

Public Agenda

Title of Meeting:	Rotherham Place Board: Partnership Business
Time of Meeting:	9.30am – 10.30am
Date of Meeting:	Wednesday 21 May 2025
Venue:	John Smith Room, Town Hall, Rotherham
Chair:	Chris Edwards
Contact for Meeting:	Lydia George: lydia.george@nhs.net Wendy Commons: wcommons@nhs.net

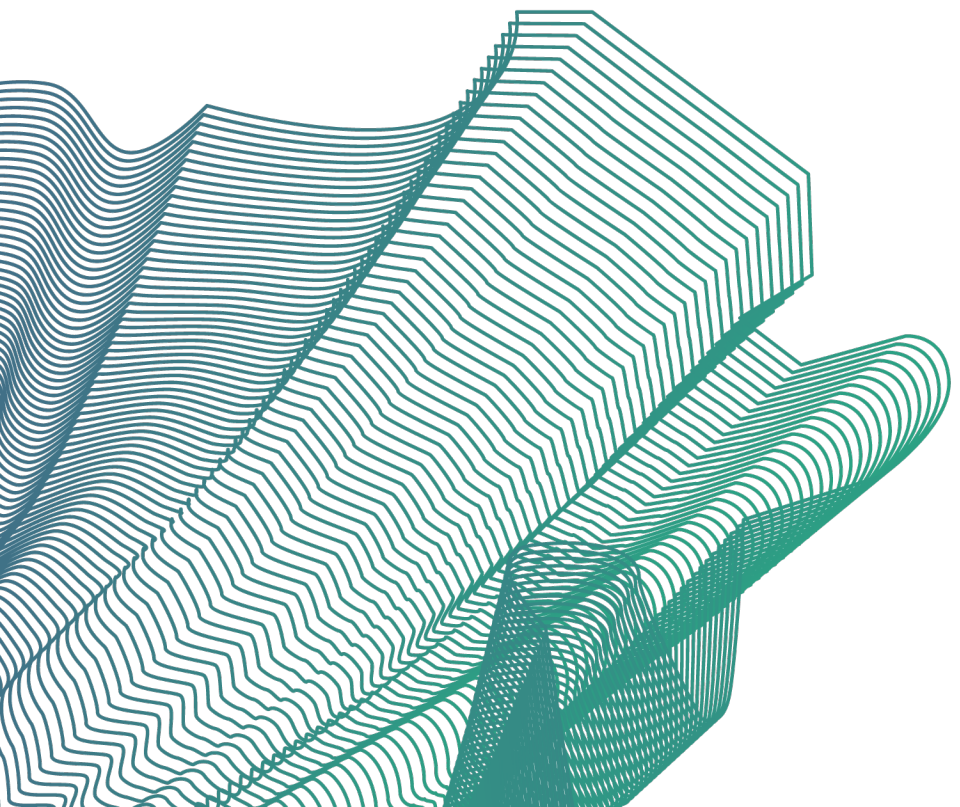
Apologies:	R. Jenkins, Chief Executive, The Rotherham NHS Foundation Trust
Conflicts of Interest:	
Quoracy:	No Partnership Business shall be transacted unless the following are present as a minimum: a) one Member from each of the ICB and RMBC; and b) two Members from any of the following Partners: TRFT, VAR, RDASH or RPCLG

Item		Time	Pres By	Encs
1	Public & Patient Questions: <i>The Chair will take questions in writing prior to meetings and will try to respond during the meeting. However, there may be occasions when a response has to be issued in writing afterwards. This being the case, responses will be published as an item for information at the next meeting.</i>		Chair	Verbal
Business Items				
2	Urgent, Emergency and Community Care Update	10 mins	Steph Watt	Enc 2
3	Rotherham Communications Update	10 mins	Gordon Laidlaw	Enc 3
4	Mental Health Pathway Update – <i>for information</i>	5 mins	Ian Spicer	Enc 4i & 4ii
5	Update from the Director of Public Health	10 mins	Alex Hawley	Verbal
6	Rotherham Place Plan Performance Report Quarter 4	5 mins	Claire Smith	Enc 6
7	Rotherham Place Partnership Update – <i>for information</i>	-	Claire Smith	Enc 7
8	Healthwatch Report: Quarter 4 – <i>for information</i>	-	Kym Gleeson	Enc 8
Standard Items				
9	Communication to Partners/ Promoting Events & Consultations	5 mins	Chair	Verbal
10	Draft Minutes and Action Log from Public Place Board from 16 April 2025 – <i>for approval</i>	5 mins	Chair	Enc 10i & 10ii
11	Risks and Items for escalation to appropriate board (<i>e.g. Health & Wellbeing Board, ICB Board</i>)		Chair	Verbal
12	June Agenda Items: Standing Items: <ul style="list-style-type: none"> • Updates from all Groups (as scheduled) • Achievements (as and when received) • Feedback from SY ICP Meeting – Bi-Monthly • Bi-Monthly Place Partnership Update 			Verbal
13	Date of Next Meeting: Wednesday 18 June 2025 at 9.30am –10.30am – John Smith Room, Rotherham Town Hall			

GLOSSARY

A&E	Accident and Emergency
BAME	Black Asian and Minority Ethnic
BCF	Better Care Fund
C&YP	Children and Young People
CAMHS	Child and Adolescent Mental Health Services
CHC	Continuing Health Care
COI	Conflict of Interest
CQC	Care Quality Commission
DES	Direct Enhanced Service
DTOC	Delayed Transfer of Care
EOLC	End of Life Care
FOI	Freedom of Information
H&WB	Health and Wellbeing
IAPT	Improving Access to Psychological Therapies
ICB	Integrated Care Board
ICP	Integrated Care Partnership
ICS	Integrated Care System
IDT	Integrated Discharge Team
JFP	Joint Forward Plan
JSNA	Joint Strategic Needs Assessment
KPI	Key Performance Indicator
KLOE	Key Lines of Enquiry
LAC	Looked After Children
LeDeR	Learning Disability Mortality Review
LES	Local Enhanced Service
LIS	Local Incentive Scheme
LOS	Length of Stay
LTC	Long Term Conditions
MMC	Medicines Management Committee
MOU	Memorandum of Understanding
NHS LTP	NHS Long Term Plan
NHSE	NHS England
NICE	National Institute for Health and Care Excellence
OD	Organisational Development
OOA	Out of Area
PCN	Primary Care Network
PTS	Patient Transport Services
QIA	Quality Impact Assessment
QIPP	Quality, Innovation, Productivity and Performance
QOF	Quality Outcomes Framework
RDaSH	Rotherham Doncaster and South Humber NHS Foundation Trust
RHR	Rotherham Health Record
RLSCB	Rotherham Local Safeguarding Childrens Board
RMBC	Rotherham Metropolitan Borough Council
RPCCG	Rotherham Primary Care Collaborative Group
RTT	Referral to Treatment
SATOD	Smoking at Time of Delivery
SEND	Special Educational Needs and Disabilities
SIRO	Senior Information Risk Officer
TRFT	The Rotherham NHS Foundation Trust
UECC	Urgent and Emergency Care Centre
VAR	Voluntary Action Rotherham
VCS	Voluntary and Community Sector
VCSE	Voluntary, Community and Social Enterprise sector
YAS	Yorkshire Ambulance Service

Urgent and Emergency Care



South Yorkshire
Integrated Care Board

**Rotherham, Doncaster
and South Humber**
NHS Foundation Trust

The Rotherham
NHS Foundation Trust

Rotherham 
Metropolitan
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What's working well

Alternative pathways to ED and Front Door Activity

- Primary care led a proof-of-concept proactive care model between December 2024 – March 2025 with the aim of enhancing quality of life for the frail and reducing unplanned admissions/attendances. PCNs risk stratified patients based on frailty scores and risk of admission and conducted an MDT review working across physical and mental health, social care and the VCS. A consultant community geriatrician trialled a high acuity pathway for those potentially in the last year of life, conducting a comprehensive geriatric assessment (CGA). Initial evaluation is positive with 288 patients having undergone an MDT, 576 patients having their care optimised and 100 patients receiving a CGA. 88% of Primary Care colleagues felt that patient/care experience will improve through this programme which is demonstrated through a 37% reduction in hospital admissions for patients on the high acuity pathway, when compared to a control group. Ongoing evaluation will allow the benefits to be fully assessed.
- Virtual ward has been nationally recognised as an area of good practice. 2817 admissions to the virtual ward between April 2024- March 2025, equivalent to nearly 8 admissions per day. Based on average LoS of 8 days, this has saved in the region of 22,536 acute bed days across the year.
- Virtual Ward now has a frailty, respiratory and heart failure pathway and has supported 65 % step up/admission avoidance and 35 % step down/discharge between April 2024- March 2025
- PUSH pathways have been implemented to provide alternative responses to ambulance conveyances, reducing wait times for patients and the risk of harm. PUSH pathways have seen 258 accepted referrals 1/04/23-29/1/24 and 573 accepted referrals, 1/04/24- 31/04/25, representing a 122% increase.

What's working well

Alternative pathways to ED and Front Door Activity cont...

- Urgent community response (UCR) has exceeded the 70% national standard of responding within 2 hours since go-live in April 2022. UCR is aimed at people who are at risk of hospital admission, providing care in their own home which improves patient outcomes, reduces risk and reduces pressures on acute beds.
- A&E wait times below 78% target for 24/25 but improved on 23/24 position. This needs to be considered in the context of unprecedented demand throughout winter – regularly seeing 300+ attendances per day which has masked some of the service improvements made
- TRFT performs well for type 1 attendances when compared nationally. For week ending 01/04/25 TRFT ranked 24/126 for type 1 performance vs 80/126 for all performance
- A mobile Xray pilot has been developed to be implemented in Q1 2025/26 which will enable radiographers to take x-rays in people's homes (according to level of risk) to improve the patient experience and reduce avoidable conveyances. This is ground-breaking as there are very few other areas currently doing this.
- Additional investment has been provided for enablement and spot purchase community beds.
- TRFT, YAS and Place partners are working together to reduce avoidable conveyances and identify new ways of working, including Project Chronos.
- SYICB has the best cat 2 response times of all Y&H ICBs and Rotherham performs well for handovers when compared across the wider ICB – broadly in line with Barnsley and 7-10 mins quicker than Doncaster and Sheffield

What's working well

Discharge

- TRFT's community base at Woodside has been adapted to expand the Transfer of Care referral and triage hub to reduce avoidable conveyances and admissions and to support timely discharge. This multi-disciplinary team includes a call centre, Yorkshire Ambulance Service, the integrated discharge team, urgent community nurses and therapists, reablement, social workers and the voluntary and community sector.
- A therapy D2A model is embedded with 758 assessments conducted at home in the period Apr 24 – Feb 25.
- Re-purposed resource has been used to create a new flow Matron and Capacity Manager roles to support system flow.
- A new transfer of care referral form is being rolled out to support a single referral process across all pathways
- Two new trusted assessor roles hosted by the TRFT care homes team conduct discharge assessments on behalf of care homes, providing expert knowledge to identify appropriate placements to support the needs of the individual and family wishes. Initial evaluation indicates a positive impact with excellent qualitative feedback from care homes and discharge teams alike. The role holders have also worked in ED to reduce avoidable admissions, supporting people to return to their care home in a timely way, reducing risk of harm and provide support for care homes following complex discharges to reduce the risk

Challenges and Risks

- Unprecedented demand in ED creating ongoing system pressures
- Increased demand on discharge pathways with IDT seeing increased numbers of referrals
- Capacity pressures on front-line staff make it difficult to create space to implement change processes
- Increased complexity and acuity levels in ED and discharge pathways as a result of aging population, socio-economic factors and impact of the pandemic
- Beds occupied by NCtR above target and ICB average and has increased on 23/24

Next Steps including...

