively the rate of discharge reached its highest level for 6 months at the end of the year with 20 children ceasing care in March 2018 indicating the Right Child Right Care programme is beginning to have some impact.

Looked After Children - Statutory Reviews

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

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

Looked After Children – Placements

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

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

In the last three months of 2017/18 there was an increase in the number of children experiencing multiple placement moves. The provisional outturn position of 13.1% (81 out of 618 children) is an increase on the 2016/17 figure of 11.9%. The local increase in LAC is part of a national trend and as a result the placement market is increasingly saturated making appropriate matching decisions an increasing challenge. The Intensive Intervention Programme being implemented by the Rotherham Therapeutic Team is clearly having some positive impact on the number of placement disruptions for the most vulnerable and challenging of our young people who are known to be at risk of placement breakdowns. However, it is also likely that the impact of the Right Child Right Care project will mean more placements will be converted to Special Guardianship Orders/Child Arrangement Orders, which will be a positive outcome for the child but may have a significant negative impact on the stable placement performance over 2018/19.

Despite the further increase in LAC numbers, the proportion of children in a family based placement remains relatively stable at 82.4% of the total cohort. Given the increasing numbers of LAC performance regarding the proportion of LAC in commissioned placements has declined to 50.5% (315 of 624 LAC). This decline is not significant and reflects the same level as October when there were only 267 LAC in the cohort. This indicates that the in-house Fostering and Placements team have become far more efficient in placing children within in-house placements.

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

Looked After Children – Health and Dental assessments

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

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

Re thinking missed appointments for children:

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

Looked After Children – Education

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

97% of eligible LAC have a Personal Education Plan (15 LAC with no PEP) and 95% have a PEP less than one term old (24 with an older or no PEP). Although this performance is high and an improvement on the Autumn term it is slightly lower than usual due to a combination of the

adverse weather which meant that several PEPs had to be rescheduled, and the fact that it was a very short school term. Also, the figure includes LAC who either did not come into care until late in the term, or who we were notified had come into care, and where there wasn't time to arrange a PEP meeting.

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

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

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

Care Leavers

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

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

The numbers of care leavers in suitable accommodation has declined, however, to 96.9% which is due to 2 more young people receiving custodial sentences. This places Rotherham in the top quartile in out of all the local authorities in England in respect of this performance measure.

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

Inspection Finding:

Ofsted Inspection Report (February 2018)

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

6 Learning and Improvement Framework

The role of the LSCB is to ensure the effectiveness of organisations individually and collectively to safeguard and promote the welfare of children. To achieve this there should be a culture of continuous improvement across the partnership.

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

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

Performance & Quality Assurance

Quality Assurance is a process that checks the quality of services and the difference they make for children. It establishes what is working well and where there are improvements needed. Conducting audits and reviews of children's cases are some of the ways in which the quality of services is monitored.

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

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

Quarterly LSCB Performance Management Framework

The report provides information to answer:

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

By using:

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

Multi-agency audits completed in 2017/18

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

Audit: Parental Contact with Children in Hospital where there are Safeguarding Concerns.

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

Audit: Partnership response to Domestic Abuse.

The partnership commissions a good range of services for victims of domestic abuse, including those assessed as lower risk and these are used well by victims. However, there are concerns about waiting times for some services.

There is a gap in the provision of services for perpetrators of domestic abuse who are not convicted and this has the potential to undermine the good work that is developing.

Safeguarding Self Assessment

Joint Adult and Children Safeguarding Self- Assessment

Section 11 of the Children Act 2004 requires each person or body to which the duties apply to have regard to any guidance given to them by the Secretary of State and places a statutory requirement on organisations to ensure that they have arrangements in place to safeguard and promote the welfare of children. In addition the Care Act (2014) requires Local Authorities to set up Local Safeguarding Adults Boards (LSAB's). The objective is to ensure that local safeguarding arrangements and partnerships act to help and protect adults at risk or experiencing neglect and/or abuse.

The Rotherham Local Safeguarding Children and Adults Boards have committed to and are developing a joint safeguarding children and adults self-assessment. The purpose of the joint assessment is to provide all organisations in the Borough with a consistent framework to assess monitor and improve their Safeguarding Children's and Adult's arrangements in line with statutory requirements and best practice. The joint self-assessment tool will be finalised in November 2018 and be implemented from January 2019.

