# Rotherham

# Local Safeguarding Children Board

# Annual Report

# 2018 - 2019

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| Status of Report | Final |
| Date | 16 October 2019 |

## Table of Contents

# 1. Foreword by the Independent Chair

Welcome to the Rotherham Safeguarding Children Board Annual Report for 2018-19. This report covers the period from April 2018 to March 2019 and will be the last annual report for Rotherham Safeguarding Children Board which will cease to exist on the 19th September 2019 and be replaced by the Rotherham Safeguarding Children Partnership.

I have been the Independent Chair for Rotherham Safeguarding Children Board since November 2015. Following the Jay and Casey Reports of 2014 and 2015 respectively, Rotherham Metropolitan Borough Council was in intervention, with all council services led by Commissioners appointed by central government. The council's children's social care services and the Rotherham Safeguarding Children Board had been judged by Ofsted to be inadequate. Significant improvement was required in South Yorkshire Police and all agencies needed to improve the way that they worked individually and together to protect children.

In the four years from 2015 to 2019 there has been significant and rapid improvement in children's social care services and the multi-agency response to protecting children. The strides in practice improvement, leadership and stability of workforce have been impressive and all concerned must be strongly congratulated. In November 2017 Ofsted inspected the local authority's children's social care services and judged it to be good overall, with further improvement required just in the services for looked after children. Improvement has continued with a positive focused inspection of Looked After Children' Services in March 2019.

These improvements have been achieved in the context of very high levels of demand for child protection and children in need services. Some of this demand could be attributed at least initially, to the reaction to inadequacy and intervention being a cautious approach to safeguarding thresholds. A factor in the levels of demand may be the fact that there is scope for early help services to be more firmly embedded across partners to support more families at an early stage and to prevent concerns reaching the level that they need statutory intervention.

Recent audits indicate that thresholds are being applied appropriately and data from different parts of the system would confirm that the right children are being referred for support. A very large factor in the levels of demand for child protection services is the activity of Operation Stovewood. This is the work being undertaken by the National Crime Agency to investigate child exploitation between 1997 and 2013. Whilst this is primarily focused on identifying victims/survivors and perpetrators from that period, the consequence of identifying a potential perpetrator is that any current risks to children must be investigated. This has necessitated careful negotiation between the National Crime Agency and local child protection services to ensure that any children in contact with suspected perpetrators are properly protected in the context of ongoing investigations. The scale of the impact of this operation on local services can be understood from the current projected figure of over 1,500 victims being investigated by a local force of what will shortly be 250 National Crime Agency officers.

Within this context the local partners must maintain and take further the improvements achieved thus far and at the same time achieve the budget savings required by national funding reductions.

The Rotherham Safeguarding Children Board will hand over to the Rotherham Safeguarding Children partnership on September 19th 2019. The details of the new partnership can be found here on the Partnership website.

Partners work together very effectively in carrying out multi-agency audits to identify areas for further improvement and these audits, together with performance analysis and inspection outcomes, have informed the business plan for the new Partnership.

The priorities for the new partnership are grouped under three key headings:

- Safe at Home
- Safe in the Community
- Safe Safeguarding Systems

Through these priority areas the new partnership will focus on specific areas for improvement, keep a strong focus on exploitation and drive further child focussed, self- reflective practice with strong challenge within and across agencies.

Christine Cassell

**Independent Chair**
**Rotherham Local Safeguarding Children Board**

# 2. Local background and context

## Rotherham demographic profile

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

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

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

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

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

### Diversity

Rotherham's Black and Minority Ethnic (BME) population is relatively small but has been growing and becoming increasingly diverse. The BME population more than doubled between 2001 and 2011 through immigration and natural increase, growing 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.

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 no by all means all.

(*The NINo figures encompass adult overseas nationals allocated a National Insurance Number for whatever reason, that is, the figures cover benefit or tax credit recipients as well as workers (including self-employed).

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 Rotherham children and young people think about their lives and communities?

***Listening to and communicating with children and young people is central to keeping them safe and promoting their welfare. The Lifestyle Survey is an annual survey which captures the voice of Rotherham children and young people on the subjects which important to them. It is a unique opportunity for a large group of young people in Rotherham to share their views on matters that impact on their lives. The questions in this survey have been shaped by our young people.***

In 2018, 3,499 young people from 12 (out of 16) secondary schools in Rotherham participated in the survey along with 3 pupil referral units. In 2018 the survey was also offered to students at all Special Schools following a successful pilot with Newman School in 2017. Schools participating in the survey gave their commitment to enabling pupils at their school to have their voice heard to share their views on health, well-being, safety and their views about Rotherham and their local areas.

Through the survey young people are asked their views about:

- Their feelings and having someone to talk to
- How they feel Rotherham could be improved and would encourage them to want to stay
- Feeling Safe Rotherham Town Centre, Bus & Train Station
- Feeling Safe at home, school, on way to and from school, on local buses, trains, in their local community and in local parks and recreational areas
- Internet safety
- Bullying
- Drugs
- Sexual Health & Healthy Relationships

**Feeling Safe:**

**Town Centre**

19.3% said they always feel safe, compared to 18% in 2017

23.3% said they never feel safe, compared to 18.5% in 2017

**Bus Station (old Bus Station)**

21.6% said they always feel safe, compared to 18% in 2017

21.5% said they never feel safe, compared to 16% in 2017

**Train Station**

23% said they always feel safe, compared to 15% in 2017

22.3% said they never feel safe, compared to 15% in 2017

In these 3 locations more young people are saying they always feel safe, but there are also more young people saying they never feel safe.

**Town Centre Risks**

Young people highlighted the 3 main issues causing them to feel unsafe in town centre locations as – people causing anti-social behaviour; people using drugs in public; people drinking alcohol in the streets.

Each school who participated in the survey is provided with a profile and analysis of the survey findings for their cohort of students to compare with the borough wide findings. The results and analysis from the survey are also provided to the Rotherham Health and Wellbeing Board.

**Feeling safe:**

**At home**

91.2% said they always feel safe, compared to 91.8% in 2017

1.6% said they never feel safe, compared to 1.2% in 2017

**At school**

57.6% said they always feel safe, compared to 59.4% in 2017

4.8% said they never feel safe, compared to 4.6% in 2017

**On way to and from school**

53.8% said they always feel safe, compared to 61.2% in 2017

5.9% said they never feel safe, compared to 4.2% in 2017

**On local buses/trains**

28.4% said they always feel safe, compared to 29.5% in 2017

12.1% said they never feel safe, compared to 11% in 2017

**In local community**

50.5% said they always feel safe, compared to 51% in 2017

6.9% said they never feel safe, compared to 6% in 2017

**In local parks or recreational areas (new survey question in 2018)**

33.6% said they always feel safe

8.8% said they never feel safe

The results and analysis from the survey have been fed back to the Safer Rotherham Partnership and the South Yorkshire Passenger Transport Executive.

**Internet Safety**

2.3% of young people said they have not been taught about internet safety, compared to 1.4% in 2017

Young people in both 2017 and 2018 highlighted their top 3 risks for using the internet as:

Someone hacking their information; cyber bullying; and people lying about who they say they are

**Bullying**

2018 saw an increase in the number of young people who said they have been bullied in the past 6 months

27% said they have experienced bullying, compared to 26% in 2017

*The analysis shows that those saying they have been bullied, show an increase in pupils being bullied both in and out of school time and those being bullied more frequently i.e. every day or more than 3 times per week has increased.*

**Bullying Reasons**

There has been an increase in the young people saying they have been bullied because of their sexuality, this has increased to 5.7% from 2.8%. Bullying for the way young people look has also increased to 14.6% from 12% in 2017

**Types of Bullying**

Verbal bullying has increased to 68.5% from 64.3% in 2017

Cyber bullying has decreased to 6.2% from 6.6%

Sexual bullying has increased to 3.2% from 2.6% in 2017

Being ignored has decreased to 6.6% from 10%

**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.

## 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
- Independent Chair of the Rotherham Safeguarding Adults Board
- Chair of the Health and Well Being Board
- Chair of the Safer Rotherham Partnership Board

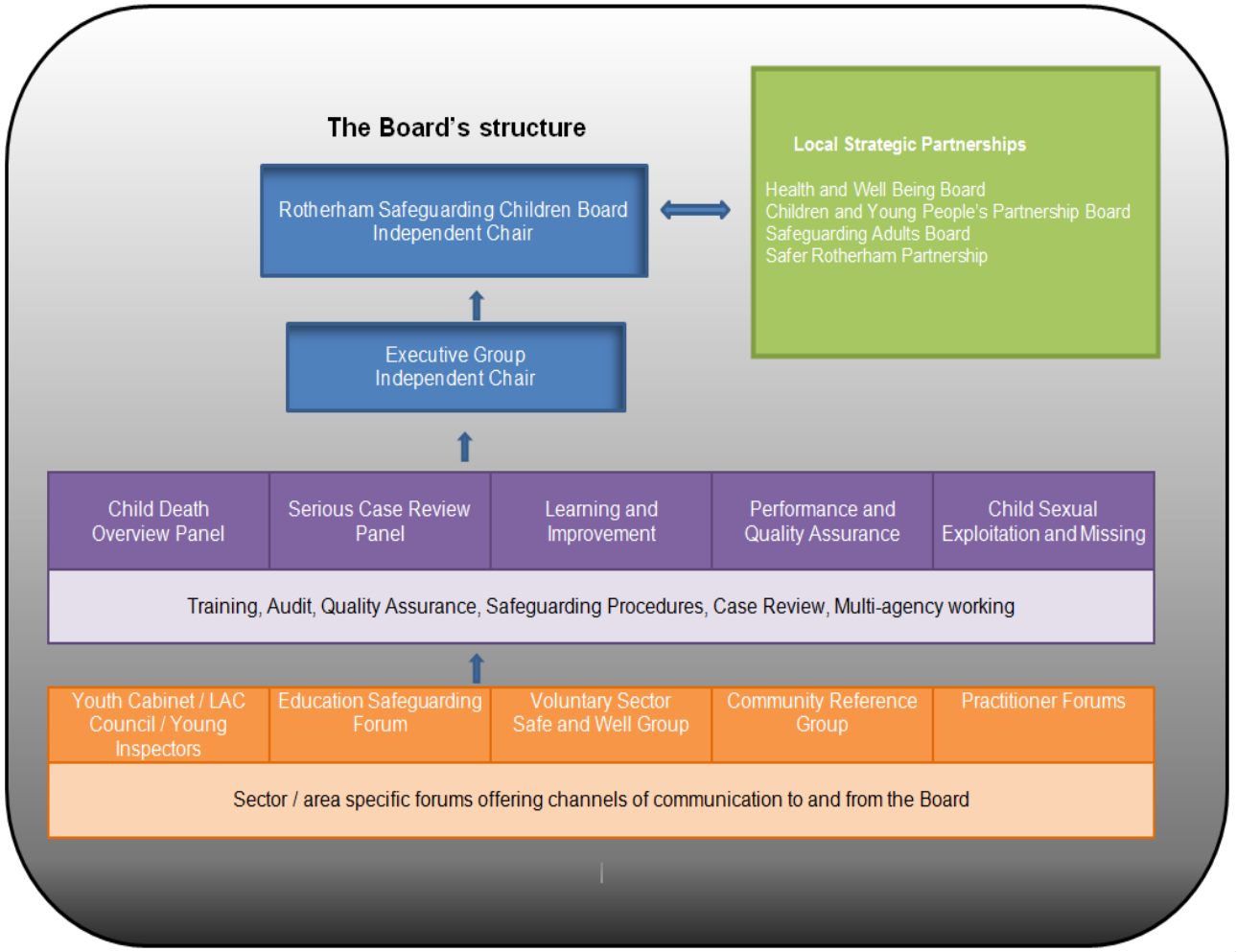
Members of Rotherham LSCB are people with a strategic role in relation to safeguarding and promoting the welfare of children in their organisation and are able to speak for their organisation with authority; commit their organisation on policy and practice matters; and hold their own organisation to 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 have been full members of the Board until September 2018, participating on the Board itself and relevant Sub Groups. Lay Members have helped 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 has met 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 (0.3 WTE)
- Learning and Development Administrator
- Child Death Overview Panel Administrator (0.65 WTE)
- Administrative Officer (0.8 WTE)

## Financial arrangements

The Board's budget is based on partner organisations contributions to an agreed formula. The funding formula and 2018-19 budget statement can be found at **Appendix 2**.

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

Budget – 2018-19 Outturn

| | | | | |
|---|---|---|---|---|
| Income: | Budget | £ 328,848 | Actual: | £ 328,848 |
| Expenditure: | Budget | £ 328,848 | Actual: | £ 328,564 |

Overall expenditure for 2018/19 was £284 under budget.