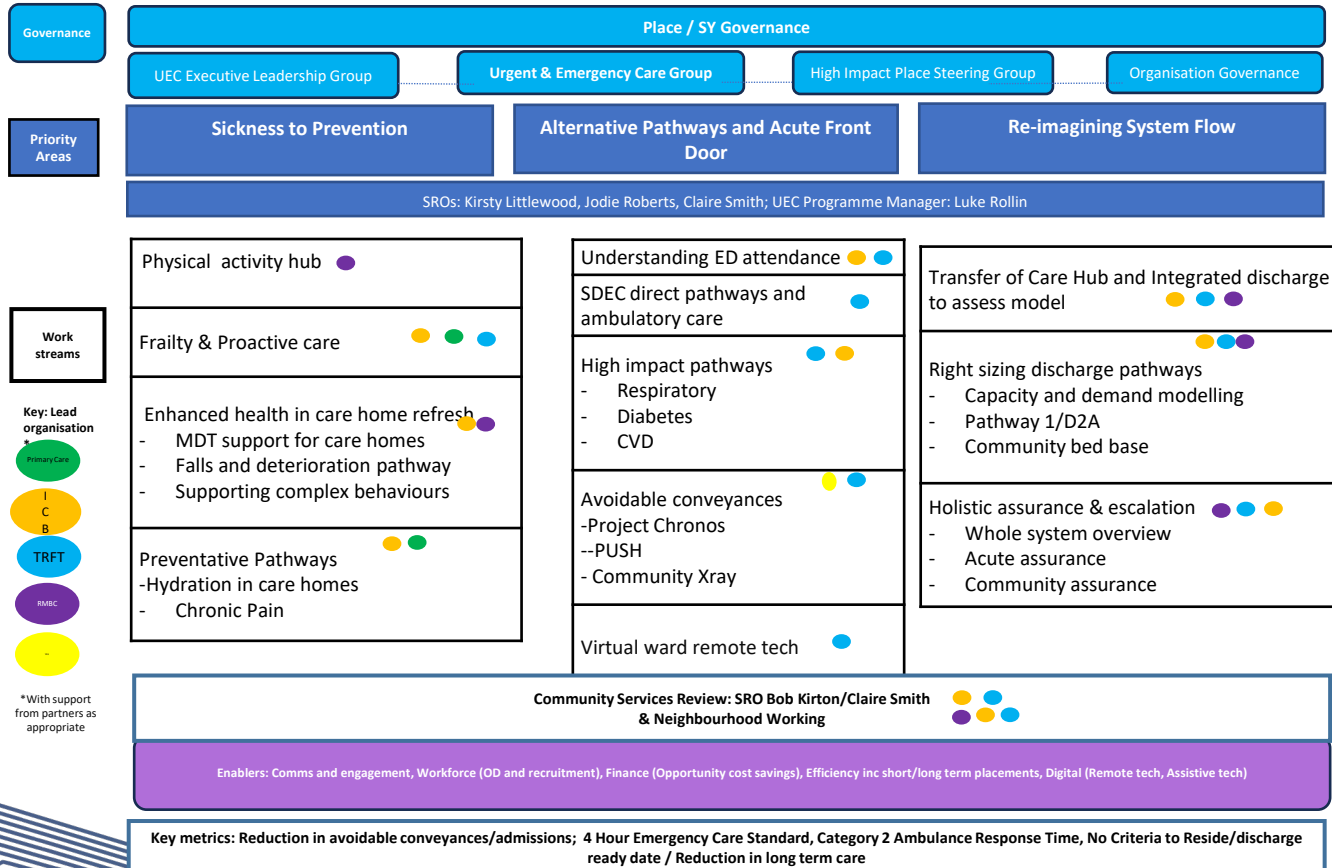
Prevention

- Conduct a community mobile x-ray pilot to reduce avoidable conveyances by diagnosing and arranging care in the community.
- TRFT have secured a £7M + capital investment, work is underway to improve flow at the front door, enhancing the same day emergency care offer and improve facilities. It is expected to reduce avoidable admissions and improve 4-hour performance by 10%
- Review and expansion of the pro-active care pilot which has received positive patient/professional feedback with initial evidence of reducing acute admissions
- The Moving Rotherham partnership secured a Place Expansion development grant from Sport England. An Active Hub will be piloted with health coaches to support people with long-term conditions into physical activity opportunities. This will include opportunities to embed physical activity into daily lives. A new post will work to identify opportunities to sustain physical activity for children and young people linked to the Children's Capital of Culture.
- Review multi-disciplinary support to care homes to ensure consistent and integrated care, according to need

System Flow

- Investigate the changing behaviours of people attending ED to inform our future community/front door offer and communication with our citizens
- Develop and implement the next phase of co-location of the Transfer of Care Hub including an extended Discharge to Assess model to begin from May 2025. The aim is to improve patient outcomes by supporting more people at home and reduce/delay the need for long-term care.
- Review changing patterns of demand/pressure points in the system to improve system flow
- Pilot the use of remote technology to support patients on the virtual ward and increase capacity

Urgent & Emergency Care Priorities 2025-6 as at 5/5/25



Key: Lead organisation

- Primary Care
- I C B
- TRFT
- RMBE
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*With support from partners as appropriate

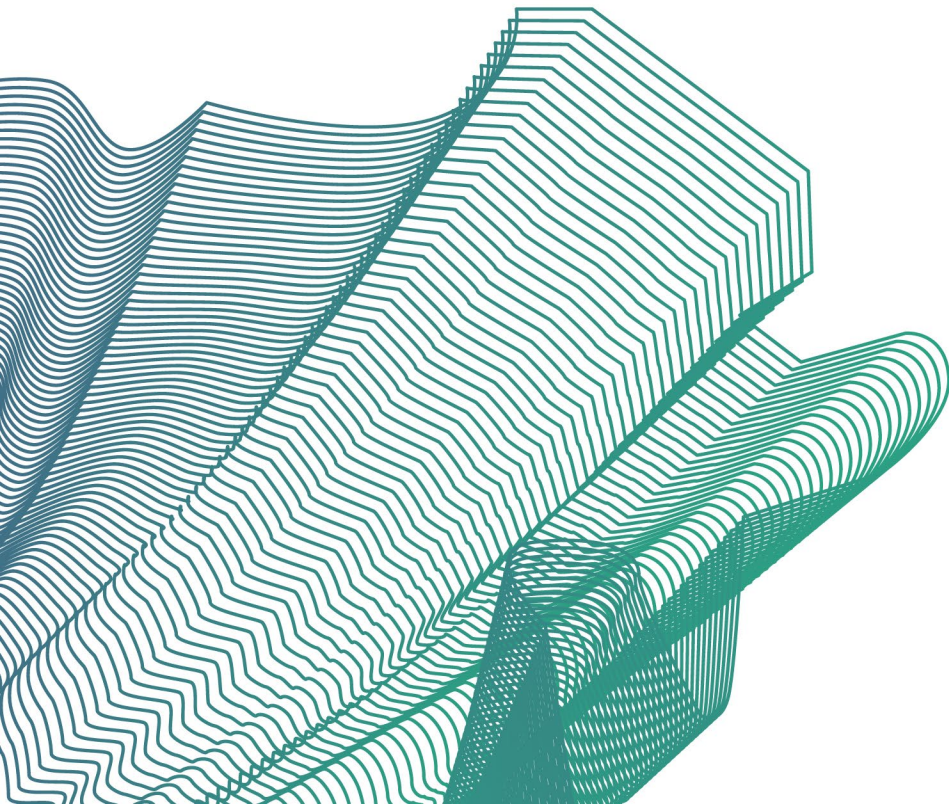
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ROTHERHAM PLACE PARTNERSHIP | HEALTH AND SOCIAL CARE

Rotherham Place Board

Communications and Engagement Update

Wednesday 21 May 2025



South Yorkshire
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What's working well

- Winter and vaccines campaign messaging
- Mental Health Awareness – Talking Therapies, Rotherhive (5yr anniversary), Shout 'EyUp' service SY launch
- TRFT working with Healthwatch Rotherham and deaf community to improve BSL provision – communication cards for patients
- TRFT's departmental moves – Public engagement events held for pre-operative assessment and Same Day Emergency Care developments.
- TRFT, RDaSH, VAR and RMBC - joint engagement with the Armed Forces Community
- South Yorkshire insight bank platform – Launch June 2025
- TRFT work with SY Acute Federation on Paediatric virtual ward pilot - Engagement event www.youtube.com/watch?v=09DmrqZLa0E&feature=youtu.be
- Rotherham Baby Packs – Implementation and PR



Challenges and Risks

- Number of consultations/involvement across Rotherham – public fatigue
- Resource and capacity – operational and strategic across place plan deliverables
- Momentum slowed down a little with transformation communications and engagement activity
- Non-Emergency Patient Transport – implementation national eligibility criteria

What needs to happen next

- Support the Health and Wellbeing Strategy – new priorities and promotion
- Support the place partnership priorities– 3 to 4 comms and engagement priorities for next 6 months?
- Celebrate Rotherham achievements and successes – Awards, conferences, case studies, blogs (HSJ digital awards shortlisting – TRFT pharmacy)
- Group review – Changing leads and structures across partners – How do we deliver partnership priorities
- Sharing and co-ordination of public consultations/involvement across Rotherham – not just health and care.

Adult Mental Health Service Review Update

Health Select Commission

Andrew Wells, Head of Safeguarding

1 May 2025

Background

In December 2023, Cabinet approved the implementation of a new Adult Social Care Mental Health model for Rotherham which included:

Implementation of a revised Mental Health Pathway

Realignment of Council employed staff to deliver social care roles and responsibilities

Alignment of Approved Mental Health Professionals (AMHPs) under Council management and co-location with the Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH) Crisis Team at Woodlands

Background (cont'd)

Provision of a collaborative approach to crisis alongside RDaSH

A commitment to strengthen effective partnerships, working to align the revised mental health pathway with RDaSH and Community Mental Health Transformation

The report acknowledged that a joint approach between health and social care, therefore designed around a collaborative delivery of both clinical and social care needs delivered a partnership approach with RDaSH and the South Yorkshire Integrated Care Board (SYICB) and the Council

Intended Benefits of the Revised Model

Provide a collaborative, preventative approach to ensure people get the right support

Raise the social care profile and solidify the social care contribution to the mental health pathway

Provide an effective, holistic and equitable response for people with mental ill-health

Strengthen the recovery model by providing preventative, proportionate social care interventions

Ensure that across the pathway, social care staff work to the legislative and statutory duties, enabling the Council to better evidence social care interventions

Prepare the Council for formal regulation of Adult Social Care by the Care Quality Commission

Support Rotherham Place to achieve its priority to collectively strengthen the mental health crisis pathway

Update

- The pathway was implemented in April 2024 the Council, SYICB, RDaSH, Primary Care and Urgent Care
- Initial impact analysis has identified no impact to partners whilst achieving positive impacts for residents through a more appropriate approach focussed on enablement and recovery
- The support provided focuses on prevention, early intervention and promotes resilience and independence
- The enhanced front door also refers people with identified unmet social care needs into the mental health enablement offer.
- The enablement pathway operates from community and health venues namely, Wellgate Court, Ferham Clinic and Swallownest Court

The community and enablement service as of mid point review (June 24)

- 178 referrals and in the 12 – 15 into enablement and the team provided 55 packages of personalised support.
- 5 peer support groups within different community settings
- Providing support for up to an hour and on average the service supports 7 people per session
- 2 dedicated sessions are held at Wellgate Court every week (Wednesday and Friday) and supports on average 8 people per session
- 65 people were screened either not appropriate or people declined the enablement offer.
- The 55 people and 16 carers who historically had support from the service remain and continue to be supported.