Voluntary and Community Sector – Safeguarding Self-Assessment

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

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

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

Schools – Safeguarding Self-Assessment (Section 175)

Schools are expected to complete the S175 on-line safeguarding self-assessment. 129 Rotherham schools, including children centres, colleges and special schools in Rotherham, are registered to

complete the self-assessment. The progress towards completion of the self-assessment, as at October 2017 is that 67 schools/education settings that have completed 90-100% of the self-assessment with a further 41 having completed over 50%.

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

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

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

Serious Case Reviews and Lessons Learned Reviews

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

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

A Serious Case Review (Child J) was undertaken jointly with Sheffield LSCB and the report was signed-off at an extraordinary meeting of the RLSCB on the 11/05/2017. The agencies that were involved in the review will be required to take forward the recommendations and action plan.

There are no firm dates or plans for publication of the report due to the criminal investigation which is still ongoing. Some of the key recommendations from the Serious Case Review which have now been implemented were:

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

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

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

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

The **Practice Review Group** considers specific cases that are referred to the group where there has been cause for concern in terms of the safeguarding of a child from significant harm where there is, or has been multi-agency involvement, but where the criteria for a Serious Case Review (SCR) have clearly not been met. The Group also reviews cases where formal dissent relating to the outcome of a Child Protection Conference is submitted in writing by a professional or agency represented at the conference; or where the Child Protection Conference Chair has concerns about multi-agency thresholds or practice.

The methodology for each learning review is determined by the circumstances of the case and agreed by the group, but can range from a desktop review, a small learning event with practitioners involved in a case, to a larger multi-agency challenge event.

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

- Inclusion of good practice examples in training and in the RLSCB newsletter.
- Multi-Agency Assessment to include invisible adult males figure within assessments of risk.
- Adult services working more closely with children's services.
- Review of the bereavement pathway.
- Use of Graded Car Profile in neglect cases.

In February 2017 a multi-agency review was undertaken on a case where an infant had received an injury. At the heart of this case was a clear missed opportunity for the child to have been referred to a paediatrician and the Multi Agency Safeguarding Hub for consideration of section 47 enquiries. As a result work has been undertaken with GPs and 0-9 practitioners re-enforcing that any non-mobile infant with a bruise should trigger a safeguarding referral and a full medical examination. A new safeguarding procedure was developed supported by a key message of:

'Babies that don't cruise, rarely get bruised'

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

Child Death Overview Panel

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

Since 1st April 2008, all deaths of children up to the age of 18 years (excluding still births and medical terminations) are reviewed by a panel of people from a range of organisations and professional disciplines. CDOP is required to reviewing every child death in the Borough in order to identify whether there is any learning that could influence better outcomes for children at both a local and national level. CDOP promotes the sharing of information and learning to all organisations, in both the statutory and voluntary sector, about how to reduce the likelihood and impact of modifiable risks which might lead to the death of a child.

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

Child Death Reviews 2017-18

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

Case	Age Range	Gender	Ethnicity	Expected/ Unexpected	Modifiability*	Category
1	5-9 yrs	Male	Black African	Unexpected	Non-modifiable	Chromosomal, Genetic and Congenital anomalies
2	<28 days	Female	White British	Expected	Modifiable	Perinatal / Neonatal event
3	<28 days	Male	White British	Expected	Non-modifiable	Perinatal / Neonatal event
4	<28 days	Female	White Asian	Expected	Non-modifiable	Perinatal / Neonatal event
5	15-17 yrs	Female	White British	Expected	Non-modifiable	Malignancy
6	10-14 yrs	Male	Asian – Pakistani	Unexpected	Non-modifiable	Trauma and other external factors
7	28-364 days	Female	White British	Expected	Non-Modifiable	Chromosomal, Genetic and Congenital anomalies
8	28-364 days	Male	White British	Expected	Non-modifiable	Perinatal / Neonatal event
9	<28 days	Male	White British	Expected	Non-modifiable	Perinatal / Neonatal event
10	1-4 yrs	Male	White Other	Expected	Non-modifiable	Chromosomal, Genetic and Congenital anomalies
11	<28 days	Male	White Other	Expected	Non-modifiable	Chromosomal, Genetic and Congenital anomalies

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

CDOP Priorities for 2018-19

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

Key Learning Points from 2017-18

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

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

Learning and Improvement

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

Multi-Agency Safeguarding Learning and Development

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

The RLSCB currently offers a wide range of multi-agency safeguarding children training which supports the development of the workforce in Rotherham who work or come into contact with children, young people and their families. Learning and development is delivered through a blended approach with face to face training, conferences, briefings, webinars and e-learning. It is offered to all staff and volunteers who come into contact with children, young people and/or their families within Rotherham, via multi-agency. The aim is to support individuals and organisations to undertake their safeguarding roles and responsibilities in a committed, confident and competent manner.