## Regulatory Inspections across the Partnership

Inspections of local agencies are routinely reported to Rotherham Local Safeguarding Children Board along with any action or improvement plans. This section summarises key findings from inspections of safeguarding board partners.

**Inspection Findings:**

**The Rotherham NHS Foundation Trust**

**CARE QUALITY COMMISSION**

Between 25 and 27 September 2018, we carried out an unannounced inspection at Rotherham General Hospital of urgent and emergency services, medical care, maternity services, and acute services for children and young people. Between 16 and 18 October 2018, we carried out an unannounced inspection of community health services for children and young people.

A further announced inspection took place between 22 and 24 October 2018 where we looked at the quality of leadership at the trust and how well the trust managed the governance of its services.

**Summary of the key inspection findings (as they relate to safeguarding children)**

**What the CQC found**

**Overall trust**

Our rating of the trust stayed the same. We rated it as requires improvement because:

• We rated safe, effective and well-led as requires improvement, and rated caring and responsive as good. All ratings were the same as the previous inspection except for responsive, which had improved one rating.

• Rotherham General Hospital was rated as requires improvement overall. Safe, effective, responsive and well-led remained as requires improvement and caring remained good.

• Community Healthcare Services remained as requires improvement overall. We inspected one core service (community healthcare services for children and young people) at this inspection and the overall ratings for effective and well-led remained as requires improvement while safe, caring and responsive remained as good.

• Issues we identified at previous inspections, such as culture, mandatory training compliance, staffing and high caseloads for practitioners in the 0-19 service had demonstrated the trust had not fully addressed ongoing concerns.

There was evidence of some progress and the trust recognised further improvement was required.

• In addition, we also undertook a focussed unannounced inspection in July 2018 and found that appropriate and timely action had not been taken to address the immediate concerns.

**Are services safe?**

Our rating of safe stayed the same. We rated it as requires improvement because:

- There were significant concerns within urgent and emergency care services that impacted upon patient safety. The service was rated as inadequate for safe, which was down one rating from the previous inspection. There was a shortage of suitable skilled staff and not all staff had the right skills, knowledge and experience to do the job they were asked to do.
- Patients had long waits to be assessed in the emergency department and there had been serious incidents resulting in patient harm due to those delays. Senior staff had not made any correlation between staffing levels and the number of serious incidents and had not taken timely action in response to the concerns raised by staff.
- Nurse staffing was an ongoing issue, particularly within medical wards. Fill rates were low on some wards and there was a high number of nurse vacancies across the trust. In the maternity service, midwives were frequently deployed from other areas to support the delivery suite, and there had been a reduction in specialist midwives to meet the needs of vulnerable women.
- Safeguarding adults and children was not always given sufficient priority and there was a lack of strategic oversight of the issues we identified during this inspection. We found the quality of safeguarding referrals was poor in some services, looked after children did not receive initial health assessments in a timely manner, and safeguarding training did not comply with the Royal College of Paediatric and Child Health intercollegiate document.

**However;**

- We found evidence of improvement in maternity and services for children and young people in relation to incident reporting. There was no backlog of incidents for review in maternity and there were systems to share learning with staff.
- There were processes in place to safeguard children and adults from abuse and risk of harm. Staff understood their responsibilities and could articulate what action they would take. However, in community healthcare services for children and young people, there was minimal oversight of safeguarding children referrals and no process for quality assurance.

**Are services effective?**

Health visiting and school nursing services continued to fail to meet performance targets, although an improvement plan was in place and the service prioritised the needs of vulnerable families.

**However;**

- There had been improvements in medical care and services for children and young people which were rated as good.
- The maternity service had made improvements and regularly reviewed clinical outcomes in formal meetings. Policies and procedures were up to date and there a review system in place.
- There was evidence of good multidisciplinary working throughout the trust. Staff with specialist skills and knowledge worked well together to benefit patients.
- Staff understood consent requirements for adults, children and young people and gained consent prior to performing care.

**Are services caring?**

Our rating of caring stayed the same. We rated it as good because:

- Staff were caring and compassionate and worked in partnership with patients, relatives and carers.
- Staff recognised the important of people's privacy and dignity and treated patients, relatives and carers with respect and kindness, and involved them in their care.
- Staff communicated with people and provided information in a way that they could understand.
- Patients told us they received compassionate care and that staff supported their emotional needs.
- Our rating of responsive improved. We rated it as good because:
- There had been improvements in services for children and young people (acute and community) which were rated as good.
- Patients knew how to complain, and staff knew how to deal with complaints they received. Complaints were investigated, and learning was shared.

**However;**

- The looked after children (LAC) service did not meet the statutory initial health needs assessment target of 20 working days from the date of becoming looked after. This was also identified as an issue at our last inspection. There was an inter-agency action plan to address the timeliness of the assessments. Regular assurance reports were provided to the service manager and the quality assurance committee.
- The culture of the organisation was reported as improving from a low base. In urgent and emergency care services, we found the culture was defensive and not open or transparent. The trust had updated its Whistleblowing policy to ensure staff members raising concerns were protected and supported and to prevent any discrimination consequently. In addition, there was an acting freedom to speak up guardian who was proactive and had lots of ideas for improvement and development, including better engagement with staff.
- There had been improvements in maternity services and in services for children and young people (acute), which were rated as good.

Rotherham Safeguarding Children Board has been monitoring the Trust's action plan in relation to these inspections and the evidence of the impact of actions taken.

**Inspection Findings:**

**Ofsted**

**Overview**

Children looked after by Rotherham Borough Council who need permanence in their lives are receiving a strong service. Progress is evident since the last inspection in 2017, when services for children looked after were judged to require improvement.

Effective strategic planning by senior leaders has significantly improved permanence planning for children in care in a coherent and sustainable fashion. Senior leaders have successfully made use of the council's existing strengths, such as performance reporting, together with increased management oversight of children's individual circumstances, to achieve sustained improvement.

Significant partners, such as the Child and Family Courts Advisory Service (CAFCAS) and the courts, report an increasing amount of good-quality social work. Social workers can articulate their plans for children in care clearly. They see children regularly and know them very well. Written plans are less well expressed because they do not always clearly state the outcomes expected for children and are not always time bound. All children in care whose cases were reviewed by inspectors had a plan for permanence firmly in place. This means that there is a real focus on securing their long-term future through both a wide range of different legal orders and finding a variety of places for them to live. In a small number of examples, due to a lack of enough in-house options, children were living in unregulated placements. Safeguarding risks are not always assessed robustly enough to inform placement planning and permanence.

**What needs to improve in this area of social work practice**

- The quality and consistency of written planning, so that it matches up to social workers' verbal accounts of their plans.
- Sufficiency of in-house options, to avoid the use of unregulated placements when finding places for children in care to live.
- Risk assessments, where risk has potential implications for stability in the lives of children in care.

**Findings**

A renewed focus on the needs of children in long-term care through senior leaders' 'Right Child Right Care' project has resulted in children's continuing needs being reassessed and options for permanence being successfully delivered. The project has also produced a sustainable

framework of permanence planning for those children who are new into care.

Unborn or new-born babies are getting an improved service because more assertive action is now taken earlier with mothers who are in a cycle of having their children removed. Inspectors saw strong evidence of twin tracking to achieve timely permanence for these babies, including adoption, special guardianship orders and reunification with family where it is safe to do so.

Reassessment of children's need for permanence, together with more assertive action for unborn or new-born babies, has resulted in a recognised increase in children's cases being presented to court. The standard of social workers' presentation and reporting to court has evidently improved and this is supported by partners such as CAFCAS and the local judiciary, who say that this is now mostly of good quality. It would benefit from being more consistent and timelier to avoid delay in the court's timetable while any deficits are resolved in children's permanence arrangements.

Notwithstanding the lack of enough in-house options, children in care are generally found places to live that match their unique needs. Therapeutic support is readily available for all children in care, and this promotes stability and prevents breakdown. Some of these arrangements are creative and well adapted to the child's needs, but a small number are unregulated. This means that the council cannot be assured that these arrangements are subject to regulatory scrutiny. For a small number of children subject to section 20 of the Children Act 1989, parental consent for placement is not compliant with legal guidance.

- Senior leaders are reflective and adaptive, and they run a learning organisation. For example, when the last inspection identified improvement in permanence planning as an area for development, they conducted two peer reviews. They have evidently taken on board learning from these reviews, for instance children's cases having too many transfer points, and have resolved the issues identified. Children in care can now get to know their long-term social worker at the earliest opportunity and this promotes effective relationship building.

- Senior leaders can demonstrate a good understanding of frontline practice. They manage an effective panel system and maintain a detailed placement tracker. Through this activity, they show a high level of awareness of children's individual needs. Overall, management audit is also of good quality and contributes to a strong understanding among senior managers of frontline practice. This means that senior leaders can effectively deliver projects and plans, because they understand in detail the needs of children in the care population.

- A useful bespoke performance reporting tool allows frontline managers to manage compliance with statutory guidance. This works well. For instance, all children are seen, and their cases are reviewed at least at statutory minimum levels. Some good examples were also seen of reflective supervision sessions between frontline managers and social workers impacting directly on the care of the child. However, the current required frequency of supervision means that if a session is missed there can be significant gaps, and this might potentially delay swift planning for some individual children.

The council has secured a permanent workforce of social workers who are well trained and make good use of established social work models when addressing risk and protective factors. Safeguarding risk management could be better, as it does not always closely inform permanence planning in the way it should. Assessments do not always sufficiently capture the unique identity of the child, for example their ethnicity. This means that matching with suitable carers is made more difficult than it needs to be.

- Social workers report high workloads, and inspection evidence demonstrates that there are several exacerbating factors to this situation. The local authority has had a higher number of children placed in care over the past two years, leading to increased use of placements outside of the borough. This means that social workers must undertake out of authority visits more frequently to build and maintain relationships with children in care. An increased demand in relation to managing children's contact with their birth families means that social workers currently manage a proportion of this activity, leading to significant travel implications. An increased complexity of need has been identified as children come into care, and this demands a high degree of social work intervention to ensure that plans are progressed effectively. The combination of these factors means that high workloads can lead to some undesirable delays, such as in the completion of life-story work and later-life letters for children achieving permanence through adoption. Given the pressures on their time, it is to social workers' credit that they make more visits than statutory minimum levels to children on their caseloads and know them so well.

Reviews of children's plans are well attended and well recorded, but actions identified do not always drive progress in plans for permanence, because they do not address deficits in social workers' plans by stating clear outcomes and deadlines. Independent Reviewing Officers' (IROs') footprints are evident from files looked at, although their impact is not always apparent. Intelligence gathered by IROs does not inform wider organisational learning. For instance, the IRO annual report is discursive and is not linked to strategic initiatives such as 'Right Child Right Care'.

# 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 across the partnership 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.

As significant elements of the Early Help Service are not mandatory, families have a choice in whether they wish to accept support and engage with Early Help process. Annual performance information for 2018/19 shows that Rotherham's local total engagement rate is high at 95.2% which is an improvement on the 2017/18 total engagement figure of 92.2%. Of those engaged 72.6% were contacted and engaged within three working days. This is a significant improvement on 2017/18 when the annual figure was 59.7%.

In 2018/19 there were 4671 contacts to Early Help, including cases which have stepped down from social care services.

The timeliness of Early Help Assessment completion in 2018/19 shows considerable improvement with 62.9% of assessments being completed within the target timeframe, compared to the 2017/18 figure of 47.0%.

**Early Help Assessments:**
Progress and support for partners to complete Early Help Assessments is ongoing and by the end of March 2019 24.9% of Assessments in 2018/2019 had been completed by partners which is a significant improvement on last year of 15.9%. Partners are also supported by the five Early Help Integrated Working Leads which are based across Early Help localities.

During 2018/19, Primary and Secondary schools completed 79.6% of Partner Early Help Assessment with the remaining Partners (including the Health economy) completing the remaining 30.4%.

### Children with Special Educational Needs and/or Disability (SEND)

Children with disability are more vulnerable to abuse and neglect for a number of reasons. They are more dependent on others to have their needs met and care may be provided by someone other than a parent or primary carer. If communication is difficult, children with disability find it hard to let someone know that abuse is occurring and behavioural issues are more likely to be dealt with in forceful or restrictive way, and indicators of abuse might be wrongly attributed to the behavioural issue.

***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 (i.e. school holiday periods).

In relation to the Conversions 98% of all Conversations were completed by the target date of April 2018 and the remaining 2% were delayed due to the complexity of the individual cases, however, were completed before the end of the Summer Term 2018.

The percentage of completed new EHCP's within 20 weeks fluctuated last year due to the necessary prioritising of the conversions and seasonal fluctuations in demand (ie school holiday periods). Cumulative performance for 2017/18 was at 57.1% for new EHCP's.