The AMHP Service as of mid point review (June 24)

The Council and RDaSH had agreed that the AMHP (social care response) and Crisis Team (Health response) would be co-located and is now delivered from Woodlands,

- To ensure a robust partnership approach to crisis intervention
- To allow urgent partnership visits if required, supporting right support at the right time

As part of AMHPs and support workers coming under the Council management

- Provide social care interventions
- Have available for the 1st time in 15 years have information and data on activity and performance to benchmark
- Staff receiving appropriate support and supervision with a focus on wellbeing and ensures compliance with employer duties

Conclusion

The overall impact of the revised pathway has been:

- The development of a prevention and early intervention approach
- People get the right support at the right time, and includes
 - Social Care intervention
 - Crisis intervention
 - Mental Health Act Assessment
 - Health intervention
 - Health and social care intervention combined
 - Signposting to appropriate service/
- Effective roles and responsibilities which partners understand

Cont'd

- Enhanced partnership working across Rotherham within mental health services.
- Clarity on roles and responsibilities of each partner agency, and each partner understands each other's contribution to the new pathway.
- Development of a partnership Mental Health Crisis Specification.
- A co-located Mental Health Crisis offer.
- Dedicated Health and Social Care offer, or combination of the two if required to support a personalised approach.



As a result of the review, the following benefits and impacts for Rotherham residents have been achieved:

- Enablement pathway to realise a preventative offer, preventing people coming into the service who do not need to and providing alternatives.
- Enhanced personalised community offer for both people experiencing mental ill health and unpaid carers.
- Development of peer support groups
- Readily available data and performance on crisis activity
- Succession planning for the AMHPs
- Social care evidence to meet the requirements of the CQC assurance of local authorities.

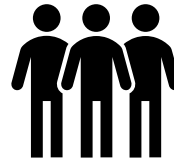
...“ I am really happy with the support I have had, I haven't felt judged”...

...“without this service, I wouldn't be here, it has saved my life”...

...“ I wouldn't have been able to do the things I've achieved without this support”...

...“LC has done a fantastic job, and has literally changed our lives, we were overwhelmed we now have the house and our health back, thank you”...

An amazing service that I can't thank enough as it has really had a massive impact on my daily life and my mental health”...



Co-designed Mental Health Strategy

- Planning for delivery of a co-designed Mental Health Strategy for the Council has commenced and it is anticipated that the strategy will provide the framework for future evolution of our mental health pathway.
- The strategy will be presented to Cabinet in December 2025 for consideration and approval.



Options Considered and Recommended Proposal

- Health Select Commission note the outcomes and impact of implementing the new Adult Social Care Mental Health model.
- Health Select Commission offer any further recommendations or insights.



Any comments or questions?



Committee Name and Date of Committee Meeting

Health Select Commission – 01 May 2025

Report Title

Mental Health Service Review Update

Is this a Key Decision and has it been included on the Forward Plan?

No

Strategic Director Approving Submission of the Report

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

Report Author(s)

Andrew Wells Head of Service – Safeguarding and Mental Health

Andrew.wells@rotherham.gov.uk

Ward(s) Affected

Borough-Wide

Report Summary

This report provides an update on the Adult Social Care Mental Health review which was implemented in April 2024. The report details the impact and outcomes since implementation.

Recommendations

It is recommended that the Health Select Commission note the:

1. Impact of the Adult Social Care Mental Health model of provision since it was implemented in April 2024.
2. And the planned development of a co-designed Council Mental Health Strategy which will be presented to Cabinet for approval in December 2025.

List of Appendices Included

Appendix 1 [Adult Social Care Mental Health Review - Report to Cabinet \(December 2023\)](#)

Appendix 2 [Mental Health Service Review - Report to Cabinet \(February 2023\)](#)

Background Papers

[Care Quality Commission \(CQC\) Assessment Framework for Local Authorities](#)

Consideration by any other Council Committee, Scrutiny or Advisory Panel

None

Council Approval Required

No

Exempt from the Press and Public

No

Mental Health Service Review

1. Background

1.1 In December 2023, Cabinet approved the implementation of a new Adult Social Care Mental Health model for Rotherham which included:

- Implementation of a revised Mental Health Pathway.
- Realignment of Council employed staff to deliver social care roles and responsibilities.
- Alignment of Approved Mental Health Professionals (AMHPs) under Council management and co-location with the Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH) Crisis Team at Woodlands.
- Provision of a collaborative approach to crisis alongside RDaSH.
- A commitment to strengthen effective partnerships, working to align the revised mental health pathway with RDaSH and Community Mental Health Transformation.

1.2 The report acknowledged that a joint approach between health and social care delivered the most personalised offer for residents. The model was therefore designed around a collaborative delivery of both clinical and social care needs, in partnership with RDaSH and the South Yorkshire Integrated Care Board (SYICB).

Benefits

1.3 The revised model was intended to realise the following benefits:

- Provide a collaborative, preventative approach to ensure people get the right support
- Raise the social care profile and solidify the social care contribution to the mental health pathway
- Provide an effective, holistic and equitable response for people with mental ill-health
- Strengthen the recovery model by providing preventative, proportionate social care interventions
- Ensure that across the pathway, social care staff work to the legislative and statutory duties, enabling the Council to better evidence social care interventions
- Prepare the Council for formal regulation of Adult Social Care by the Care Quality Commission
- Support Rotherham Place to achieve its priority to collectively strengthen the mental health crisis pathway

2. Update

2.1 The revised pathway was implemented in April 2024 following a partnership approach with the Council, SYICB, RDaSH, Primary Care and Urgent Care. Initial impact analysis has identified no impact to partners whilst achieving positive impacts for residents through a more appropriate approach focussed on enablement and recovery.

2.2 As part of the pathway, Adult Social Care embedded a consolidated, enhanced front door. This has provided an all-inclusive point of contact, ensuring a simpler and consistent approach and experience for people.

2.3 The support provided focuses on a preventative and early intervention approach and builds upon preventative and enabling offer and supports independence and resilience, providing people with personalised support options. The enhanced front door also refers people with identified unmet social care needs into the mental health enablement offer.

2.4 A new Mental Health Enablement Pathway operates from a variety of community and health venues namely:

- Wellgate Court
- Dinnington Old Library
- Swallownest Court
- Ferham Clinic

2.5 Activity in the community and enablement pathways was summarised at the mid-point review held in June 2024:

- 178 referrals into the 12 – 15-week enablement pathway and the team provided 55 packages of personalised support.
- 5 peer support groups within different community settings were providing support for up to an hour and on average the service supported 7 people per session.
- 2 dedicated sessions are held at Wellgate Court every week (Wednesday and Friday) and supports on average 8 people per session.
- 65 people were screened either not appropriate or declined the enablement offer.
- The 55 people and 16 carers who historically had support from the service remain and continue to be supported.

2.6 The Mental Health Enablement Team have developed a feedback leaflet and have captured feedback from people using the new enablement pathway. People who the service have told us:

"without this service, I wouldn't be here, it has saved my life"

"we want you to know what great support we have had, LC has helped us to sort out our bills and helped to make our home, our home again"

“CB is the only person to ever really support us, he has helped with our housing application and practically in our home”

“I am really happy with the support I have had, I haven’t felt judged”

“KL has been such an amazing support for me, in the weeks we’ve done so far I have gotten more sorted than in the year previous and things had just begun to pile up. She is always bright and chirpy, level headed in a panic, extremely empathetic and we get on really well which is rare for me. An amazing service that I can’t thank enough as it has really had a massive impact on my daily life and my mental health”

“More support from MB and JG in the last few weeks than I have had over the last few years from others”

“I feel the plan is going well and that I would like to continue focusing and working towards the same goals, as I has already made steps towards progress, the support is working well and is positive, and she also listens on the phone and doesn’t rush me”

“I wouldn’t have been able to do the things I’ve achieved without this support”

“I couldn’t have sorted some of my problems out without this help”...

“LC has done a fantastic job, and has literally changed our lives, we were overwhelmed we now have the house and our health back, thank you”

Adult social care will continue to seek feedback from people who draw on our services to evidence the positive impact and outcomes to residents’ lives.

- 2.7 The Council and RDaSH had agreed that the AMHP (social care response) and Crisis Team (Health response) would be co-located and is now delivered from Woodlands. The rationale was to ensure a robust partnership approach to crisis intervention, utilising both health and social care expertise and to have a dual response if required.
- 2.8 Due to the co-location, the Council and RDaSH have a robust offer and can undertake urgent partnership visits if required. This negates having two separate approaches, and potentially two visits to the person in crisis and can quickly ascertain how to support each person or situation effectively, and who has what responsibility and legal duty. This in turn supports the right support at the right time for the person in crisis.
- 2.9 As part of the AMHPs coming under the direct management of the Council, the Council can now provide holistic social care interventions as part of the crisis pathway, and this can be evidenced via the social care case management system. The Council has for the first time in over 15 years,

direct access to information and data on activity and performance and can benchmark against other Councils.

- 2.10 A Mental Health Partnership Crisis Specification was also developed with support of the SYICB to complement the review and provide clarity on roles and responsibilities across the partnership.
- 2.11 All Council employed staff including AMPHs and Support Workers are now under the line management of the Council. This means that staff are receiving appropriate support and supervision with a focus on their wellbeing, to ensure compliance with our duties as an employer.
- 2.12 In addition, the Council have developed a dedicated training programme for the AMHP staff to ensure that they continue to meet their Continued Professional Development (CPD). Furthermore, we have developed a continuity plan to ensure that Social Workers who join the mental health team in Rotherham can go onto train as an AMHP, thereby ensuring succession planning to meet the Councils statutory duties and have the appropriate numbers of qualified AMHPs required to meet the remit of the Mental Health Act 1983.

Conclusion

- 2.13 The overall impact of the revised pathway has been the development of a prevention and early intervention approach, meaning that people get the right support at the right time, this includes a social care intervention, crisis intervention, Mental Health Act assessment, a health intervention or a combination of both health and social care or signposting to the most appropriate support or service.
- 2.14 In addition, roles and responsibilities in mental health services are clear and understood across the partnership through the development of the Crisis Specification led by SYICB and supported and signed off by each agency.