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

Partnership newsletter: In January 2018 the LSCB launched its 'digital newsletter' to 495 subscribers, devoted to single and multiple news items, including information on serious case reviews, procedure changes and learning and development opportunities. All services and organisations are encouraged to submit news items relevant to safeguarding children.

Safeguarding Children Training

The LSCB training offer is continually reviewed to ensure that it responds to local need and priorities and the training strategy takes into account national, regional and local factors, including acting on the recommendations of serious case reviews, child death reviews, and other lessons learned. In September 2017 the LSCB launched e-learning as part of its training offer and the 8 courses were launched. Over 350 e-learning courses were completed in the 6 monthly period Oct 17 – March 2018 by partner organisations.

E-Learning courses:

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

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

Themed Training:

Designated Safeguarding Lead Workshop

Attachment Training

Group 3 Safeguarding Core Workshop

Graded Care Profile

Safeguarding Young People at Risk of Child Sexual Exploitation - A Multi-Agency approach to Supporting Young People at Risk

Safer Recruitment for Schools

Child Death Review Process

Digital Safeguarding Training

Early Help Pathway Workshop

Working with Resistant Families

Prevent Training

Safer Recruitment (evening)

The Toxic Trio, Safeguarding Children – Parental Domestic Abuse, Substance misuse and Mental Health

Attendees are asked to provide evidence of the impact of the training both on their practice and for children and families. The evidence shows that the majority of attendees report increased confidence, improved skills and the fact that having attended the training they felt it had impacted positively on their safeguarding practice. The following offers an insight into some of the feedback received:

Safeguarding Children at Risk of Sexual Exploitation

Early Years Worker, Rotherham Council

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

Working with Resistant Families

Support Worker, Rotherham Hospice,

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

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

Early Years Support worker, Rotherham Council

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

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

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

Foster carer – Rotherham Council

My understanding of parental mental health has improved

In January 2018 a training evaluation event analysed 84 multi-agency training courses which were delivered between Apr-Dec 2017 and attended by 1,987 people. The event looked at the impact

of the training after 3 months of attending the course and how it has improved practice with children and young people. The response overall was respondents could evidence improvement in their practice; there were improved outcomes for the child, young person and family and they had shared their learning back in the workplace which had supported their colleagues.

Group 3 Core Workshop

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

'Greater awareness of safeguarding issues'

'Discussions with staff in supervisions and at clinical review meetings'.

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

Training for Designated Leads in Schools and Colleges

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

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

Safer Recruitment Workshop

When asked to explain how their practice had improved,

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

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

'More vigilant when recruiting new staff members'

Safeguarding Children Procedures

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

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

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

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

New procedures -

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

The following procedures were reviewed and amended -

- Protocol for Safeguarding Children in Whom Illness is Fabricated or Induced
- Allegations Against Staff, Carers and Volunteers
- Rotherham Multi-Agency Continuum of Need Guidance
- Multi-Agency Threshold Descriptors
- Referring Safeguarding Concerns about Children
- Action Following Referral of Safeguarding Children Concerns
- Early Help Guidance: Integrated Working With Children, Young People and Families With Vulnerable or Complex Needs
- Safeguarding Children and Young People from Sexual Exploitation
- Abuse by Children and Young People
- Safeguarding Children who are at Risk because of Communication Technology and Social Media
- E-Safety
- Safeguarding Children Subject to Private Fostering Arrangements
- E-Safety – 2 new documents added as links
- Prevent – link to new document
- Supporting children who are bereaved
- Gang activity
- Domestic abuse
- FGM - link to new document
- Forced Marriage and Honour Based Violence
- Children who go missing from home or care

Work has commenced on the safeguarding procedures update which will go live in June 2018. The Learning and Development sub group have given priority to updates to procedures that needed to incorporate Signs of Safety language and terminology, any changes required from serious case reviews and the anticipated changes from the revised Working Together statutory guidance.