There were new incremental quarterly targets set and monitored for 2018/19 with the aim of the service achieving performance levels of 90% in the following reporting year (2019/20). Performance for the proportion of Education and Health Care Plans completed within the statutory timescales of 20 weeks is below.

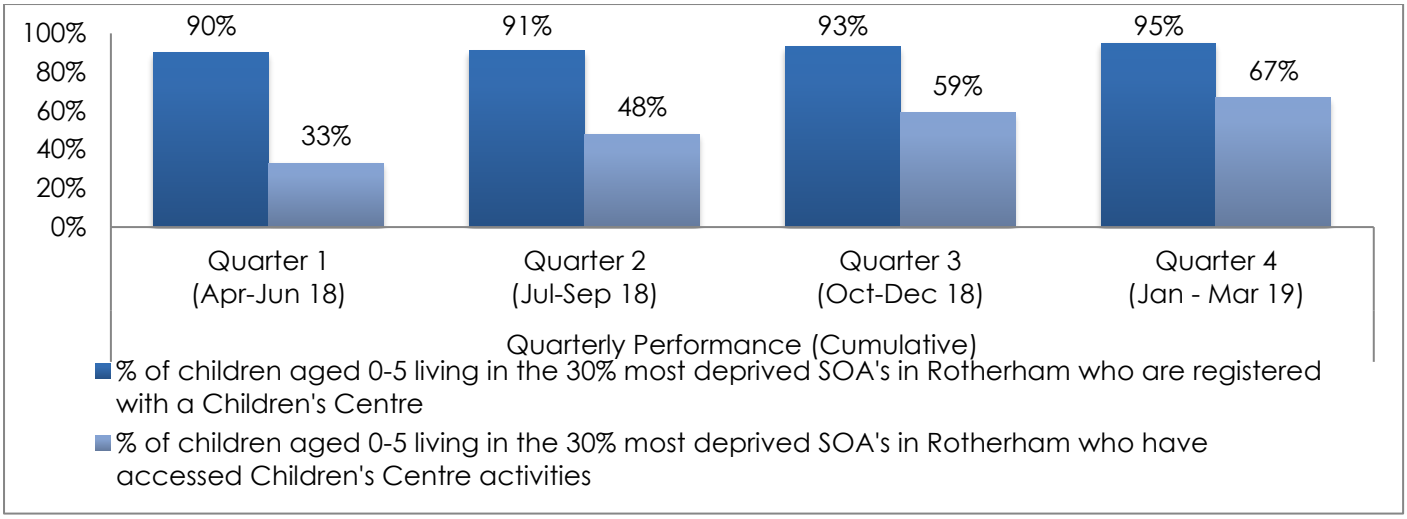
| Quarter 1 | Quarter 2 | Quarter 3 | Quarter 4 |
|---|---|---|---|
| Performance was 48%<br><br>(Target 45%) | Performance Was 65%<br><br>(Target 65%) | Performance Was 51%<br><br>(Target 75%) | Performance Was 64%<br><br>(Target 90%) |

The Education, Health and Care Assessment Team underwent a restructure in October 2018 with some vacant posts which are impacting on performance; these vacant posts are to be filled by the end of April 2019 and a new EHCP Manager starting in post from May 2019.

## Children's Centres

***A children's centre is somewhere local families with young children can go to enjoy facilities and receive any needed support. The facilities and activities that are offered are designed especially for parents who may be expecting a new baby, or for those with a child under the age of five.***

Children's Centres performance in the 30% most deprived Super Output Area (SOA) neighbourhoods remains strong with 95% of children registered (meeting the target).




Engagement rates saw a similar trend with the 30% most deprived SOA's achieving overall performance of 67% against a 66% target. This is a slight decrease when compared with 2017/2018 when performance reached 68%.

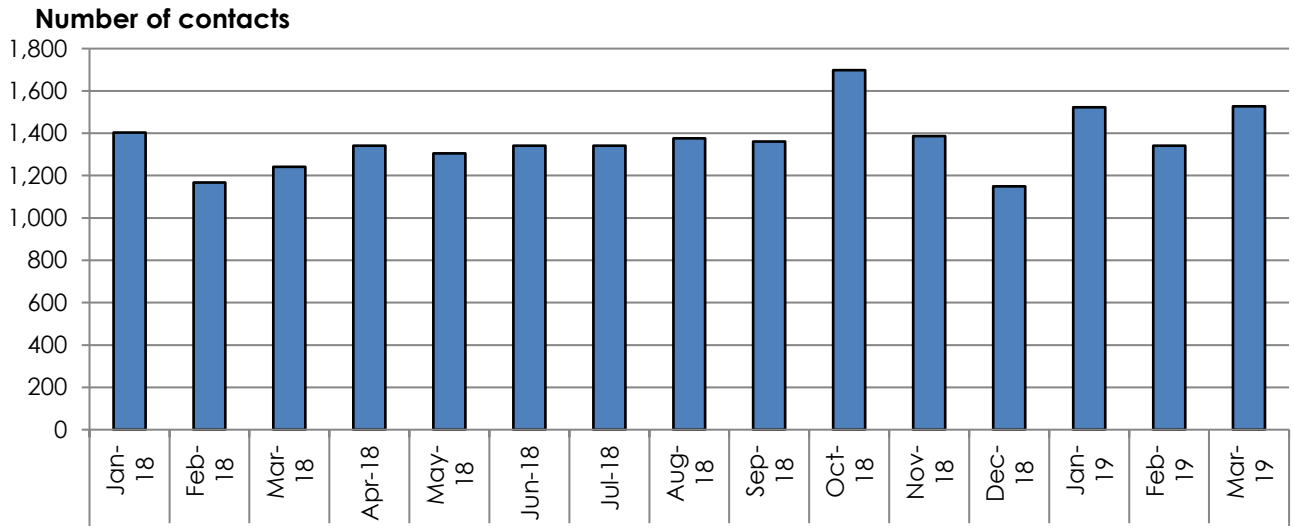
Children's centres provide a vital role in communities and are an important element of proving early help, aiming to improve outcomes for young children, ensuring they are happy, healthy and ready to begin school. Centres can provide help and support to children and young families whenever they need it, as well as helping to prevent any problems from developing in the future.

### Contacts and Referrals to the Multi-Agency Safeguarding Hub

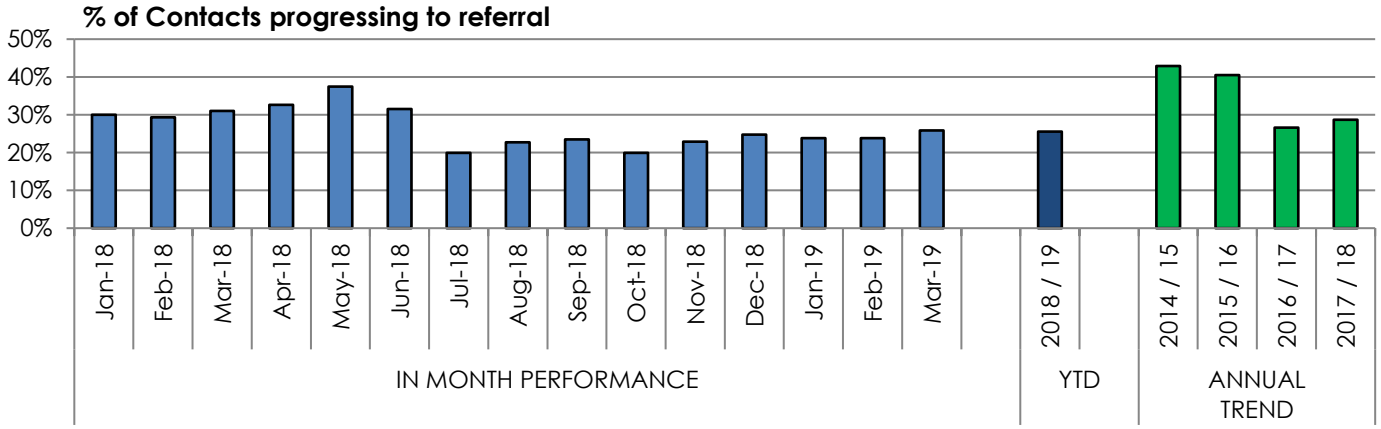
***A "Contact" is a request for help when a child is thought to have support needs or to be at risk of harm. If there are concerns which cannot be managed through the provision of early help services, a referral is made for a multi-agency assessment to be undertaken, led by a social worker.***

In total 16,694 contacts were received during the year which is a 6.5% increase when compared with last year (15,671). Alongside this increase there has been a slight increase in the number of contacts having a decision made within one day, 81% compared to 79.5% in 2017/18. The number of referrals going onto an assessment has also improved by 1% (98.2%) when compared with 2017/18. These figures reflect the quality in the operational process of the Multi-Agency Safeguarding Hub (MASH), suggesting the majority of screening activity takes place earlier and ensuring progression to social care referral only takes place when appropriate.

Over the last 12 months the re-referral rate has continued to follow a downward trend reaching 21.3% at the end of March 2019 which is a 1.8% decrease on 2017/18 and below the latest National Average figure of 21.9%.




The % of contacts which progress to a referral – a contact progresses to a referral when a social work led multiagency assessment is required for a child, determined by considering any need or risk issues and applying thresholds.



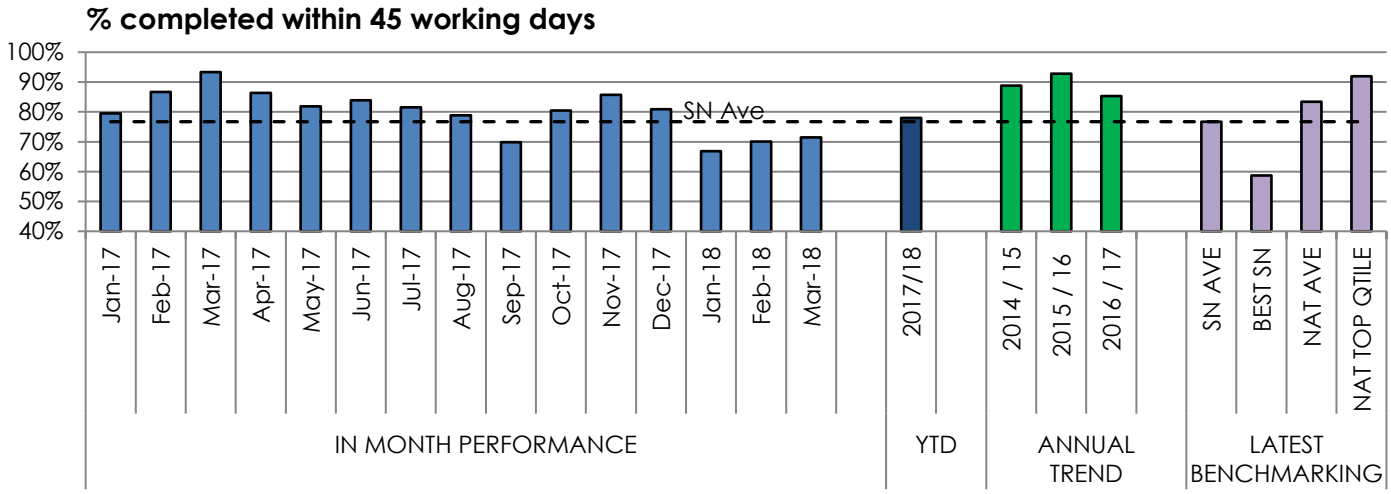

The number of referrals going onto an assessment has also improved by 1% (98.2%) when compared with 2017/18. These figures reflect the quality in the partnership processes of the Multi-Agency Safeguarding Hub (MASH), suggesting that the majority of screening activity takes place earlier and ensuring progression to social care referral only takes place when appropriate:

## Assessments

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

During 2018/19 4797 new assessments (excluding assessment updates) were started which shows a decrease of 398 (8.2%) when compared with 2017/18.

Assessments completed:




Timeliness of assessments (% completed within 45 days) annual performance for 2018/19 improved slightly to 81.1%, an increase of 2.1% on the previous year.