As a result of the review, the following benefits and impacts for Rotherham residents have been achieved:

- Enhanced partnership working across Rotherham within mental health services.
- Clarity on roles and responsibilities of each partner agency, and each partner understands each other's contribution to the new pathway.
- Development of a partnership Mental Health Crisis Specification.
- A co-located Mental Health Crisis offer.
- Dedicated Health and Social Care offer, or combination of the two if required to support a personalised approach.
- Enablement pathway to realise a preventative offer, preventing people coming into the service who do not need to and providing alternatives.

- Enhanced personalised community offer for both people experiencing mental ill health and unpaid carers.
- Development of peer support groups
- Readily available data and performance on crisis activity
- Succession planning for the AMHPs
- Social care evidence to meet the requirements of the CQC assurance of local authorities.

2.15 Planning for delivery of a co-designed Mental Health Strategy for the Council has commenced and it is anticipated that the strategy will provide the framework for future evolution of our mental health pathway. The strategy will be presented to Cabinet in December 2025 for consideration and approval.

3. Options considered and recommended proposal

3.1 Health Select Commission note the outcomes and impact of implementing the new Adult Social Care Mental Health model.

3.2 Health Select Commission offer any further recommendations or insights.

4. Consultation on Proposal

4.1 Not applicable

5. Timetable and Accountability for Implementing this Decision

5.1 The proposal to implement a new Adult Social Care Mental Health model was approved by Cabinet in December 2023 and formally implemented in April 2024.

6. Financial and Procurement Advice and Implications

6.1 There are no financial or procurement implications associated with this report.

7. Legal Advice and Implications

7.1 There are no legal implications associated with this report.

8. Human Resources Advice and Implications

8.1 There are no HR implications associated with this report.

9. Implications for Children and Young People and Vulnerable Adults

9.1 The implementation of the new Mental Health pathway ensures that all young people in crisis or preparing for adulthood can:

- Grow up prepared for the future.
- Have improved health and wellbeing.
- Are able to exercise control over the support they receive.
- Are able to receive support locally from a range of services that everyone values.
- Have an opportunity to have their own ‘front door’.
- Can access the right support in the right place, based on where the young person lives.

10. Equalities and Human Rights Advice and Implications

10.1 The proposals in this report support the Council to comply with legal obligations encompassed in the:

- Human Rights Act (1998), to treat everyone equally with fairness dignity and respect with a focus on those who are disadvantaged as a result of disability and Page 12 of 13
- Equality Act (2010) to legally protect people from discrimination in the wider society

11. Implications for CO2 Emissions and Climate Change

11.1 There are no direct CO₂ Emissions and Climate Change implications associated with this report

12. Implications for Partners

12.1 All relevant partners and key stakeholders including RDaSH and the SYICB were engaged in developing the new model for Mental Health and are actively engaged through the Rotherham Mental Health and Learning Disability Transformation Board.

13. Risks and Mitigation

13.1 There were risks associated with the previous mental health model in operation to ensure a robust social care identity, a pathway which provided support to people at the right time and was focussed on enablement and recovery. The new model has addressed these associated risks.

14. Accountable Officers

Ian Spicer, Strategic Director of Adult Care, Housing and Public Health
ian.spicer@rotherham.gov.uk

Approvals obtained on behalf of Statutory Officers:

Named Officer	Date

Chief Executive		Click here to enter a date.
Strategic Director of Finance & Customer Services (S.151 Officer)	Choose an item.	Click here to enter a date.
Assistant Director, Legal Services (Monitoring Officer)	Choose an item.	Click here to enter a date.

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Rotherham Public Place Board – 21 May 2025
2023-25 Health and Care Place Plan Performance Report
Q4 2024/25

Lead Executive:	Claire Smith, Deputy Place Director – NHS South Yorkshire ICB (Rotherham)
Lead Officer:	Lydia George, Strategy & Delivery Lead – NHS South Yorkshire ICB (Rotherham)

Purpose:

To provide members with a performance report for the 2023-25 Health and Care Place Plan as at quarter 4 2024/25 (end March) reporting period.

Background:

The Place Board has received a quarterly performance report to show delivery against the Rotherham Place Plan since 2018. The report covers both metrics, milestones and timescales against priorities for each of the transformation workstreams. The impact of the covid pandemic on metrics meant that it was either not possible or that the reporting was very skewed as performance had been severely impacted, therefore the reporting of metrics was stalled over that period.

The 4th Rotherham Health and Care Place Plan was agreed in July 2023. The attached Performance Report was produced to provide an overview of delivery against the plan and represents the position as at end Q34 end March 2025.

Analysis of key issues and of risks

The Q4 2023/24 report received at Place Board in July 2024 has been subject to review by lead officers. The review particularly looked at milestones, metrics and timescales to ensure they were fit for purpose. Milestones complete as at Q4 2023/24 report have been removed.

Officers also reviewed priorities to ensure they remained relevant, following this the priorities within the Urgent and Community workstream have been updated; partly as a result of year one delivery and also to bring them in line with the High Impact Priorities identified as a key focus this year.

An action for the year 2 report was to address the number of milestones and metrics with either no baseline, no data captured or still to be confirmed. The update has addressed that issue and there are now significantly less metrics still to be confirmed, those missing are due to reporting timescales impacting on the availability of data. There are no milestones to be confirmed.

Milestones: The quarter 4 position represents performance at the end of the 2nd year of delivering on the 2023-25 Plan. The position in Q4 is 87% of milestones either complete or on track, which is a 21% improvement compared to Q3. In Q4 13% of milestones are either off track or slightly off track compared to 34% in Q3. Overall this represents a strong improvement on the final year 2 position of delivering the Place Plan.

Metrics: The quarter 4 position represents performance at the end of the 2nd year of delivering on the 2023-25 Plan, this shows 59% of metrics are on track, slightly lower than the Q3 position of 62%.

Further analysis can be seen at the beginning of the report.

Approval history:

Rotherham Place Leadership Team – 7 May 2025

Recommendations:

Members are asked to receive and comment on the Place Plan Performance Report, noting the report provides a position as at Q4, end March 2025.

Place Plan Performance Report for the period 2024-2025

Rotherham Place Leadership Team: 7 May 2025

Rotherham Place Partnership Public Board: 21 May 2025

Reporting Period: Quarter 4, end March 2025

Key for Milestones

Red	Milestone significantly off target
Amber	Milestone slightly off target
Green	Milestone on target
Blue	Milestone complete
Grey	Milestone not due/ not commenced

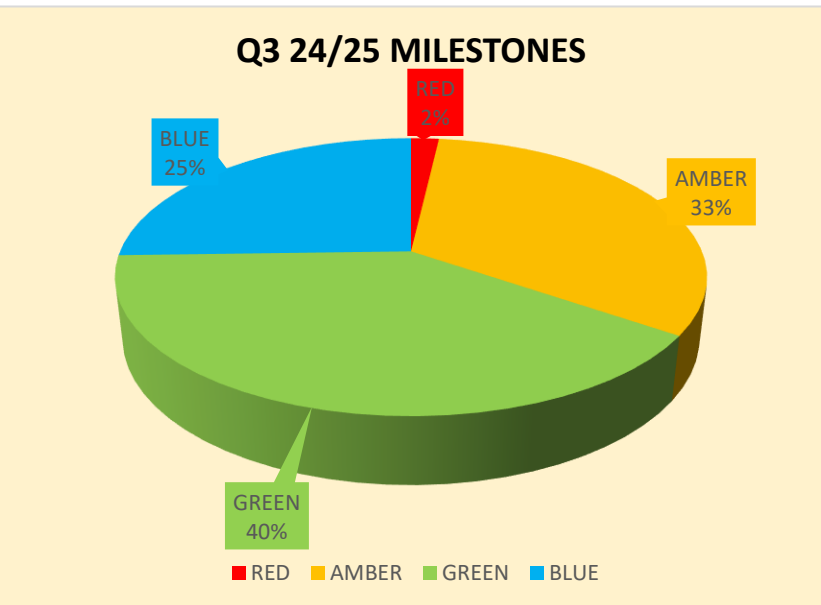
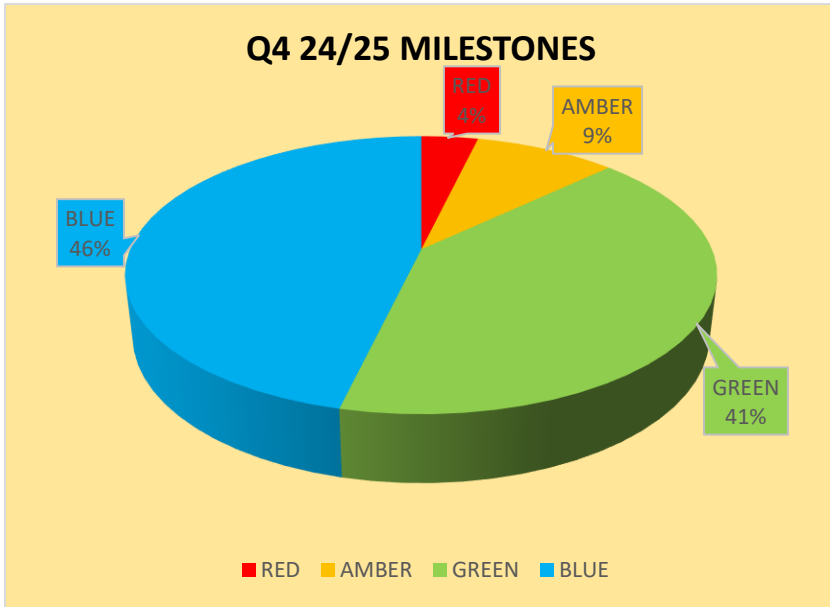
Key for Metrics

Red	Metric significantly off target
Amber	Metric slightly off target
Green	Metric on target
Grey	Metric to be confirmed/established

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1 Overall Position for Milestones



All priorities and milestones have been reviewed for the 2024/25. The priorities in Urgent and Emergency have been updated, partly as a result of positive delivery in 2023/24 and also to align to the chosen high impact priorities that have been identified in year.

Milestones that were complete as at Q4 2023/24 have been removed. Some new milestones have been added and existing milestones rolled over. In reviewing the milestones some of the timescales have been amended to reflect the current position.

In the revised report for 2024/25 there are 54 milestones used to form part of the Performance Report. These are key milestones that have been identified that enable members to gain an understanding of overall progress in delivery of the Place Plan. As at Q4, of the 54 milestones, there are:

RAG	Q2 Position		Q3 Position		Q4 Position		Q3 Position
	Number	%	Number	%	Number	%	
TBC	0	0%	0	0%	0	0%	Milestone not due/ not commenced
RED	1	2%	1	2%	2	4%	Milestone significantly off target
AMBER	9	16%	18	32%	5	9%	Milestone slightly off target
GREEN	30	55%	21	39%	22	41%	Milestone on target
BLUE	14	27%	14	27%	25	46%	Milestone complete

In the last quarter there are slightly more milestones on target by 2%, however there has been a significant improvement in the number of milestones complete from 27% in Q3 to 46% in Q4.