7 Safer Workforce

Managing Allegations against staff, volunteers and foster carers

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

Working Together 2015 (updated in 2018) requires that each Local Authority has a designated officer or team of officers, to deal with allegations made against professionals who are a part of the children's workforce.

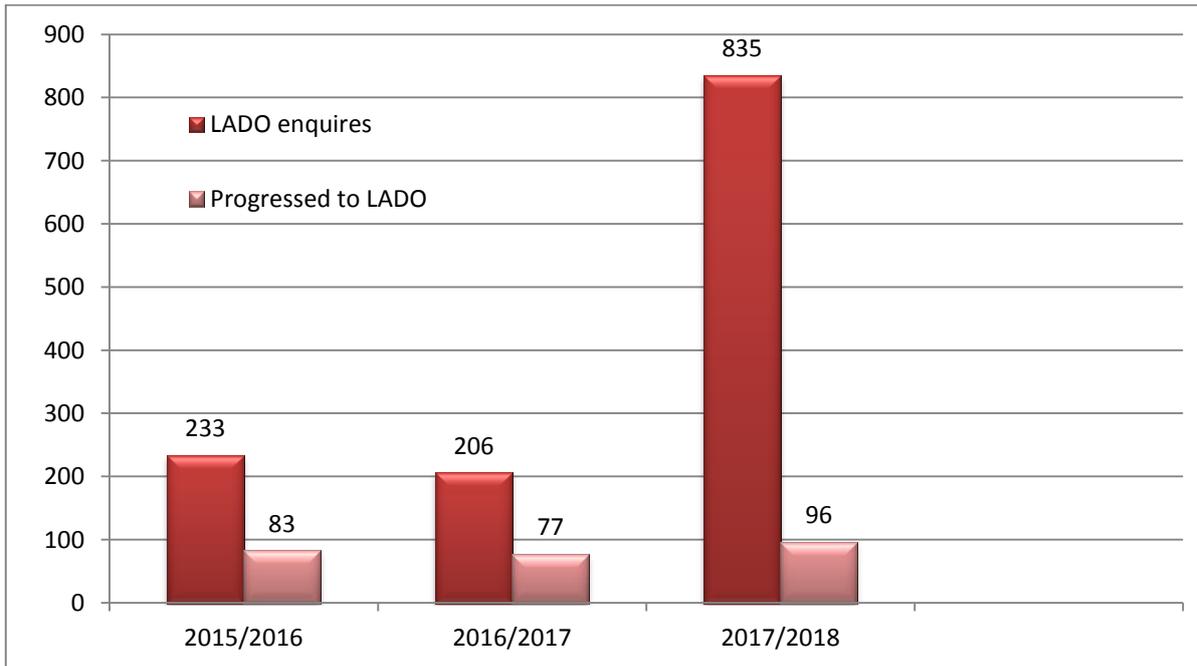
In practical terms, the role of the Local Authority Designated Officer (LADO) is to:

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

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

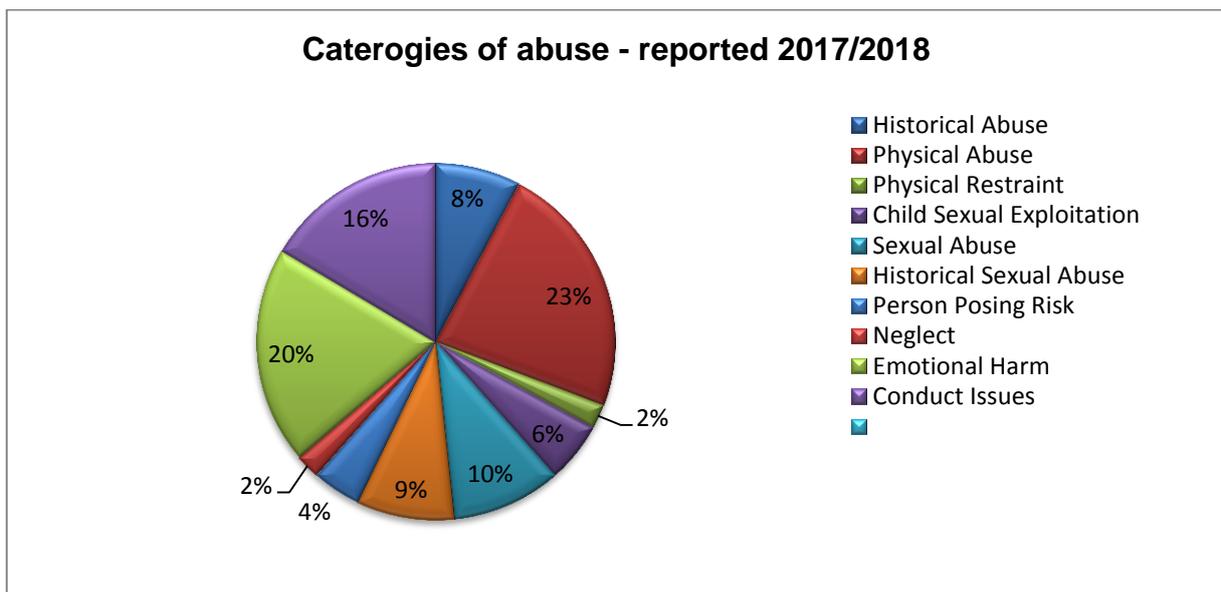
- Cause or potentially cause harm to a child;
- Commit a criminal offence against or related to a child; or
- Indicate that he or she would pose a risk of harm if they were to work regularly or closely with children.