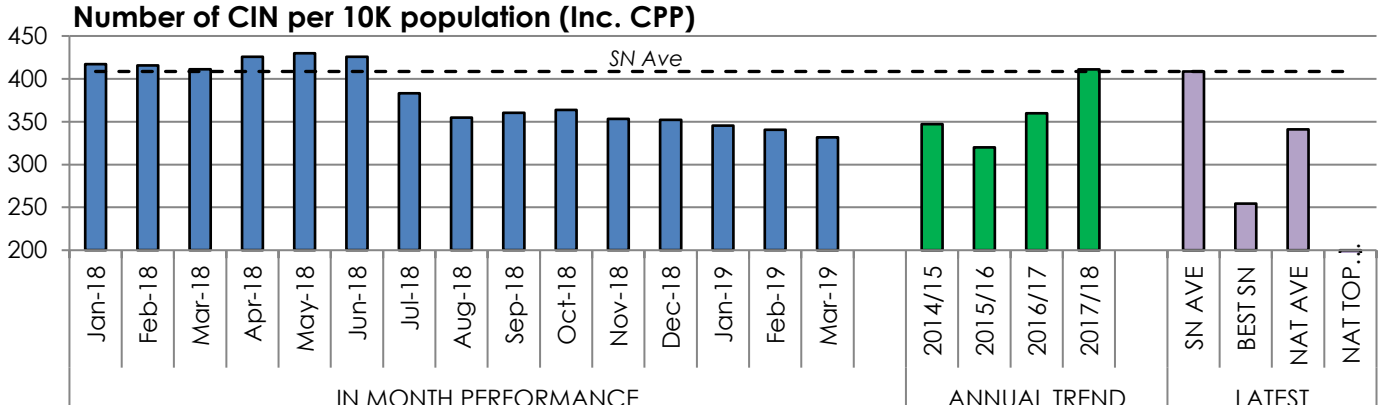
Assessment outcomes have increased slightly throughout 2018/19 with 67.9% either receiving Early Help or on-going Social Care support when compared with 65.2% in 2017/18.

## 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.

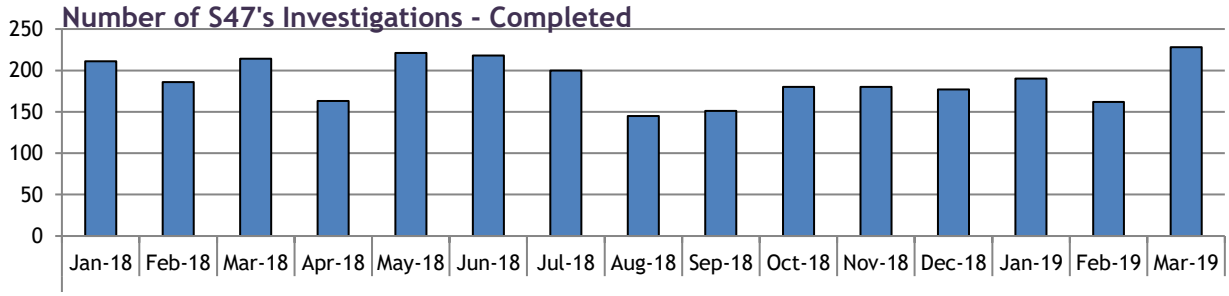
The overall Children in Need (CiN) population has reduced by 295 children since March 2018 (1678) and now stands at 1383 at the end of 2018/19. Overall the number of children in need per 10k of population (DfE definition) has dropped to 331.7 bringing Rotherham below the national average per 10k of population. Of these children, those with an up to date CiN plan have increased to 90.5% when at the same time last year performance was 82.8%.




## 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 continues to suggest high volumes compared to both the national and statistical neighbour average.

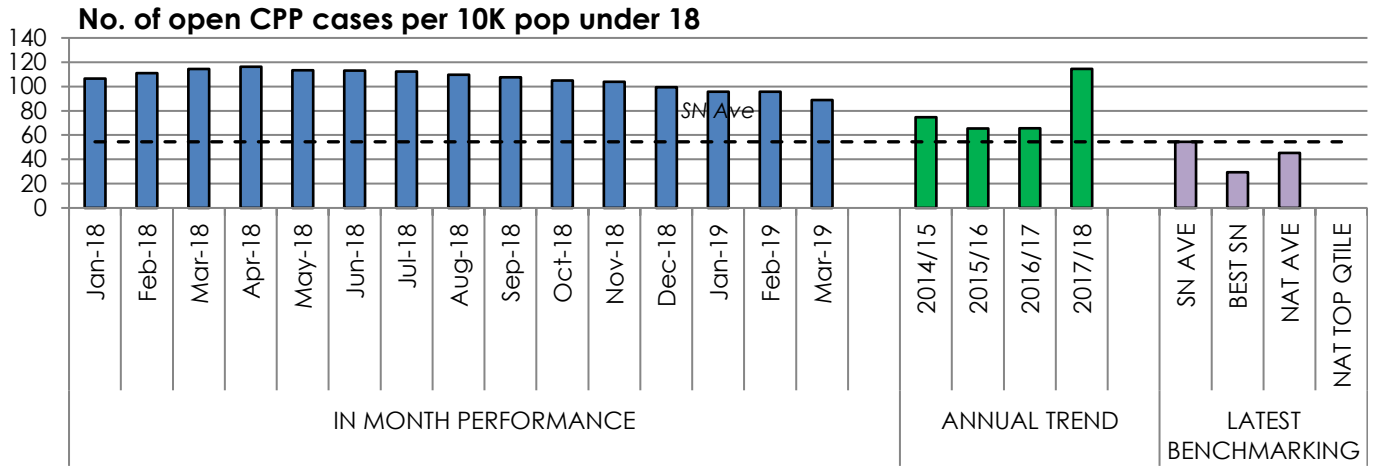



Following audit activity and the outcomes of investigations it is suggested that the majority of these are appropriate. Overall 93.3% of S47 concerns were either 'substantiated with continuing risk', or 'substantiated with no continuing risk'. This indicates continued improvement over the last three consecutive years in terms of applying thresholds appropriately to indicate child abuse.

## 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.**

The trend for the number of children per 10K population with a Child Protection Plan (CPP) remains significantly higher (88.9) than that of statistical neighbours (54.5) and the national average (45.3). However, the numbers of children becoming subject to a plan each month has steadily reduced since June 2018.




The timeliness of Initial Child Protection Conferences (ICPC) in March 2019 declined from a high of 91% to 77.4% (41 children out of 53 children had an ICPC in timescale). In response the Child Protection Service Manager has worked closely with fieldwork managers to ensure that the systems in place to prevent late notification are understood and used effectively. Out-turn for the year was 86.8% which was 2.8% higher than the previous year.

Performance in the timeliness of Review Child Protection Conferences has seen a positive improvement in March 2019: to 99.3% being undertaken in timescale despite a high volume of conferences. 151 out of 152 children had their CP plan reviewed in timescale, which equates to one conference out of time. This is an improvement on last year where 93.8% of CP cases were reviewed within timescale.

In the last 12 months the proportion of children subject to repeat plans within 24 months has started to see an improving trend which may be an indication that the continuing work with families is making a sustainable impact in keeping children safe. The repeat plans 'ever' measure has also seen an improvement but at a slower rate which is reflective of longer term poor practice.

The data suggests that the services ability to reach a timely resolution for children at risk continues to be good. This is likely to relate in large part to increasing numbers of children in care and subject of legal proceedings. There is increased evidence of better use of family group conferencing and edge of care support in addition to the pre-proceedings PLO (Public Law Outline) process. There has been an overall positive reduction in the number of children on a plan for more than 2 years but with a peak in recent months. The situation for these children was expected and is well understood with planning deemed appropriate by senior social care managers. Regular reviews and management oversight of these cases ensure that we have the right children, subject to the right plan, at the right time.

**Child Protection Advocacy Service (Barnardo's)**

Barnardo's are commissioned to provide an advocacy service for children to have their views and voice heard at Child Protection Conferences.

Advocates will visit children at home or by telephone and work creatively to seek their views and will either support them to attend the Conference in person or attend on their behalf.

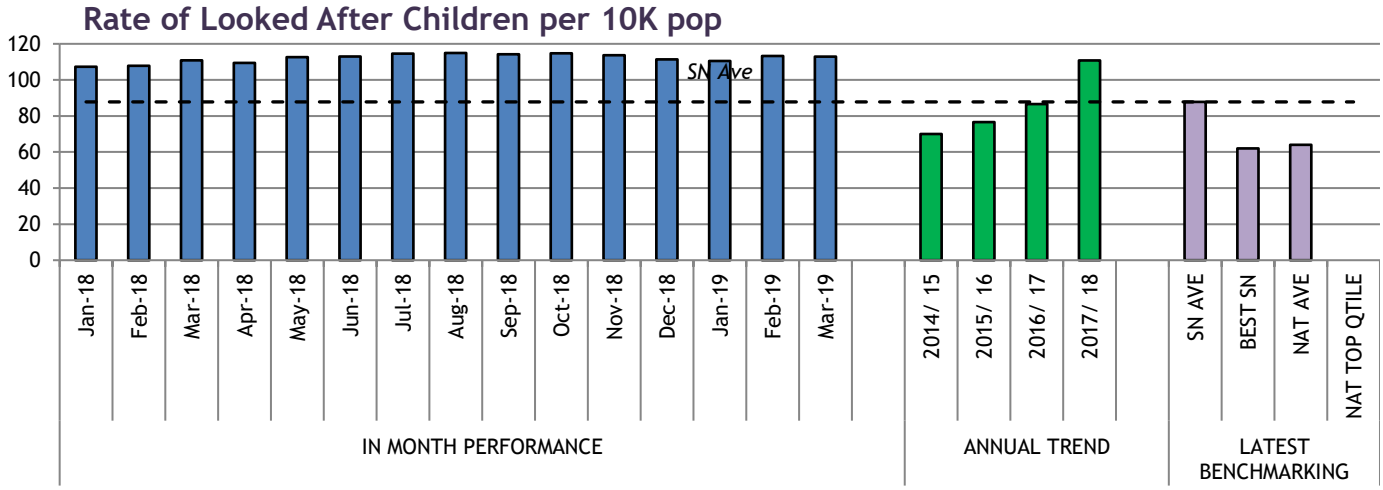
In 2018/19 the service engaged with 415 children to enable them to have their voice heard at a Child Protection Conference, a slight decrease on the previous year.

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 risk of 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**

During March 2019 the LAC numbers stabilised at 643 following a net increase of 16. LAC numbers at the same time the previous year were 627.




In March there was an Ofsted Focused Visit which reviewed the permanence planning within Rotherham - a previously identified area for development. Feedback was extremely positive and this has been endorsed by the year end performance in respect of permanence with 31.3% of LAC being discharged from care to permanence, up from 27% in the previous year, and 12.6% ceasing LAC by virtue of a Special Guardianship Order (previous years - 9.8% and 8.2%). This is higher than statistical neighbours and the national average although not in the top quartile range.

The number of children experiencing 3 or more placement moves reduced in March by 8 (13.9% in February to 12.7% in march). However, Rotherham remains below the statistical neighbour average in both measures, although the on-going drive for permanence is likely to continue to impact on long-term placement stability figures.

Statutory visits within timescales have also remained consistently high ending the year at 95.5%. There has been a slight decrease in review performance with 88.3% of these completed in time during the year (90.6% in 2017/18).

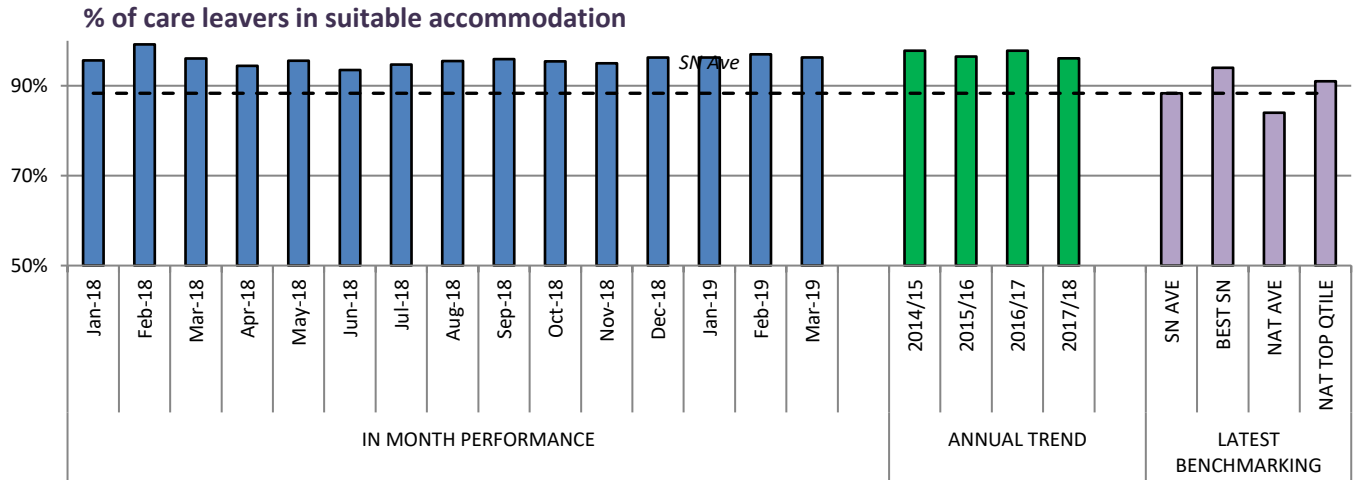
The number of Initial Health assessments completed within the 20 day timescale declined slightly in March 2019 with 56.3%. Overall performance for the year is 52% which is a slight decline on the previous year (55.7%).