One milestone has deteriorated from **Amber** to **Red**:

CYP 9	Implement and embed preparation for adulthood guidance
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There is one further **Red** milestone which was also red in Q1, Q2 and Q3:

CYP 7	Actively engage in recruitment activity to increase the number of foster carers
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Summary of Performance against milestones

Workstream	Priority Area	No. of Milestones	Red	Amber	Green	Blue	TBC/Not started
Best start in Life - Maternity, Children & Young People	Best Start for Life	3	0	0	0	3	0
	Children and young people's mental health and emotional wellbeing	2	0	2	0	0	0
	Looked After Children	2	1	0	0	1	0
	Children and Young People with Special Educational Needs and/ or Disabilities	0	0	0	0	0	0
	Preparation for Adulthood	2	1	0	0	1	0
		9	2	2	0	5	0
Enjoying the best possible mental health and wellbeing	Delivery of the Adult Severe Mental Illness in Community Health Transformation Plan	6	0	0	3	3	0
	Delivery of the Mental Health Crisis & Liaison	6	0	0	0	6	0
	Suicide Prevention Programme	2	0	0	1	1	0
	Dementia pathway transformation	3	0	0	1	2	0
	Delivery of the Better Mental Health for all Plan, also includes the loneliness delivery plan	2	0	0	1	1	0
		19	0	0	6	13	0
Supporting People with Learning Disability and Autism	Increase the uptake of enhanced health checks for people with a learning disability aged 14 upwards	2	0	1	1	0	0
	Support development of SY Pathways to reduce the need for inappropriate admissions into mental health services	1	0	0	1	0	0
	Ensure people with a learning disability and autistic people have better access to employment opportunities	1	0	0	1	0	0
	To further develop accommodation with support options	1	0	0	1	0	0
	Refresh the Vision and Strategy for people with a learning disability through coproduction and codesign	1	0	0	1	0	0
	Develop a new service model for day opportunities for people with high support needs	0	0	0	0	0	0
		6	0	1	5	0	0
Urgent, Emergency and Community Care	Frailty	4	0	1	2	1	0
	Ambulatory Care	3	0	0	1	2	0
	Integrated Discharge to Assess	5	0	0	2	3	0
	Cross cutting workstreams	3	0	1	1	1	0
		15	0	2	6	7	0
Palliative and End of Life Care	<ul style="list-style-type: none"> Enhance personalised palliative and end of life care Implementation of ReSPECT across Rotherham Benchmark against the Ambitions Framework Inform future commissioning through patient and Carer experience 	5	0	0	5	0	0
		5	0	0	5	0	0
Overall Totals		54	2	5	22	25	0

2 Overall position for KPIs for Q4

The position for the 46 KPIs is improved to that in Q3:

RAG	Q2 Position		Q3 Position		Q4 Position		Definition
	Number	%	Number	%	Number	%	
TBC	7	15%	7	15%	5	11%	Metric not due/ not commenced
RED	2	4%	2	4%	2	4%	Metric significantly off target
AMBER	12	26%	9	19%	12	26%	Metric slightly off target
GREEN	22	48%	25	55%	18	39%	Metric on target
BLUE	3	7%	3	7%	9	20%	*NOTE, target was for 23/24 and was achieved

Red Metrics: there are two red metrics which have been the same in Q1, Q2, Q3 and Q4:

- **CYP KPI 7: Increase the % of Children in Care living in a family-based setting** – 74% as at end December 2024 against a target of 85%, This remains a key area of focus for the service and will throughout 2024-2025.
- **CYP KPI 9: Increase the number of CYP in a Rotherham fostering placement by March 2025 (to reach 151 by year end)** - Continue to progress the Fostering Action Plan to support the recruitment of more foster carers and to retain existing foster carers

There has been **deterioration** in the following 2 metrics from **Green to Amber**:

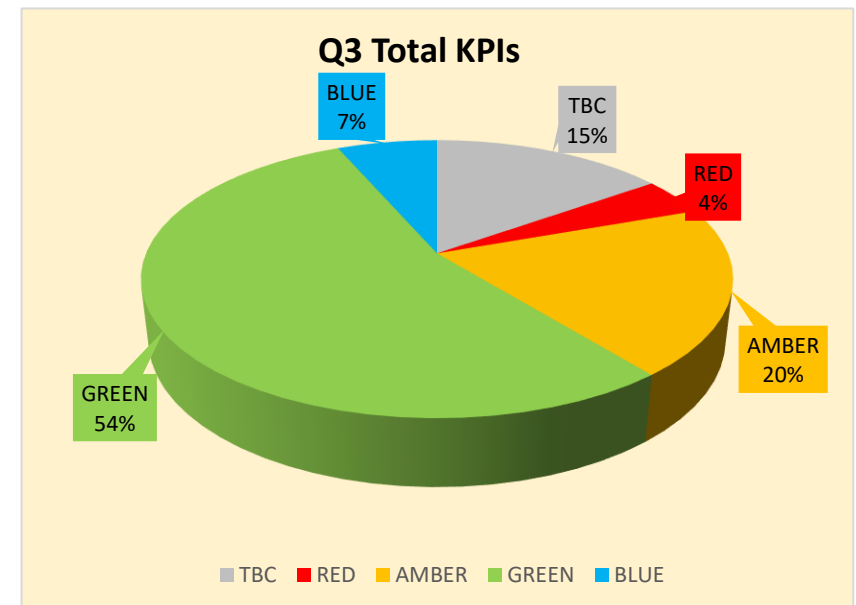
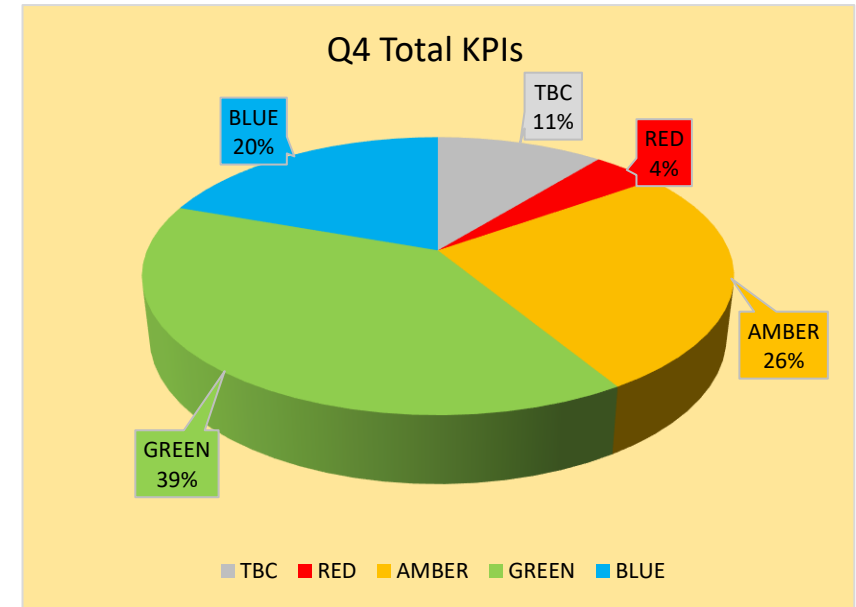
UEC KPI 8	Reduction in long lengths of stay in Acute bed base at 14 days % of acute bed
UEC KPI 9	Reduction in long lengths of stay in Acute bed base at 21 days % of acute bed
LDA KPI 3	Reduction in the numbers of people needing to be detained in mental health services

There has been an **improvement** in the following 7 metrics **Green to Blue**:

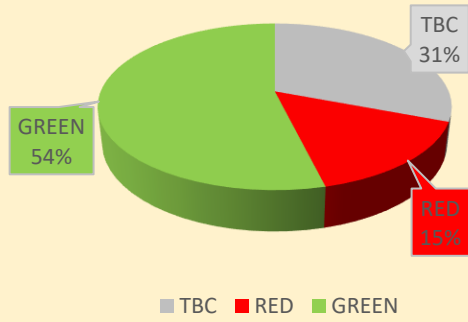
MH KPI 2	Access to transformed Community Mental Health Services for adults and older adults with SMI
MH KPI 4	Reduce inequalities by working towards 75% of people SMI receiving a full annual physical health check with at least 60% receiving one by Mar25
MH KPI 6	Increase in the number of people accessing alternative to Crisis provisions
MH KPI 7	Increase in referrals to amparo
MH KPI 8	Improve quality of life, effectiveness of treatment and care for people with Dementia by increasing the Dementia diagnosis rate to 66.7% by March25
MH KPI 10	Improved access to support for people with dementia and their Carers.
MH KPI 11	Reduction in dementia waiting list

There has been an **improvement** in the following metric **Amber to Green**:

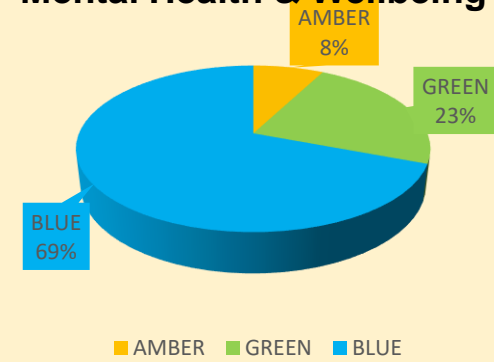
UEC KPI 4	Improve ambulance response times
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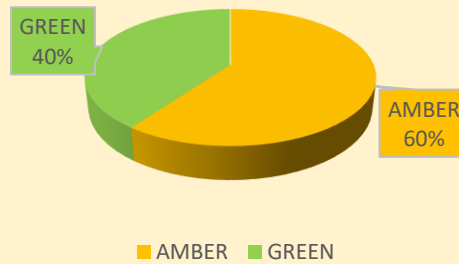
Children and Young People



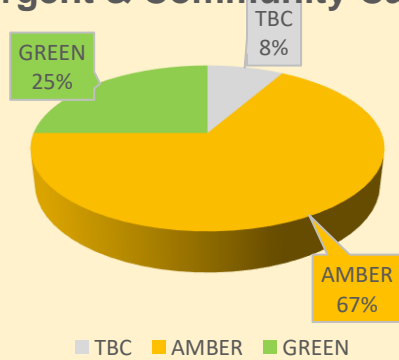
Mental Health & Wellbeing



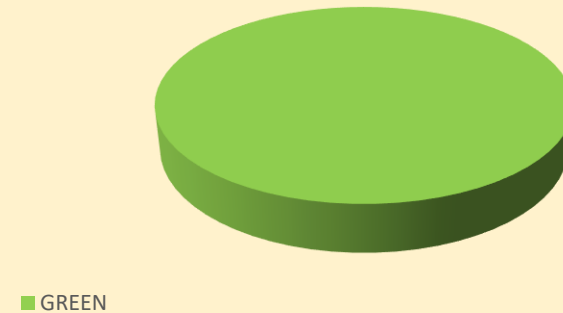
Supporting People with Learning Disabilities and/or Autism



Urgent & Community Care



Palliative & End of Life Care



3 Transformation Workstream: Best start in Life - Maternity, Children & Young People

Priority 1: Best Start for Life **Lead Officer: Helen Sweaton**

Milestone		Target for Delivery	Q4 Position (23/24)	Q1 Position (24/25)	Q2 Position (24/25)	Q3 Position (24/25)	Q4 Position (24/25)	Key actions from the last period / identify achievements	Any risk, including mitigation
CYP MS 1	Develop and implement the "Start for Life Pack" for all families taking a proportionate universalism approach to targeted engagement.	Q2 2024/25						Q2: The hard copy of the Family Hubs guide has been produced and is now being provided in 'The personal child health record' (red book). There has been a targeted launch event celebrating this with the Parent Carer Panel.	
CYP MS 2	Embed the Breastfeeding friendly Borough Declaration through the delivery of Breastfeeding Friendly initiatives.	Q4 2023/24	16 breastfeeding peer support workers trained	20	30			Q2: The training courses in September took place with a further 10 peer support workers trained. Children's centres are working towards stage 1 of BFI accreditation and are hoping to have this by the end of Q4 24/25.	
CYP MS 3	Review the Child Development Centre to ensure children in Rotherham will have timely access to an assessment and intervention when developmental needs are identified.	Q3 24/25						Q4 – the review is complete: <ul style="list-style-type: none"> • Work on the CPD offer and graduated response is progressing well. • 80 children have transferred over from the CDC to RDASH and are being offered assessments • A new streamlined assessment pathway has been introduced in the CDC • Backlog money for the CDC has been agreed and transferred to TRFT. Additional staff are currently being recruited. 	Children are waiting for assessment. Additional non-recurrent funding identified to create capacity to meet pandemic related (and the notable year on year increased) demand on service.