Volume of LADO contacts and enquires



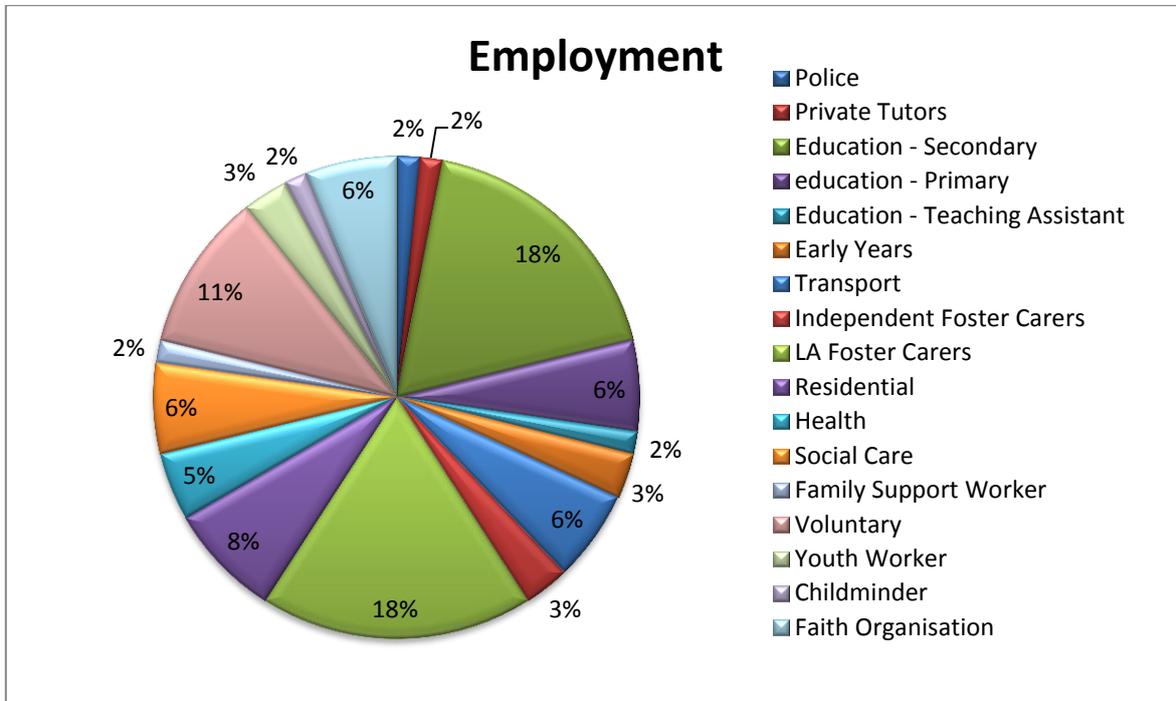
During the year 1st April 2017 – 31st March 2018, 96 enquiries progressed to the LADO process. This represents an increase in the volume from the previous year from 77 enquiries. In addition to these, there were a number of other LADO enquiries which did not meet the LADO criteria or that required intervention from another Local Authority LADO. An additional 739 of this type of query were taken in the year but they lacked the detail or content to be formally recorded as LADO investigation but advice and guidance was provided. A new improved recording system was introduced in 2017-18 which now includes all enquires of a LADO nature and accounts for the apparent increase in volume from 2016-17.