## Care Leavers

**A care leaver is defined as a person aged 25 or under, who has been looked after away from home by a local authority for at least 13 weeks since the age of 14; and who was looked after away from home by the local authority at school-leaving age or after that date.**

At the end of March 2019 there were 301 care leavers, the highest number to date. The number of care leavers with an up to date pathway plan has increased this year with 79.1% when compared with the same time last year when 70.3% of plans were up to date. However, there has been a decline in the % of care leavers with a pathway plan in place, with performance reaching 84.5% at the end of March (93.9% March 2018). Performance in respect of care leavers who are in employment, education or training (EET) and in suitable accommodation has also dipped very slightly but both measures are still well above the national averages, 51% and 84% respectively.

**Suitable accommodation is defined as any that is not prison or bed and breakfast.**




## Child Exploitation

***Child sexual exploitation**; 'child sexual exploitation is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age is 18 into sexual activity (a) in exchange for*

***something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if they sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology' (DfE, 2017).***

***Child criminal exploitation**; 'Child criminal exploitation occurs where an individual or group takes advantage of an imbalance of power to coerce, control, manipulate or deceive a child or young person under the age of 18. The victim may have been criminally exploited even if the activity appears consensual. Child Criminal Exploitation does not always involve physical contact; it can also occur through the use of technology' (Home Office, 2018).*

In 2019 it has been five years since the publication of the Independent Inquiry into Child Sexual Exploitation in Rotherham. The EVOLVE service, true to its name, has continued to evolve from an investigative team to a service that fully supports the Rotherham's 5 P's through partnership working:

- **Prevent** children and young people from child Exploitation through effective leadership, governance and a wider culture embedded within organisations and communities that recognises the root causes of CSE, the signs and risk indicators and do all they can to tackle them.

- **Protect** children and young people who are at risk of all forms of Child Exploitation as well as those who are already victims and survivors.

- **Pursue**, relentlessly, perpetrators of child exploitation, leading to prosecutions of those responsible, and ensure there is effective risk management of perpetrators in the community and the region.

- **Provide** support for survivors of Child Exploitation, recognising the importance of trauma informed practice, ensuring their needs are met.

- Ensure the **participation** of all children and young people, their families and communities and community leaders, in awareness raising. To ensure their voices as well as the voices of survivors are heard and responded to in reviewing and coproducing services.

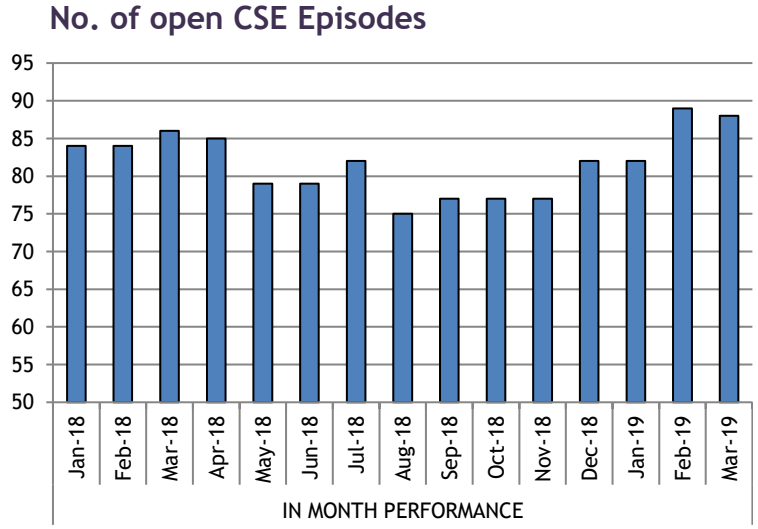
The EVOLVE CSE team has continued to develop as the partnership learns and reflects on what work to support and minimise the harm for victims and those identified as at vulnerable to CSE. The EVOLVE Social Workers offer a co-working service for young people open to Children and Young Peoples' Services, that focuses on Trauma stabilisation and direct work. This reflects the confidence held that the wider workforce understands and is knowledgeable about CSE identification and assessment. Co-located with the Police, Health Partners and Barnardo's there is a connection between supporting the investigation and providing support to work with families to keep young people safe; and to develop young people's skills and awareness around safe and healthy relationships. The recognition of CSE teams offering a co-working practice as the most effective way to support victims of CSE is identified in the 2014 Ofsted Thematic report.

Operation Stovewood, led by the National Crime Agency (NCA), focuses on the historical sexual exploitation that took place between 1997 and 2013. The operation has demonstrated its success

via the number of arrests achieved, the number of on-going investigations, the positive identification of perpetrators and the support for victims. The original estimate of historical victims of CSE by Alexis Jay in 2014 was 1,400; the latest figure from the NCA identified 1,523 potential victims. South Yorkshire Police lead on any investigations from 2014 onwards and work closely with the NCA to manage and support arrests. Operation Stovewood should not be considered purely a 'historical' investigation, as the profiles of the suspects (many of whom are still under 40 years of age) indicate that not only that past victims still at risk, but that there is a continuing threat to current and future generations of children.

The Safeguarding Children Board continues to ensure that learning form Operation Stovewood and the EVOLVE informs current practice. . The partnership is committed to being tenacious in checking and challenging itself and individual agencies to continue to improve our understanding and response to CSE. A recent Multi-agency CSE Audit highlighted that there no child was found to be at risk of significant harm that had not been identified and responded to effectively.

The structures within the partnership maintain a focus on training and awareness, oversight of complex investigations, improving community awareness, work to reduce safeguarding risks related to repeat missing episodes and a focus on needs led commissioning of services There has also been an agreed performance scorecard developed, supported by a sharing and generation of intelligence and information across the partnership to provide a focused safeguarding response. Enforcement and disruption activity has also been planned and evaluated by the partnership to support maximise impact relating to victim, offender and where appropriate, location.




The cohort of young people involved with the EVOLVE service has stabilised over the past 12 months and there is a very low level of referrals back into the service. This indicates positive impact from the safeguarding response, intervention and disruption. The EVOLVE service works with those young people assessed as high risk or medium risk and average caseloads through the year have settled at around 58. This is a reduction on the previous year, with a small number of young people, placed out of area that are not open to EVOLVE but accessing local bespoke CSE support.

All young people assessed at risk of CSE; low, medium or high have a 12 weekly review of their risk assessment. This a multiagency review and timeliness has improved, with oversight offered by the Team manager from EVOLVE to ensure consistency.

There are areas that we continue to seek to strengthen; for example our understanding of the constantly changing impact of technology and social media on abuse and the immediacy of the harm and risk as a result. We are seeking to promote more child led prosecutions by listening to children and minimising the impact of the criminal process when there are witnesses; and consider how we understand the impact of the abuse, the trauma it leaves in its wake and to be 'trauma informed' in both our language and practice across all partners.

A key area of work for the partnership at the end of March 2019 was to consider a review of the CSE Strategy. This review has supported the development of the 2019-2022 Strategy to Tackle and Prevent Child Exploitation. Under this strategy the partnership has worked to ensure the child is seen first, before their behaviours in all forms of exploitation; that we consider the context that the child lives in and recognise the harm that can come from outside of the family. The strategy focuses on Child Sexual Exploitation, Child Criminal Exploitation, Radicalisation, Modern slavery and trafficking, Honour based Violence and Forced Marriage, and Female Genital Mutilation.

## 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.***

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 2018/19**

- Strategy Meetings
- Sexual Abuse in the family
- Child Sexual Exploitation
- Female Genital Mutilation

The findings from multi-agency audits are developed into improvement action plans for the partnership and are monitored through the Learning and Development Delivery Group. Some re-auditing is scheduled to measure the impact of improvements to practice and outcomes for children.

**Multi-Agency Audit: Strategy Meetings**

**What's working well**

- Agency participation in Strategy Meetings was mostly good
- Timescales for holding the meeting were met in the majority of cases
- The thresholds for risk of significant harm were applied consistently
- Legal action appropriately sought where this was needed
- Information sharing was good (except with GPs)

**What are we worried about**

- GPs were not invited to share information or participate
- Some Strat Meetings were out of timescales
- Action plans were not focused and lacked a contingency
- Meetings were not specific about sharing information with parents

Feedback has been reported to the partnership and this area of practice is to be re audited in summer 2019.

**Audit: Female Genital Mutilation (FGM)**

**What's working well**

- The contact/referral was proportionate to the risks known in 100% of the cases.
- Referrals are being made from a variety of organisations showing good awareness of this aspect of safeguarding.
- The cases that were progressed to strategy meeting and/or social care assessment from MASH were all appropriate
- Where an emergency application has been made for an FGM Protection Order, the Court statement from the local authority is excellent and identifies research, physical and psychological implications.
- New practice within TRFT means that 0-19 practitioners are conducting risk assessments when FGM is identified for mother.

**What are we worried about**

- Some referrals often lack detail which does not support MASH screening and assessment
- Children's specific ethnicity, nationality, language spoken is not routinely being clearly sought to assist with the assessment.
- Within the cases audited, there is limited exploration of the influence of wider family members or community.
- Children are often not being seen following contact/referrals about FGM and

**Multi-Agency Audit - Child Sexual Exploitation**

**What is working well**

- There is some good multi-agency working in relation to information sharing, strategy meetings, assessments and planning for the child.
- There is generally a prompt response to safeguarding concerns, and the CSE screening tool has been used in 100% of the cases audited and completed within a multi-agency setting.
- There is a good offer and take-up of support from the lead CSE nurse; the service is accessible, child-led and has a good rate of engagement.
- There is evidence of positive, child-centred direct work being completed, led by practitioners in the Evolve service.
- Children are referred to a wide range of statutory and voluntary services, according to their needs.

**What are we worried about**

- GP's are routinely not invited to be involved in any safeguarding responses to CSE cases; in some cases minimal information has been provided to GP's.
- In over half of the cases audited, there was a delay of 4 weeks or more for the partnership to utilise the CSE screening tool.
- There is also some concern about the value-base and purpose of the screening tool – this includes the perceived specialist nature of the tool, requiring an Evolve Social Worker to take the lead on completing this.
- Within the cases, there is limited information about how children and young people are given the opportunity to provide feedback on the services they have received.

## 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 and implemented from June 2 019.

## 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 2018 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 h*ad 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 voluntary sector self-assessment tool was reviewed in consultation with the members of the Children, Young People and Families Consortium and a revised version was launched during 2018/19.

## Schools – Safeguarding Self-Assessment (Section 175)

Schools are expected to complete the S175 on-line safeguarding self-assessment. 128 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

March 2019 is that 80 schools/education settings that have completed 90-100% of the self-assessment with a further 39 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 educations sector and the LSCB. In 2018 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.

## 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 (AR17) was undertaken and the report was signed-off at an extraordinary meeting of the RLSCB on the 07/06/2018. 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. 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 key learning points from this review which have now been implemented include:

- Over-reliance on medical evidence when assessing risks to the chid.
- 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.

A further serious child safeguarding incident was notified to the LSCB in February 2019 and the decision was to commission a serious case review; the serious case review will be concluded by October 2019.

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.

Child B is a teenage boy who lived with an elderly relative for a number of years because his mother could not care for him. There were a number of concerns that Child B was the carer for his elderly relative and this meant that his own needs were not being met. He returned to live with his mother and he became neglected and was not attending school.

**Missed opportunities?**

All professionals involved with the case were invited to review the case and a number of missed opportunities were identified:

- Delay in addressing child B's Health needs
- A delay in assessing the neglect issues for Child B
- Agencies not being informed at the point at which he returned to live with his mother
- Consideration of extended family as potential carers for him..
- There was no contingency plan for when his elderly relative could no longer care for him.

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 years 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.**

**A comprehensive child death overview panel - annual report for 2018-19 is available here**

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 2018-19**

During 2018-19 CDOP met on two occasions, with a total of 10 deaths being reviewed to completion (other cases came to panel, but with actions or information still outstanding at the end of the year). CDOP would normally expect to meet more frequently than this, but sets the number of meetings to match the number of cases in the pipeline that are ready to come to panel (i.e. there is sufficient information for a well-informed review and there are no essential outstanding items).