Priority 2: Children and young people’s mental health and emotional wellbeing **Lead Officer: Helen Sweaton**

Milestone		Target for Delivery	Q4 Position (23/24)	Q1 Position (24/25)	Q2 Position (24/25)	Q3 Position (24/25)	Q4 Position (24/25)	Key actions from the last period / identify achievements	Any risk, including mitigation
CYP MS 4	Children in Rotherham will have timely access to an assessment and intervention for neurodevelopment disorders when a need has been identified. (Transforming health care)	Q2 2024/25						Q4 – Longest waits have continued to reduce, meeting the trajectory with increased throughput of assessments.	Q4 Awaiting signoff of a revised trajectory Referral numbers continue to rise. Although children are not waiting as long, numbers waiting for assessment are not reducing. Exploration of a research paper to better understand local need is underway with public health..
CYP MS 5	Re-develop, implement, and embed a tiered sleep pathway.	Q3 2024/25						Q4- Connect Healthcare have issued a contract to TRFT. Staffing is in place, and service delivery is due to start this quarter.	Gap analysis has identified a lack of capacity to deliver targeted interventions. An invest to save business case is being prepared. Q1 - It should be noted that there is currently a shortfall of £23k in the budget. ICB is aware of the shortfall and will review it in month 6 of service delivery.

Priority 3: Looked After Children **Lead Officer: Helen Sweaton**

Milestone		Target for Delivery	Q4 Position (23/24)	Q1 Position (24/25)	Q2 Position (24/25)	Q3 Position (24/25)	Q4 Position (24/25)	Key actions from the last period / identify achievements	Any risk, including mitigation
CYP MS 6	Re-development and implementation of our therapeutic offer to looked after children, in-house foster carers/ residential care providers.	Q2 2024/25						Q4 - New service structure is due to go live on 28.04.25, vacant job positions are being advertised and further reviews regarding SGO/Kinship local offer are underway and due at DLT and cabinet for ratification (Chris McDonald as Kinship lead is leading on this area of work).	Q4 - The new restructure will reduce the generic offer of therapy as part of a trauma pathway and this is a gap that needs consideration through the partnership/CAMHS, as was highlighted in the review documentation. It will however increase the therapeutic intervention offer to children returning home to family and to carers/residential for placement stability concerns.

Milestone		Target for Delivery	Q4 Position (23/24)	Q1 Position (24/25)	Q2 Position (24/25)	Q3 Position (24/25)	Q4 Position (24/25)	Key actions from the last period / identify achievements	Any risk, including mitigation
CYP MS 7	Actively engage in recruitment activity to increase the number of foster carers.	25 new foster families during 2024/25	17	2	2 (4 ytd)	3 (7 ytd)	5 (12 in total for 2024/25)	Two foster families were recruited in both Q1 and Q2, with a further three in Q3, and five in Q4 which equates to twelve in total during the 2024/25 financial year.	<p>We regularly review and strengthen the BrightSparks and Place Based marketing and recruitment campaign at the Fostering Operational and Strategic Board.</p> <p>The recruitment and retention strategy is being reviewed by the Service Manager and the Marketing Manager regularly to ensure it is flexible and responsive.</p>

Priority 4: Children and Young People with Special Educational Needs and/ or Disabilities **Lead Officer: Helen Sweaton**

All milestones were complete this remains a priority and will be assured via the metrics

Priority 5: Preparation for Adulthood **Lead Officer: Helen Sweaton**

Milestone		Target for Delivery	Q4 Position (23/24)	Q1 Position (24/25)	Q2 Position (24/25)	Q3 Position (24/25)	Q4 Position (24/25)	Key actions from the last period / identify achievements	Any risk, including mitigation
CYP MS 8	Work to provide a 'health passport' to support transition from paediatric to adult services.	Q4 2024/25						<p>Q2 – Rotherham Health Record has been developed to provide summary information to GPs. Further development of the summary information agreed to include key flagged indicators from system one (in addition to those already included from meditech). Engagement with GPs planned to promote the use of Rotherham health record.</p> <p>Engagement with parent carers and young people to be planned to raise awareness of summary information available on Rotherham health record.</p> <p>Work underway to consider whether summary pdf document can be provided to young people and parent/ carers.</p> <p>A range of health passports (to suit individual need) are now being promoted. There is a section on health passports in the draft transition to adulthood guide. Further work is needed to raise awareness with practitioners and young people to further spread use.</p>	

								<p>Q3 – Development work underway. Engagement activity planned once protocol developed.</p> <p>Q4 – There are a range of health passports available on the Local Offer. Oliver McGowan training for all health practitioners has been completed to help raise awareness. The passport will also be include in the transition brochure.</p>	
CYP MS 9	Implement and embed preparation for adulthood guidance, including involving families in transition planning.	Q3 2024/25						<p>Q1 - First draft of the Transitions/ Preparation for Adulthood guidance was shared at the PfA strategic Board on 17th June 24. Further work is planned based on feedback from the multi-agency group and parent/ carers, young people and young adults.</p> <p>Q2 - Further workshop held 4th October 2024 to agree final content and structure.</p> <p>Q3 – Successful Futures Fair held at New York Stadium to share preparation for adulthood guidance with young people and families. Publication of parent guidance delayed, final draft being developed with comms.</p> <p>Q4 – Quality Assurance of parent guidance still not complete. Awaiting final sign off for publication.</p>	

Metric	2024/25 target	Q4 Position (23/24)	Q1 Position (24/25)	Q2 Position (24/25)	Q3 Position (24/25)	Q4 Position (24/25)	Comments if off track	Any risk, including mitigation
CYP KPI 1 % of children aged 0-5 living in the 30% most deprived SOA's in Rotherham who are registered with a Children's Centre (within the Family Hub.)	95%	94.5%	92.0%	93.4%	96.0%	99.6%	<p>N.B. this data currently relates to children's centres (0-5) and not the wider Family Hub. Work is ongoing to develop reporting as part of the Family Hub programme.</p> <p>Q4 – performance has exceeded target at 99.6%.</p>	There is a risk that this target won't be achieved. The continued development of Family Hubs will help with registration rates moving forwards as well as the universal roll-out of baby packs over the next 2 years.

Metric		2024/25 target	Q4 Position (23/24)	Q1 Position (24/25)	Q2 Position (24/25)	Q3 Position (24/25)	Q4 Position (24/25)	Comments if off track	Any risk, including mitigation
CYP KPI 2	% of children aged 0-5 living in the 30% most deprived SOA's in Rotherham who have accessed Children's activities.	65%	80.6%	48.6%	68.7%	75.1%	85.2%	NB this data currently relates to children's centres (0-5) and not the wider Family Hub. Work is ongoing to develop reporting as part of the Family Hub programme. Q4 – performance has exceeded target at 85.2%.	The target of 65% is for the full year (Apr-24 to Mar-25), therefore the percentage gradually increases throughout the quarters.
CYP KPI 3	Increase breastfeeding continuation status at 6-8 weeks.	62%	78%	78%	78%	Not currently available	Not currently available	Q4 position is expected April 2025.	
CYP KPI 4	Increase the proportion of births that receive a face-to-face New Birth Visit within 14 days by a HV	89% by 2024/25 (by Mar-25)	84%	83%	85%	89%	Not currently available	Q4 update: Data for Q3 show that 89% of births received a face-to-face New Birth Visit within 14 days by a Health Visitor (Adjusted data - long stay hospital patients removed).	
CYP KPI 5	Increase the number of early help assessments completed by partners.	Last year outturn (23/24) was 27.5%	27.5%	37.9%	27.2%	29.2%	28.8%	The ambition is to increase Early help assessments completed by partners. Q4 – slight decrease on the previous quarter but still above last year's outturn of 27.5%.	
CYP KPI 6	Percentage of eligible children accessing their 2-2.5yr health visitor checks.	84% contractual target (93% RMBC Council Plan target)	88%	92%	92%	93%	Not currently available	Q4: Data for Q3 24/25 shows 93% of children received a 2-2.5 year review. Note that the RMBC Council Plan has an ambition to overperform on the contractual 84% due to the importance of checks for child development, achieving school readiness and reducing inequalities.	
CYP KPI 7	Increase the % of Children in Care living in a family-based setting to 85% by March 2025 (CYPS scorecard measure).	85% by March 2025	75.3%	73.6%	74.0%	74.0%	77.6%	Q4 – slight increase but still below target of 85%.	This remains a key area of focus for the service and will throughout 2024-2025.
CYP KPI 8	Ensure the number of Children in Care (rate per 10k population 0-17) remains better than or in line with statistical neighbours (sn).	In line or better than stat neighbour average	88.4	88.0	87.3	86.6	83.0%	Q4 – this has continued to improve and remains well above statistical neighbour average, which is currently 100.9.	
CYP KPI 9	Increase the number of CYP in a Rotherham fostering placement by March 2025. (to surpass the net gain of 23 new placements in 2023/24)	Increase by 6 per quarter to reach a total of 151 by year end.	127 112	118 115	112 109	113	114	There were 114 children in care (CiC) placed in an in-house foster placement at the end of 2024/25. A significant amount of work has taken place to validate the information being extracted from Liquid Logic. Previously reported figures are now thought to be incorrect due to recording errors, on-going system issues and delays in recording. The figures have been refreshed to match what is currently being reported from Liquid Logic. However, service is still working with the systems team to rectify ongoing issues.	We continue to progress the Fostering Action Plan to support the recruitment of more foster carers and to retain existing foster carers. We also use the Pathway to Care Policy to enable more foster carers to provide additional placements for children in care.