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



The highest figures of abuse category are physical and emotional harm.

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

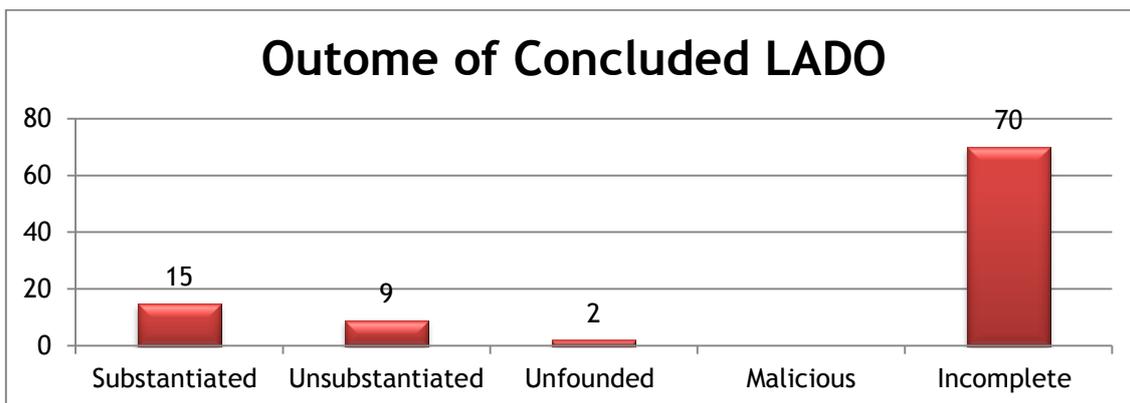


The highest figures in relation to employee's has been in relation to foster carers and secondary education staff, where physical restraint is an area that is been repeatedly considered by LADO from professionals working in environments with young people who can present with challenging behaviours.

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

Inspection Finding:
Ofsted Inspection Report (February 2018)
 Allegations against professionals are robustly managed. All referrals to the designated officer are made through the MASH, which ensures that risks to children are identified at the earliest opportunity and are appropriately managed. Evidence was seen of effective information sharing through allegations management meetings that resulted in clear actions, which are reviewed as required.

Of the 96 enquiries that progressed to Allegation Management Meeting, the outcome of the investigations was as follows:



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

8 Conclusion

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

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

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

9 Strategic Priorities for 2016-18

The LSCB priorities for this period have been:

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

Partnerships governance and communication

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

Neglect

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

Engagement with practitioners and the local community

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

The voice of children and their families

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

Effectiveness of early help

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

Child Sexual Exploitation and Missing

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

Safeguarding Looked After Children

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

Performance, Quality Assurance and Learning and Improvement

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

As the new multi-agency safeguarding arrangements are developed, partners will review the current priorities and a new business plan will be produced and published in 2019.

10 Appendices

Appendix 1 – Board Member attendance 2017-18

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

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

Appendix 2 – Financial Statement 2017-18

Budget Statement 2016/17 Outturn	Funding Formula	Budget 2017/18	Outturn 2017/18
	%	£	£
Income			
Annual Contributions			
Rotherham MBC	48%	163,432	163,432
Rotherham CCG	22%	75,315	75,315
South Yorkshire Police & Crime Commissioner	13%	44,475	44,475
National Probation Service	<1%	1,077	-6472
CAFCASS	<1%	550	1100
South Yorkshire Community Rehabilitation Company	<1%	300	-300
Surplus from previous year	3%	10,000	10,000
Rotherham CCG - L&D contribution	6%	22,000	22,000
Rotherham MBC - L&D contribution	6%	22,000	22,000
Delivered Training to GP's	<1%	0	400
Total Income		339,149	331,950
Expenditure			
LSCB Salaries & Staff Costs		233,344	232,806
Public Liability Insurance		1,600	1,356
IT & Communications		1,000	1,513
Printing		3,000	3,171
Stationery and Equipment		330	63
Learning & Development		33,425	18,879
Independent Chair & Other Independent Consultants		49,000	64,959
Software licences & maintenance contracts		13,500	19,600
Memberships & Conferences		3,000	1123
Miscellaneous		950	131
Total Expenditure		339,149	343,600
Deficit			11,650

Appendix 3: Contact details

Rotherham LSCB

Independent Chair: Christine Cassell

Vice Chair: Rob Odell

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

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