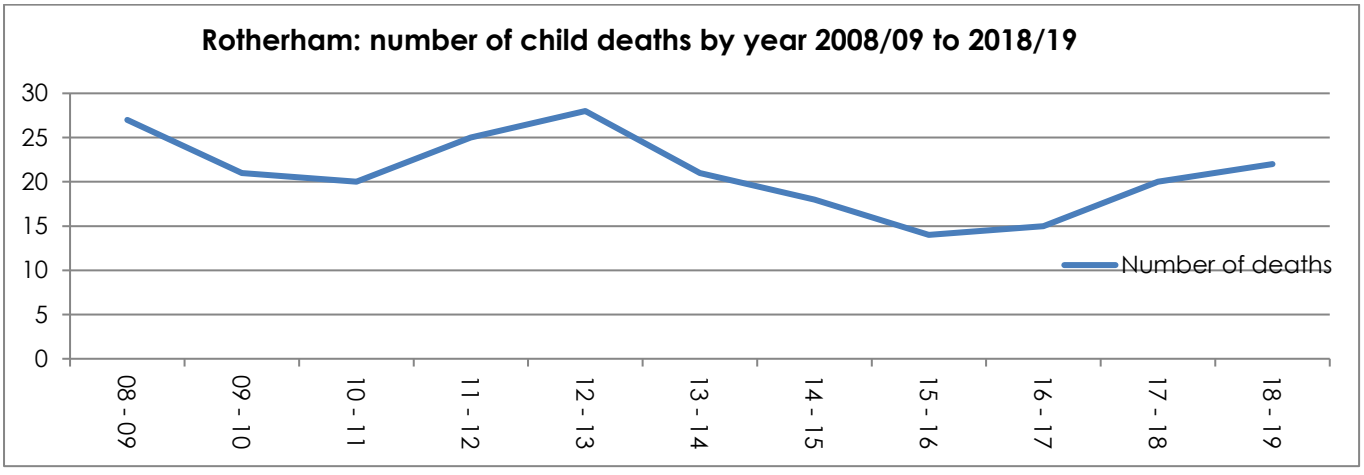
**Child Death Reviews since 2008**

Over the life of the panel, on average about 18 cases are reviewed per year. Since 2008, the Panel has reviewed a total of 194 cases, with each case taking an average of just over 12 months to come to panel. This should be considered alongside the new guidance for child death reviews, which, whilst not stipulating a required review timeframe, does envisage the majority of cases being reviewed by CDOP within six weeks of receiving the report from the child death review meeting, which itself should ideally happen within three months of a child death occurring.

**Modifiability**

Of the ten cases reviewed during the year 2018-19, two were regarded by the panel as being modifiable - i.e. there were factors that may have contributed to the death or increased the risk of death, which could potentially have been altered in a way that might have reduced the risk or even led to a different outcome.

It is rarely straightforward for the panel to make a decision about modifiability, and there is some variability evident over the years in the propensity to view a death as modifiable. Over the life of the panel, out of 194 cases reviewed, 35 were regarded as modifiable deaths by the panel. The proportions for each year are shown below.



A large proportion of child deaths occur in the neonatal period (the first 28 days of life). Of the 231 child deaths in Rotherham since CDOP began in 2008, 105 have been aged 28 days or less at death, of which 72 were perinatal deaths (i.e. they died in the first week of life). 52 non-neonatal deaths were within the first year of life; 18 were aged between 1 and 5 years; 56 were aged 5 and over.

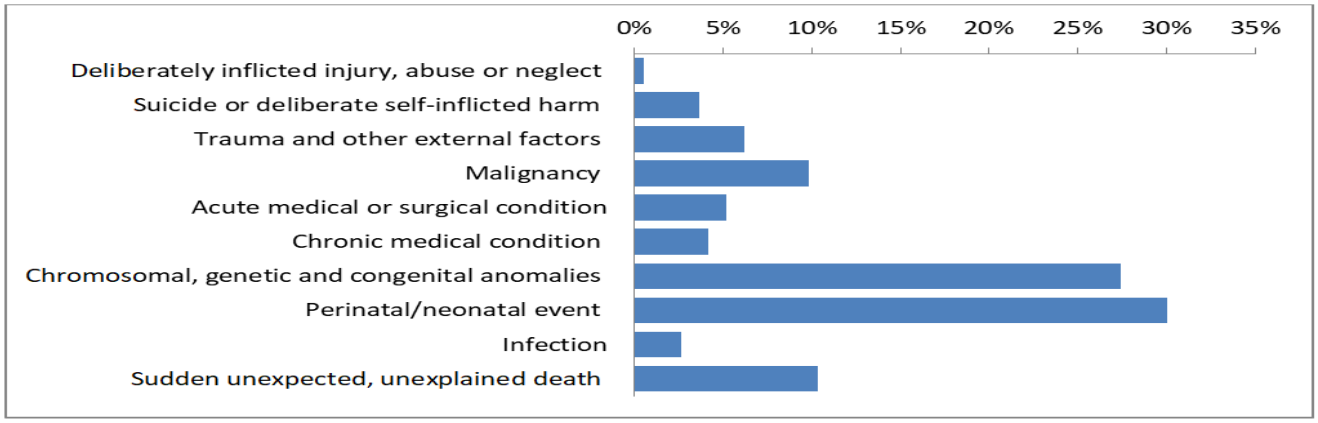
A large proportion of child deaths occurred to children with postcodes within the most deprived lower super output areas (LSOAs). 44% of 223 matched postcodes were within the most deprived quintile of LSOAs in England. This exceeds the proportion that might be expected from the profile of the general Rotherham population, 31.5% of whom live within such deprived locations. This suggests that living in high levels of deprivation in Rotherham confers a greater risk of infant mortality. This is an example of health inequality that has been observed more generally across the UK (Weightman, Morgan, Shepherd, Kitcher, Roberts, & Dunstan, 2012)

| Year | Number of cases reviewed | Number regarded as modifiable | Proportion modifiable |
|---|---|---|---|
| 08 - 09 | 12 | 4 | 33% |
| 09 - 10 | 21 | 3 | 14% |
| 10 - 11 | 21 | 7 | 33% |
| 11 - 12 | 18 | 2 | 11% |
| 12 - 13 | 22 | 4 | 18% |
| 13 - 14 | 19 | 1 | 5% |
| 14 - 15 | 29 | 2 | 7% |
| 15 - 16 | 7 | 1 | 14% |
| 16 - 17 | 24 | 8 | 33% |
| 17 - 18 | 11 | 1 | 9% |
| 18 - 19 | 10 | 2 | 20% |
| **Grand Total** | **194** | **35** | **18%** |

* 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.

**Category of death**

The panel assigns a category to each death that it thinks most usefully summarises the main cause. There are ten such categories, with "chromosomal, genetic and congenital anomalies" and "perinatal/neonatal event" being the most frequently chosen. The categories are shown below, along with the proportions assigned by the panel over its eleven years of reviewing cases:




## 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.

## Future changes to Child Death Review Arrangements

Following the Children and Social Work Act (2017), new statutory guidance was published in 2018 - Working together to safeguard children 2018 (replacing the 2015 guidance) – along with more specific further statutory and operational guidance for Child Death Reviews.

Some of the key changes to the child death review processes arising from this new guidance are set out below:

### Governance

Changes in responsibility for the child death review process from Local Safeguarding Children Boards to local CDR (Child Death Review) partners, which are the local authorities and clinical commissioning groups (CCGs) within the relevant geographical footprint. From Rotherham's point of view, however, governance is likely still to fall within the remit of the new child safeguarding arrangements.

### Minimum footprint

The new guidance indicates that CDR partners should represent a geographical footprint that will enable the review a minimum of 60 deaths each year. Whilst Rotherham's CDOP only reviews around 20-30 child deaths each year, the footprint will remain unchanged, as it mirrors the local patient flows and agency responsibilities that best enable data collection and review. In order for thematic learning to take place across a larger footprint, a sub-regional thematic panel will meet on a less frequent basis to consider review findings from the four South Yorkshire CDOPs.

### Joint Agency Response

The requirement to perform a Joint Agency Response, resources will need to be identified to coordinate a new multi-agency response (on-call health professional, police investigator, duty

social worker), if a child's death: is or could be due to external causes; is sudden and there is no immediately apparent cause (including SUDI/C); occurs in custody, or where the child was detained under the Mental Health Act; where the initial circumstances raise any suspicions that the death may not have been natural; or in the case of a stillbirth where no healthcare professional was in attendance.

## Child Death Review Meetings

Establishment of local multi-agency Child Death Review Meetings (CDRM). A resource will need to be identified to co-ordinate new local multi-agency meetings, and relevant professionals may need additional time in order to attend or feed into CDRMs.

## Future role and responsibilities

A number of new or enhanced roles in the CDR process are identified, including:

- The establishment of a 'key worker' role to act as a single point of contact with the bereaved family for the duration of the death review process. Some additional resource is likely to be needed to be identified to fulfil this function – it may need to be included in relevant job plans. In addition to the key worker, an appropriate 'medical lead' (i.e. consultant neonatologist or paediatrician) should also be identified after every child's death to support the family, and to liaise with the key worker.
- In the case that a Joint Agency Response is needed, a lead health professional should be assigned, in order to co-ordinate health responses and liaise with police and other agencies. The lead health professional will be also be responsible for organising and chairing the CDRM.
- Child Death Review partners should appoint a Designated doctor for child deaths to be responsible for the child death review process, to work closely in an advisory and co-ordinating capacity with the CDOP Administrator and the Chair of CDOP, and to work with the Chair in preparing an annual report of CDOP activities.

## Child Death Overview Panels

CDOP panels are expected to include representation from: public health; the Designated doctor for child deaths (and a hospital clinician if the Designated doctor is a community doctor or vice versa); social services; police; safeguarding; primary care; nursing and/or midwifery; lay representation; other professionals on the merits of the cases being considered.

The Child Death Overview Panel will continue to prepare an annual report for the Child Death Review Partners.

### Timeline for implementation of changes

The key dates for the new requirements are:

**29th June 2019** – All Child Death Review Partners in England must publish their plans to meet the new requirements and send these plans to NHS England at England.cypalignment@nhs.net.

**29th September 2019** – All Child Death Review Partners in England must complete the transition to the new arrangements. After this date they must be compliant with the new statutory requirements.

The new Child Death review arrangements in Rotherham are scheduled to meet these statutory timeline for implementation.

## Learning and Improvement

***The Learning and Improvement Delivery 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 2018-19 the LSCB website was reviewed and updated for all audiences including, Professional and Volunteers, Children and Young People, Parents and Carers. The Youth Cabinet had provided some excellent feedback about the website and this has influenced its development. 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 throughout 2018-19 from the previous year.

## Safeguarding Children Training and Awareness

**Partnership Safeguarding Newsletter:** In 2018 the LSCB launched its 'digital newsletter' and now has over 1000 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.

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 2018-19 1028 E-Learned courses were completed by professionals and volunteers across the partnership in Rotherham.

Free E-Learning courses on offer:

- 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 2018/19 the LSCB provided 20 different themed training courses and 1,410 professionals and volunteers 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 Safeguarding 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

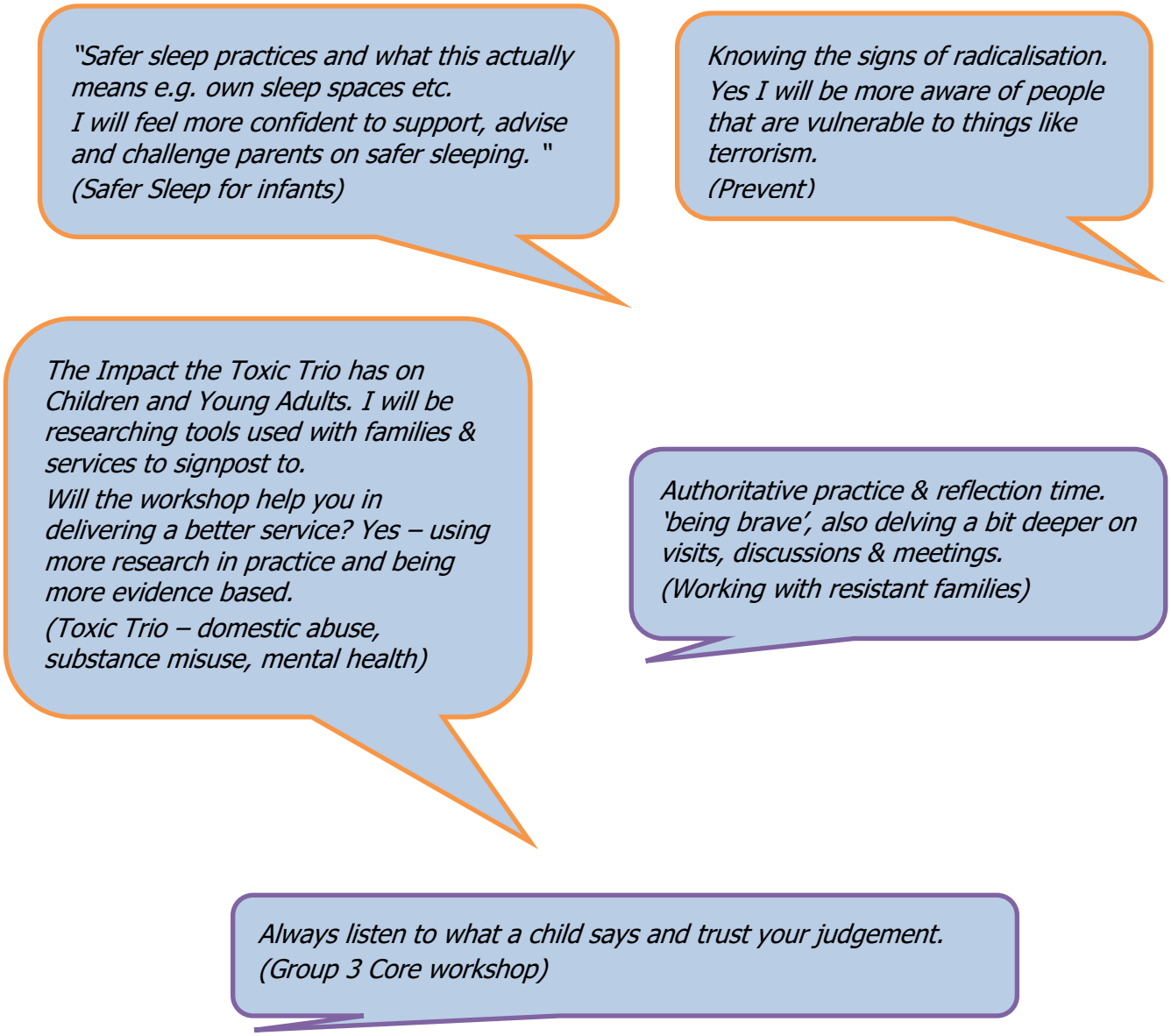
Safer Recruitment (evening)