Metric		2024/25 target	Q4 Position (23/24)	Q1 Position (24/25)	Q2 Position (24/25)	Q3 Position (24/25)	Q4 Position (24/25)	Comments if off track	Any risk, including mitigation
CYP KPI 10	Increase the number of overall visitors to the Local Offer website.	Launched in May 2023. Baseline to be set during 23/24. Target increase to be agreed for 24/25	Baseline being established Q1 May-June only – TBC Q2 - 5643 Q4 5300	5100	5500	7215	8088	Numbers continue to increase overall although there was a slight dip in February which coincides with school holidays. The increases in March include both the overall number of visitors and the number of engaged sessions of more than 10 seconds.	Spam or bot activity may inflate user data. Engaged sessions data continue to be valid and reflect actual user data.
CYP KPI 11	Number of requests for corrections (contacts/broken links etc) resolved within a 4 week timescale from the date the request was received.	100%	100%	17 *100%	100% *91%	100%	100%	Requests continue to be made with in a timely manner now the team is back to full strength.	No risks at present.
CYP KPI 12	Increase % of young people aged 14 or over with learning disabilities offered enhanced GP Annual Health Checks (this info runs over a Financial Year - April to March and is cumulative over this time).	In line with national – 68% March 24	69.7%	14.1%	26.3% 28.9%	53.1%	Not currently available	This is a cumulative measure per financial year, so the % is always going to be lower in Q1, increasing throughout the year to Q4. Q2 data has been updated from 26.3% to 28.9%.	
CYP KPI 13	Increase % of Adults Transitions cases aged 17 and a half and over, who were referred to transitions prior to turning 18, who have a Care Act Assessment in place.	70%	69.9%	76.4%	78.2%	72.7%	71.8%		

To note, no routine data for CYP Neuro waits/completed assessments. There is a possibility that reporting is moving to automated, but this has been paused until September for this pathway, the list of draft metrics they will be reporting against are:

- Number of children referred to the Mental Health Pathway
- Number discharged from service Mental Health Pathway
- Number of children referred for the Neuro-Developmental pathway
- Number of Neuro-Developmental assessments Completed
- Number of CYP seen for assessment within 4 Weeks
- Number of CYP discharged from the Neuro-Developmental pathway

New PfA metrics are currently being looked at by Adult Services – this is due for discussion at their PfA Board on 17/10/24. See metrics CYP KPI 12 and CYP KPI 13.

4 Transformation Workstream: Enjoying the best possible mental health and wellbeing

Priority 1: Delivery of the Adult Severe Mental Illness (SMI) in Community Health Transformation Plan | Lead Officer: Kate Tufnell

Milestone		Target for Delivery	Q4 Position (23/24)	Q1 Position (24/25)	Q2 Position (24/25)	Q3 Position (24/25)	Q4 Position (24/25)	Key actions from the last period / identify achievements	Any risk, including mitigation
MH MS 1	Implementation of Mental health ARRS roles in Primary Care in line with year 3 ambition	Q1 24/25						MH ARRS roles are integrated within the Primary Care - ARRS Mental Health Primary Care Pathway in place.	
MH MS 2	Primary care integrated Mental Health Hubs launched	Q1 24/25						Achieved in 23/24. Primary Care Mental Health Hubs went live 5 December 2023. Regular updates shared re hubs and staffing between partners.	
MH MS 3	Community Mental Health Transformation pathways in place (targeted work on Community rehab, complex needs/PD & eating disorders)	Q1 24/25						NHSE have established criteria for when services are deemed to be transformed. Rotherham MH services have now met these criteria. A number of milestones on the roadmap have been achieved and the roadmap may be closed down and a new programme plan devised in line with the MH Needs Assessment when available. Eating Disorders continues to be a risk. A Primary Care Education Session planned in Q4 regarding pathways and links between partners.	
MH MS 4	Finalisation of the outcomes and performance metrics for the Rotherham Community Mental Health transformation programme	Q3-24/25 Q2 25/26 Realigned to allow further work to be completed						Proposed metrics were considered by the CMHT Steering Group and the MH, LD & ND Transformation Group in September 2024. Feedback on the metrics was shared to RDASH in Sept. Meeting with RDASH and Primary Care scheduled for April 2025. A full CMHT dashboard for metrics has been drafted and shared to the group, we continue to work with RDASH and the PCN's re their data.	Raised at MH & LDA Transformation Group January 25.
MH MS 5 New	Increase access to Adult Community Mental Health Services	Q4 24/25						See CMH Access metric below for positive performance. During early Q4 Rotherham provided assurance to NHS England on progress against the national Community Mental Health Transformation Roadmap (key milestones and deliverables). The access figures and trajectory will be added to the Q1 update.	

Milestone		Target for Delivery	Q4 Position (23/24)	Q1 Position (24/25)	Q2 Position (24/25)	Q3 Position (24/25)	Q4 Position (24/25)	Key actions from the last period / identify achievements	Any risk, including mitigation
MH MS 6 New	Continue to monitor uptake of the SMI Annual Health checks	Q4 24/25						A conversation has commenced with partners to identify what else could be done to support/improve data quality and recording of SMI Annual Health Checks. New ICB SMI data dashboard helpfully provides quarterly performance by GP practice, however data is usually a quarter behind. National target is 60% and for Q3 Rotherham achieved 72% which is above.	Changes to the SMI QOF 25/26 The impact on this indicator need to be understood

Priority 2: Delivery of the Mental Health Crisis & Liaison programme **Lead Officer: Kate Tufnell**

Milestone		Target for Delivery	Q4 Position (23/24)	Q1 Position (24/25)	Q2 Position (24/25)	Q3 Position (24/25)	Q4 Position (24/25)	Key actions from the last period / identify achievements	Any risk, including mitigation
MH MS 7	Rotherham Crisis Care Concordat established	Q4 23/24						Achieved Q3 24/25	
MH MS 8	Place Crisis pathway Health and Social Care delivery action plan agreed and considered at RMBC Cabinet	Q3 23/24						Achieved in 23/24.	
MH MS 9	Development of a Place Crisis Service specification	Q2 24/25						Achieved Q4 24/25	
MH MS 10	Expansion of the alternative to crisis offer	Q2 24/25						Achieved. Q2 24/25 Note: Rotherham Vista project to be launched April 2025	
MH MS 11	Implementation of a new Health and Social Care Crisis Pathway	Q1 24/25						Achieved. The new pathway went live 1 April 2025	
MH MS 12 New	Embed the Rotherham Safe Space offer/service within wider system pathways.	Q3 24/25						The Service is embedded across Rotherham and have good relationships with partners. MHM self-referral trajectory is 58% and for Q3 they achieved over 80% in self referrals.	New staff have started in the team, staff turnover continues to be monitored at contract meetings.

Priority 3: Suicide-prevention programme **Lead Officer: Ruth Fletcher-Brown**

Milestone		Target for Delivery	Q4 Position (23/24)	Q1 Position (24/25)	Q2 Position (24/25)	Q3 Position (24/25)	Q4 Position (24/25)	Key actions from the last period / identify achievements	Any risk, including mitigation
MH MS 13	Procurement for Attempted Suicide Pilot	Q4 2024/25						New provider appointed. Action complete	
MH MS 14	Refresh of the suicide prevention and self-harm action plan in line with the National strategy	Q4 2024/2025						<ul style="list-style-type: none"> Held symposium on 2 December to shape the refreshed suicide action Plan Action plan with partners, due to go to H&WBB in June 	

Priority 4: Dementia pathway transformation **Lead Officer: Kate Tufnell**

Milestone		Target for Delivery	Q4 Position (23/24)	Q1 Position (24/25)	Q2 Position (24/25)	Q3 Position (24/25)	Q4 Position (24/25)	Key actions from the last period / identify achievements	Any risk, including mitigation
MH MS 15	Dementia Partnership Plan to be developed and approved	Q3 2024/25 Revised date for delivery Q4 2025/26						Dementia Review working groups are being formed. An event is being planned for July 2025	The Dementia Partnership continues to be at the development stage and is not yet sufficiently mature to identify and agree the key priorities and actions for a Dementia Partnership plan. In light of this the timescale for delivery of the Dementia Plan/Strategy has been revised. Potential changes to the ICB structure may limit capacity later in the year.
MH MS 16 New	Review Admiral Nurse Service to understand effectiveness, impact and options for future model	Q2 2024/25						Review complete.	Risk of impact from the end of the pilot, to understand the flow. Work is underway with partners to understand the impact of the end of the Admiral Nurse pilot on Rotherham Dementia Pathway. An EIA has been completed
MH MS 17 New	Dementia system mapping, undertaken jointly with RMBC of commissioned services, non-commissioned, gaps in service and possible duplication	Q4 2024/25						Phase 1 of the mapping is complete. This may need to be revisited throughout the review process to inform that process.	

Priority 5: Delivery of the Better Mental Health for all Plan, also includes the loneliness delivery plan | **Lead Officer: Ruth Fletcher-Brown**

Milestone		Target for Delivery	Q4 Position (23/24)	Q1 Position (24/25)	Q2 Position (24/25)	Q3 Position (24/25)	Q4 Position (24/25)	Key actions from the last period / identify achievements	Any risk, including mitigation
MH MS 18	Delivery of Action plan in response to the Prevention Concordat	Q4 24/25						<ul style="list-style-type: none"> Delivery of Action Plan by Partners of the Better Mental Health for All Group. Progress is measured through the BMH for all group but majority of actions are on target Most actions complete, due to refresh better MH for all strategy over the summer onwards which will incorporate elements the prevention concordat 	
MH MS 19	Delivery of the Rotherham Loneliness action plan	Q4 24/25						<ul style="list-style-type: none"> An update went to H&WBB in September. Progress is measured through the BMH for all group but majority of actions are on target Actions on track and refresh of loneliness action plan due in the Autumn 	

Metric		2024/25 Target	Q4 Position (23/24)	Q1 Position (24/25)	Q2 Position (24/25)	Q3 Position (24/25)	Q4 Position (24/25)	Comments if off track	Any risk, including mitigation
MH KPI 1	Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services	Rotherham 2900 on a rolling 12-month basis (NHS National Objective)						This metric relates to 2023/24. See revised MH KPI 2 below.	
MH KPI 2 Revised Metric	Access to transformed Community Mental Health Services for adults and older adults with SMI	12 month rolling basis. Rotherham target 2470						Data for this metric comes from the National Mental Health Services Standard Data Set (MHSDS). The most recent national data available is for January 2025 (12 months rolling) 3575. RDaSH are reporting a position of 3605 for March 2025.	
MH KPI 3	People on the GP SMI Registers receiving all six physical Health Checks (in the 12 months to period end) 75% of those living with SMI (LTP ambition/Core20PLU5)	Q4 2023/24 60%						This metric relates to 2023/24. See revised MH KPI 4 below.	