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:

**Key Messages taken from training:**




**Safeguarding Children Procedures**

***These are the multi-agency procedures, processes and guidance that professionals working in Rotherham 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 2018/19 there were two updates to the online multi-agency safeguarding children procedures which included new or updates to existing safeguarding procedures:

- Children Affected by Gang Activity and Youth Violence
- Practice Guidance: Significant Harm – The Impact of Abuse and Neglect
- Female Genital Mutilation Risk and Safeguarding guidance for Professionals
- NHS CP-IS (Child Protection Information Sharing) system
- Updated Information Sharing Guidance as a result of Working Together 2018 and to reflect the General Data Protection Regulation (GDPR) and Data Protection Act 2018.
- Children of parents with learning difficulties
- Children from Abroad, including Victims of Modern Slavery, Trafficking and Exploitation
- Protocol on the handling of 'so-called' Honour Based Violence/Abuse and Forced Marriage Offences between the National Police Chiefs' Council and the Crown Prosecution Service
- A guide to Eligibility for Criminal Records Checks
- Definitions and Signs of Child Abuse – NSPCC updated fact sheet
- Updated whistleblowing at work guidance

Work has commenced on the safeguarding procedures update which will go live in December 2019. The Learning and Improvement Delivery Group have given priority to updates to safeguarding procedures which needed to incorporate Signs of Safety methodology and any changes required from serious case reviews or 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 or care for 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;

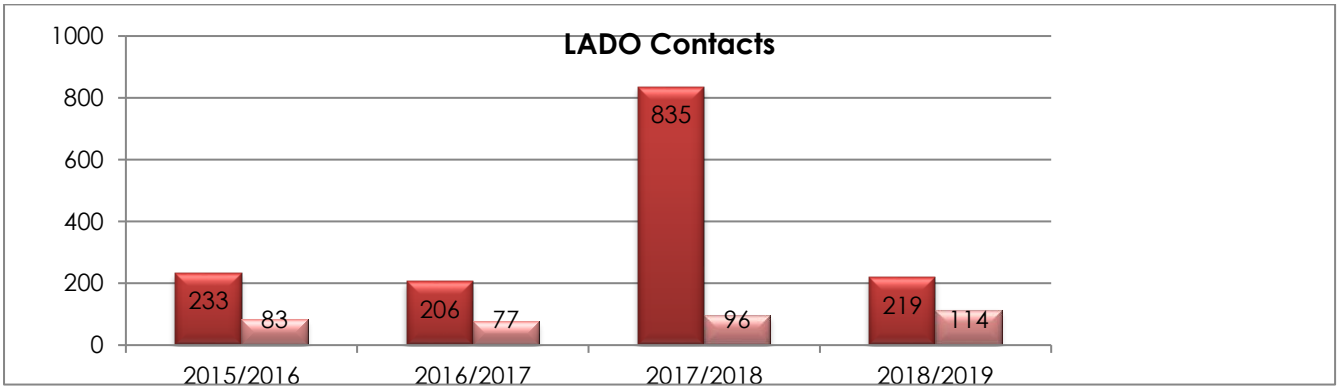
- manage and oversee individual cases from the commencement of the process through to conclusion and outcome.

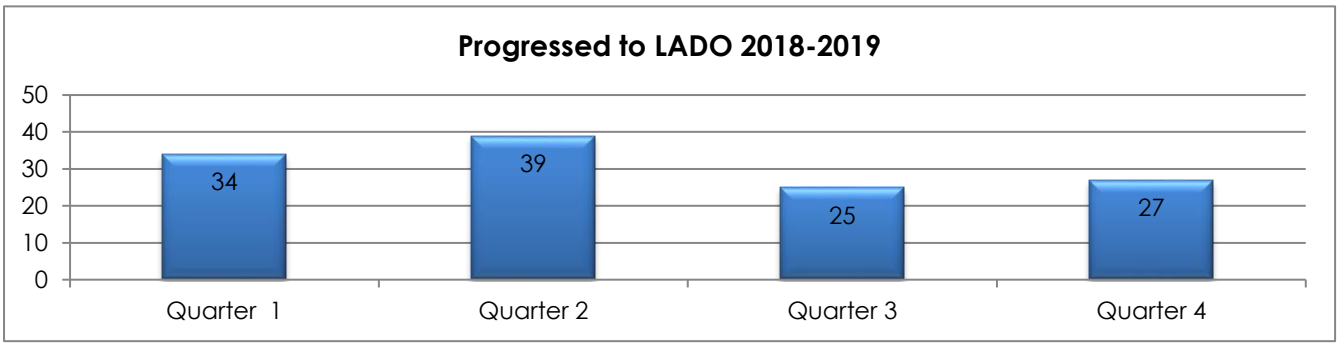
The LADO will become involved where there is reasonable suspicion that a person who works with children (whether paid or unpaid) has behaved in such a way as to:

- 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.

**Number of LADO contacts and enquires**

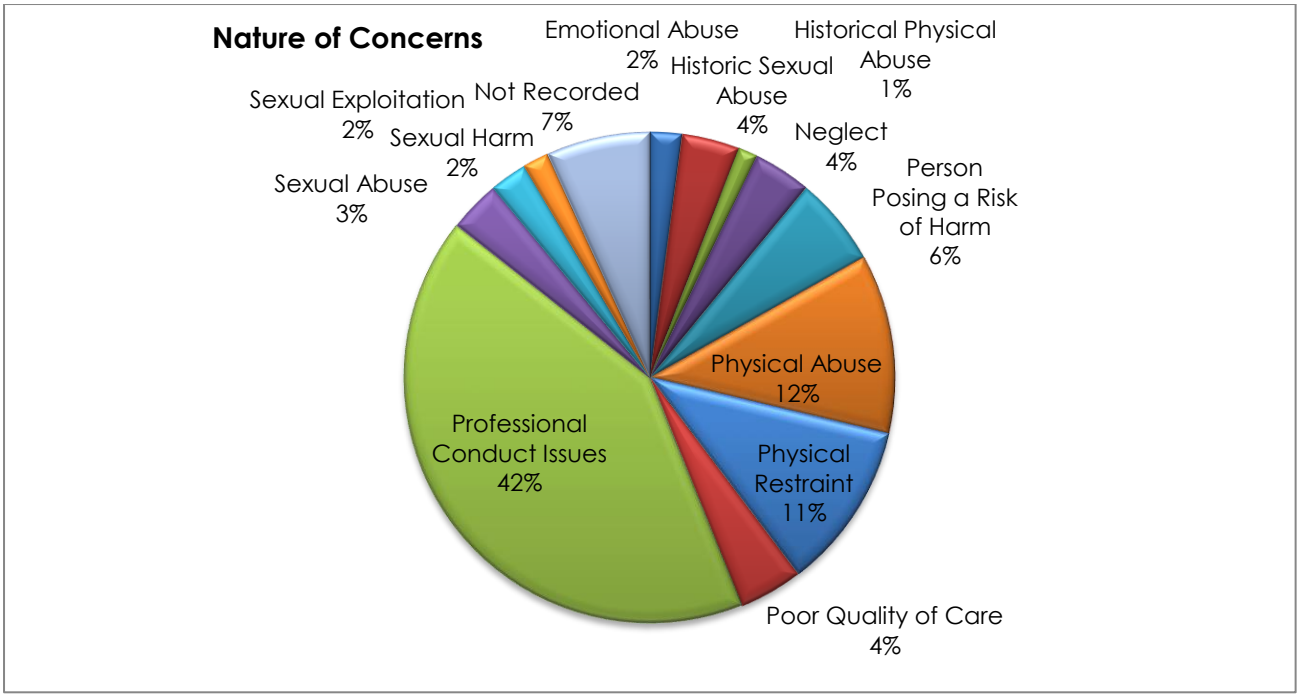
Over the last four years the annual figures for LADO have remained relatively stable. Last year 2017-2018 there was an anomaly in LADO contacts, due to the transition to the generic computer system LiquidLogic Care System (LCS). It is evident that now the new recording system is embedded the data demonstrates that the figures for 2017-18 were incorrect and was identified and reported on last year.



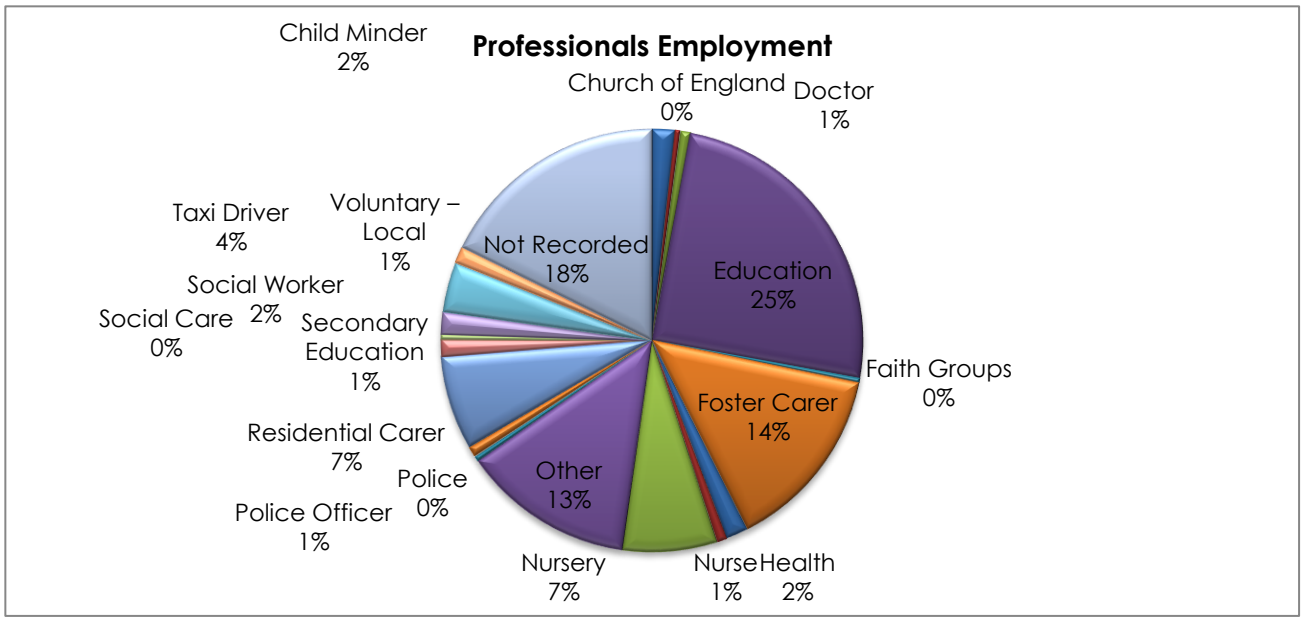




There has been work undertaken to raise internal awareness within RMBC and across the partnership of LADO supporting a hypnosis that professionals are more aware of LADO and their responsibilities within safeguarding, resulting in a higher proportion of LADO contacts.

Out of the 114 contacts that progressed to LADO, the nature of concerns is separated into categories of harm.

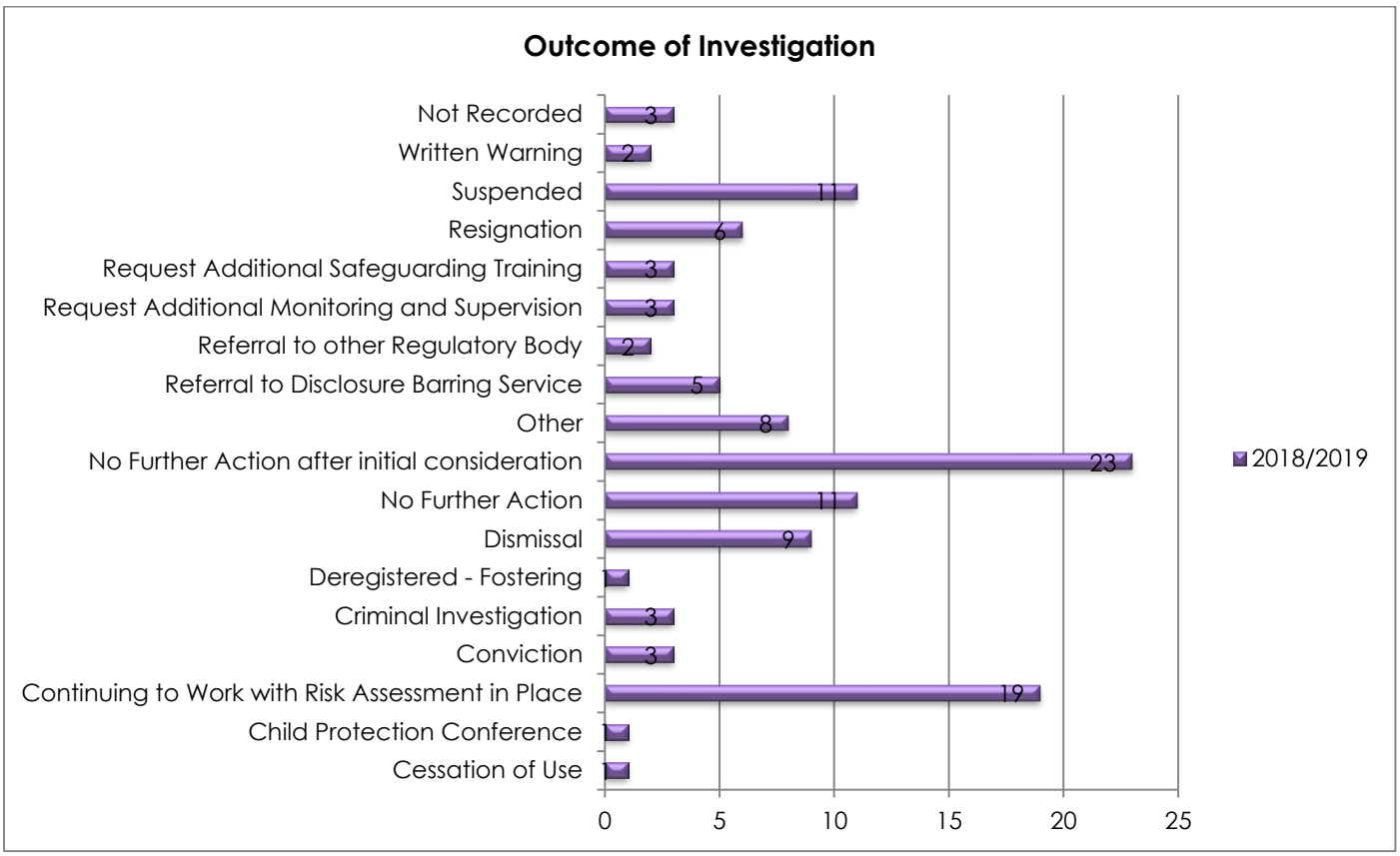



There continues to be a high number of professional conduct issues which result in investigations that are overseen by LADO. The concerns around sexual abuse remain low as do emotional abuse. Physical abuse through restraints and injury remain high. In breaking down the nature of concern into professionals, our highest considered professionals are education staff and foster carers, this is not unusual, what we know is these professionals will have the most contact with children and young people and in terms of physical restraints and altercations are more likely due to the high level of care and supervision they are providing.




LADO contacts cover a wide range of professionals over the children's workforce; in 2018/2019 the majority of professionals where LADO allegations were made covered secondary education and Local Authority Foster Carers. The Local Authority are working with current and new foster

carers to support them in understanding the role of LADO and how this impacts on them as carers for Rotherham children in care.




The figures for 2018/2019 demonstrate that out of the 114 contacts that progressed to a LADO investigation a significant amount continued within employment via a risk assessment, further safeguarding training or with a written warning.

**What's working well?**

- The referrals that are progressed to LADO are appropriate and in the main meet threshold.
- The referral process through the MASH continues to work well and the allegations workspace is now being used consistently by all Conference Chairs.
- The performance scoresheet has provided a detailed overview of LADO contacts, progressions to LADO, categories of abuse and the outcomes; this provides for detailed analysis and monitoring.
- LADO leads have developed a training package for Social Care Staff and partner agencies within the LSCB prospectus and positive work is taking place with the fostering service.

**What are we worried about?**

The timeliness of the progression of contacts is impacted on when further screening is required to ascertain the details of the concerns and whether a LADO is required. The timeliness of the

decision making should improve even more with the plan to use the two separate codes to differentiate between contacts that need further screening and advice.

We are mindful of the impact of LADO on our foster carers and recognise that the LADO process can impact on foster carers trust in the service. Planned work with the fostering service to both speed up the process and develop some transparency for foster carers around LADO is taking place.

This process needs to be understood by all professionals in the multi-agency network which is still not embedded and training is planned.

The visibility of LADO requires strengthening especially in Health, Police (referrals made in relation to Police) and voluntary agencies

Managing allegations of alleged perpetrator / owner and proprietor of the company: These 'one person' setups have no regulation or governance around them and rely on parents to be vigilant and safeguard their children.

**What needs to happen?**

The timeliness of LADO needs to be continually reviewed to ensure allegations are addressed immediately without unnecessary delay.

A session with DBS is to be arranged to discuss, how LADO information is shared and used

An information leaflet for professionals to support them in understanding the LADO process is too be developed further.

The use of Signs of Safety is to be developed within LADO, we will be exploring transparency in the LADO process.

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.

# 8 Conclusion and Strategic Priorities for 2019 - 21

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.

Of paramount importance to the effective safeguarding of children is for professionals to keep a clear focus on the child and what life is like from the child's perspective. Professionals must be constantly curious about children's lives, noticing and asking questions about their behaviour and must be strongly self- reflective about their assessments of children and their families. They must challenge one another in multi-agency meetings to ensure that robust decisions are being made and be tenacious in ensuring that good safeguarding decisions are made. We will look for evidence of these professional behaviours in our audit activity and case reviews.

The new business plan for the new Rotherham Safeguarding Children Partnership builds on the work of the previous Safeguarding Children Board and its intention is to strengthen further the multi-agency work across the borough to keep children safe.

There are three key themes to our priorities for the next two years:

- Safe at Home
- Safe in the Community
- Safe Safeguarding Systems

## Safe at Home

The majority of children who need help and support are suffering from some form of neglect. This may be because parents do not understand how to meet their child's needs or because their ability to do so is impaired as a consequence of substance or alcohol abuse, mental health needs or domestic abuse. Our aim through the Rotherham neglect strategy to help professionals to spot the early signs of neglect and to intervene as early as possible with the right level of support to improve outcomes for children.

We will continue our focus on the safety and well-being of children who are looked after by the local authority, seeking assurance that there are sufficient quality places for children in or near Rotherham and that their needs, including their health needs are assessed and met in a timely fashion.

## Safe in the Community

We continue to give priority to child sexual exploitation to maintain the significant progress made across the partnership and to further improve practice. We are now integrating our work on CSE with other forms of exploitation through the Child Exploitation Strategy and will take account of the recent research on contextual safeguarding.

The partnership will also consider the implications of the research on the impact of adverse childhood experiences on children's development and well-being and agree actions to ensure that services for children are informed by this.

## Safe Safeguarding Systems

The partnership will deliver a programme of audit and workforce development tied to the priorities we have established. A new safeguarding self- assessment across adults and children's services will be introduced and the evidence in these self-audits will be tested through multi-agency challenge. We will also examine the findings from audits undertaken within agencies and undertake a programme of multi-agency audit to measure the effectiveness of practice.

# 9 Appendices

## Appendix 1 – Board Member attendance 2018-19

| Attendance at RLSCB 2018-19 | Apr (Dev. Day) | June | Sept | Dec | Mar | % Attendance |
|---|---|---|---|---|---|---|
| Independent Chair | ✓ | ✓ | ✓ | ✓ | ✓ | 100% |
| **Statutory members** | | | | | | |
| Adult services, RMBC | Apols | Apols | D | D | D | 60% |
| CAFCASS | Apols | Apols | Apols | Apols | ✓ | 20% |
| Rotherham CCG | ✓ | ✓ | ✓ | ✓ | ✓ | 100% |
| Councillor – Cabinet Member, CYPS | Apols | Apols | Apols | Apols | Apols | 0% |
| CYPS consortium | ✓ | Apols | D | ✓ | ✓ | 80% |
| CYPS, RMBC | ✓ | D | ✓ | ✓ | ✓ | 100% |
| Housing, RMBC | D | Apols | D | Apols | D | 60% |
| Lay members | ✓ | ✓ | - | - | - | 100% |
| National Probation service | Apols | ✓ | ✓ | Apols | Apols | 40% |
| NHS England | D | ✓ | Represented by CCG | | | 100% |
| Public Health, RMBC | ✓ | ✓ | Apols | D | ✓ | 80% |
| Rotherham Doncaster & South Humber NHS Foundation Trust | ✓ | ✓ | ✓ | ✓ | ✓ | 100% |
| Schools & colleges | ✓ | Apols | ✓ | Apols | Apols | 40% |
| SY Community Rehabilitation Company | D | D | D | D | ✓ | 100% |
| SY Fire & Rescue | Apols | ✓ | Apols | ✓ | Apols | 40% |
| SY Police | ✓ | ✓ | ✓ | D | D | 100% |
| Rotherham NHS Foundation Trust | ✓ | ✓ | ✓ | ✓ | D | 100% |
| Youth Offending Service, RMBC | ✓ | ✓ | ✓ | Apols | Apols | 60% |
| **Professional Advisors to the Board** | | | | | | |
| LSCB Business Manager | ✓ | ✓ | ✓ | ✓ | ✓ | 100% |
| Head of Service, CYPS, RMBC | ✓ | ✓ | ✓ | ✓ | ✓ | 100% |
| Designated Nurse, CCG | ✓ | ✓ | D | ✓ | ✓ | 100% |
| Legal Services, RMBC | Apols | Apols | - | - | - | 0% |
| Comms. Team, RMBC | Apols | Apols | Apols | Apols | Apols | 0% |

| 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 2018-19

| Budget Statement 2018/19 Outturn | Funding Formula | Budget 2018/19 | Outturn 2018/19 |
|---|---|---|---|
| | % | £ | £ |
| Income | | | |
| Annual Contributions | | | |
| Rotherham MBC | 50% | 163,432 | 163,432 |
| Rotherham CCG | 23% | 75,315 | 75,315 |
| South Yorkshire Police & Crime Commissioner | 14% | 44,475 | 44,475 |
| National Probation Service | <1% | 1,077 | 1,077 |
| CAFCASS | <1% | 550 | 550 |
| | | | |
| Rotherham CCG - L&D contribution | 6% | 22,000 | 22,000 |
| Rotherham MBC - L&D contribution | 6% | 22,000 | 22,000 |
| Total Income | | **328,848** | **328,848** |
| | | | |
| Expenditure | | | |
| LSCB Salaries & Staff Costs | | 237,320 | 240,681 |
| Public Liability Insurance | | 1,600 | 1,402 |
| Stationery and Copying | | 2, 650 | 1,645 |
| Computer Software and Maintenance | | 15,000 | 17,423 |
| Learning & Development | | 21,000 | 15,165 |
| Independent Chair & Other Independent Consultants | | 47,000 | 49,224 |
| Memberships & Conferences | | 2,500 | 600 |
| Hospitality & Catering | | 478 | 1,028 |
| Phone | | 1,300 | 1,396 |
| | | | |
| **Total Expenditure** | | **328,848** | **328,564** |
| | | | |
| **Underspend** | | | **£284** |

## Appendix 3: Contact details

### Rotherham LSCB

**Independent Chair: Christine Cassell**

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

**Emails to:** CYPS-SafeguardingBoard@rotherham.gov.uk