Metric		2024/25 Target	Q4 Position (23/24)	Q1 Position (24/25)	Q2 Position (24/25)	Q3 Position (24/25)	Q4 Position (24/25)	Comments if off track	Any risk, including mitigation
MH KPI 4 Revised Metric	Reduce inequalities by working towards 75% of people SMI receiving a full annual physical health check with at least 60% receiving one by March 25	Q4 2024/25						For Q1 the actual was 69% For Q2 the actual was 70% For Q3 the actual was 72.5% For Q4 the actual was 79.4%	
MH KPI 5	Increase in number of mental health ARRS workers in Primary Care (expected 6 per year, a total of 18 in year 3 = is 3 per PCN).	A total of 18 MH ARRS by March 2024						Contractual arrangements were in place to meet the 18 MHARR's roles in Primary Care. However, the full capacity was not realised due to recruitment and retention challenges. The Team also experienced issues with long term sickness which reduced capacity.	Recruitment, retention, levels of sick leave. Meetings have taken place to address these partnership issues. Contracts due to be renewed 25/26.
MH KPI 6	Increase in the number of people accessing alternative to Crisis provisions	By end of Q4 200 people						<p>Rotherham Safe Space – the Service transferred to a new provider (Mental Health matters) in Q1 following a procurement exercise. The new provider commenced a 4 night a week service in July 2024.</p> <p>At the end of Q2 49 people accessed the service. 194 support sessions were provided in total (face to face or telephone)</p> <p>At the end of Q3 87 people accessed the service. 242 support sessions were provided in total (face to face or telephone)</p> <p>Q4 – 160 people accessed the service between January and February 2025. 153 support sessions were provided in total (face to face or telephone) In March 2025, 152 people accessed the service, 98 supported by phone/video and 43 accessing face to face support.</p> <p>Rotherham Samaritans mental health wellbeing pathway: Q1 - 71 referrals received. Q2 - 64 referrals Q3 - 63 referrals Q4 - 68 referrals</p> <p>Target achieved with 562 people seen.</p>	

Metric		2024/25 Target	Q4 Position (23/24)	Q1 Position (24/25)	Q2 Position (24/25)	Q3 Position (24/25)	Q4 Position (24/25)	Comments if off track	Any risk, including mitigation
MH KPI 7	Increase in referrals to amparo	Increase on 23/24 (2023/24 was 37)						6 referrals in Q1 10 referrals in Q2 19 referrals in Q3. 7 referrals in Q4 Total number of referrals 42 24/25 Note: These figures are Rotherham referrals into a South Yorkshire wide service.	
MH KPI 8	Improve quality of life, effectiveness of treatment and care for people with Dementia by increasing the Dementia diagnosis rate to 66.7% by March 2025	Above 67% (NHS National Objective)						NHS England Data for February 2025 shows that Rotherham has a Dementia Diagnosis rate of 89.7% (Throughout the year the diagnosis rate has been consistently higher than the national target)	
MH KPI 9	New Improve the timeliness of Dementia diagnosis (Referral to Treatment Time).	Q4 2024/25						Contract reporting from RDaSH shows the Referral to treatment target of 18 weeks has been met consistently from April 24 to February 2025. RDaSH Contract Performance reporting shows that most people waiting less than 8 weeks for treatment during January and February 2025. Data not yet available for March 2025.	
MH KPI 10	Improved access to support for people with dementia and their Carers.	500 per year						Dementia Carers Resilience Service received 569 referrals	
MH KPI 11	Reduction in dementia waiting list	92% seen within 12 weeks						Contract reporting from RDaSH as of February 2025 (latest available data) shows that 99% of people were seen within 12 weeks.	
MH KPI 12	The number of MECC sessions delivered in the quarter	4 sessions per quarter, 12 sessions in total.	2 courses Feb and March					Q2 – 2 Q3 – 8 (7 Damp & Mould, 1 Loneliness) Q4 - 9 (all Damp & Mould)	
MH KPI 13	The number of people attending a MECC session in the quarter	Minimum of 120 staff and volunteers trained across Place in 24/25.	17 sessions held					Q2 – 60 Q3 - 209 (198 Damp & Mould, 11 Loneliness) Q4 - Total attendees - 119	

5 Transformation Workstream: Supporting People with Learning Disability and Autism

Priority 1: Increase the uptake of enhanced health checks for people with a learning disability aged 14 upwards | **Lead Officer: Garry Parvin**

Milestone		Target for Delivery	Q4 Position (23/24)	Q1 Position (24/25)	Q2 Position (24/25)	Q3 Position (24/25)	Q4 Position (24/25)	Key actions from the last period / identify achievements	Any risk, including mitigation
LDN MS 1	Additional support will be offered to GP Practices to undertake enhanced health checks	Q4 24/25						<p>276 health checks have been completed in Q3. This puts Rotherham above the planned trajectory – see below</p> <p>Legend: Number of Health Checks (1) (Blue bars), Trajectory (Red line with squares)</p> <p>X-axis labels: Q3 2/22/23, Q4 2/23/23, Q1 2/23/23, Q2 2/23/23, Q3 2/23/23, Q4 2/24/24, Q1 2/24/24, Q2 2/24/24, Q3 2/24/25</p> <p>NB The final outturn for Rotherham's performance in 2024/25 will be confirmed in Q1 25/26</p>	NHSE have indicated that are wishing to stretch the 75% target. Further guidance is awaited.
LDN MS 2	Focus on increasing the numbers of eligible young people to access GP enhanced health checks	Q4 24/25						<p>Work is ongoing to support GP's to promote the uptake of enhanced health checks in the 14 -17 cohort of young people. Increase in uptake is being reported. SYICB discussions have occurred to increase uptake</p>	NHSE have indicated that are wishing to stretch the 75% target. Further guidance is awaited.

Priority 2: Support of the development of South Yorkshire Pathways to reduce the need for inappropriate admissions into mental health services **Lead Officer: Garry Parvin**

Milestone		Target for Delivery	Q4 Position (23/24)	Q1 Position (24/25)	Q2 Position (24/25)	Q3 Position (24/25)	Q4 Position (24/25)	Key actions from the last period / identify achievements	Any risk, including mitigation
LDN MS 3	SY ICB to source a suitable provider who has the skills, knowledge and values who can provide this Service	Q2 24/25 (SYICB led)						<p>Kelly Glover (SY ICB Lead) has stated that the tender has been awarded to Voyage. Voyage are in the process of finding a suitable property. Preferred option is located in Sheffield</p> <p>In speaking to SY ICB lead this project remains on track</p>	Questions

Priority 3: Ensure people with a learning disability and autistic people have better access to employment opportunities **Lead Officer: Garry Parvin**

Milestone		Target for Delivery	Q4 Position (23/24)	Q1 Position (24/25)	Q2 Position (24/25)	Q3 Position (24/25)	Q4 Position (24/25)	Key actions from the last period / identify achievements	Any risk, including mitigation
LDN MS 4	Monitor SEND Supported Internships action plan	Q4 2024/25						<p>This plan has been approved. The Rotherham SEND Employment sub group are tracking the plan.</p> <p>A year's additional funding has been agreed by DFE to extend the project for another year. The supported internship project will now close 25/26</p>	

Priority 4: To further develop accommodation with support options **Lead Officer: Garry Parvin**

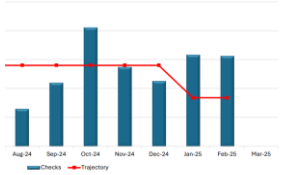
Milestone		Target for Delivery	Q4 Position (23/24)	Q1 Position (24/25)	Q2 Position (24/25)	Q3 Position (24/25)	Q4 Position (24/25)	Key actions from the last period / identify achievements	Any risk, including mitigation
LDN MS 5	To expand the number of providers on the Rotherham FPS	Q3 24/25						The supported living FPS has increased to now include 18 providers	

Priority 5: Refresh the Vision and Strategy for people with a learning disability through coproduction and codesign | Lead Officer: Garry Parvin

Milestone		Target for Delivery	Q4 Position (23/24)	Q1 Position (24/25)	Q2 Position (24/25)	Q3 Position (24/25)	Q4 Position (24/25)	Key actions from the last period / identify achievements	Any risk, including mitigation
LDN MS 6	Embed the Vision and Strategy for people with a learning disability and the Autism Strategy.	Q4 24/25						<p>Coproduction has completed. Refreshed strategy presented to cabinet in February 2023 and approved</p> <p>Coproduction to develop an action plan is in train</p> <p>A yr 1 review is being completed</p>	

Priority 6: Develop a new service model for day opportunities for people with high support needs | Lead Officer: Garry Parvin/Debbie Ramskill

Actions completed for this period, building due to be complete 2026

Metric		2024/25 Target	Q4 Position (23/24)	Q1 Position (24/25)	Q2 Position (24/25)	Q3 Position (24/25)	Q4 Position (24/25)	Comments if off track	Any risk, including mitigation
LDN KPI 1	Rising numbers of young people aged 14-25 accessing enhanced Health checks.	60% Q4 24/25	66.7%	12.5%	26.3%	61.2%		<p>The position is comparable with previous years; Rotherham GPs complete most health checks in the last quarter</p> <p>A task and finish group has been convened to review NHSE diagnostic codes, which may indicate that a young person has a learning disability and eligible for a health check</p> <p>Final outturn for 24/25 will be known in Q1 25/26</p>	Not all practices conduct health checks each month for 14 to 17 year olds. If no checks were conducted for a practice the national data excludes that practice's data.
LDN KPI 2	75% of people with a learning disability in Rotherham will have access to GP enhanced health check.	75% Q4 24/25 (NHS National Objective)		Apr health checks 83, Trajectory 56	July health checks 101 Trajectory 140	In Oct 205 health checks were completed	In February 2025 156 Health checks were completed	<p>The position is comparable with previous years,</p>  <p>October 2024 was exceptional in the number of health checks complete. The data above highlights that performance has outstripped the planned trajectory. Final Q4 data will be reported in Q1</p>	NHSE have indicated that are wishing to stretch the 75% target

Metric		2024/25 Target	Q4 Position (23/24)	Q1 Position (24/25)	Q2 Position (24/25)	Q3 Position (24/25)	Q4 Position (24/25)	Comments if off track	Any risk, including mitigation
LDN KPI 3	Reduction in the numbers of people needing to be detained in mental health services	8 people by Q2		Increase to 9	Maintain at 9	Decrease to 6	Maintained at 6	The demography of the transforming care cohort has shifted. Most admissions to mental health services are autistic people without a learning disability. This a pattern repeated across the SY ICS footprint.	Proposed SY safe space pilot will offer some mitigation. However, there is an emerging issue of sufficiency. This is being mitigated by a review of the emergency respite bed in Rotherham
LDN KPI 4	An increase in the number of young people accessing supported internships by 2025.	TBC	TBC	TBC	TBC	36 supported internships have been created this year. This will be the baseline	Maintained at 36	<ul style="list-style-type: none"> The supported internships delivery plan is being reviewed and Delivery partners are being consulted. Currently 31 young people access supported internships. The Supported Employment Team further expanded in early 2024, to deliver Council-led Supported Internship Programme which ensures a structured, work-based study programme for 16 to 24-year-olds with SEND, who have an Education, Health and Care plan. Supported internships are a great opportunity to improve the life chances of young people with SEND by supporting them into sustained, paid employment. There are also benefits for the economy, employers, families, the local community and wider society. 	
LDN KPI 5	12 units of supported living are created every year	12 per year To maintain						New capacity opening in Thrybergh On track	Out of borough providers creating services without appropriate consultation

6 Transformation Workstream: Urgent, Emergency and Community Care

Priority 1: Frailty **Lead Officer: Steph Watt \ SROs: Dr Rod Kersh, Jodie Roberts, Kirsty Littlewood**

Milestone		Target for Delivery	Q4 Position (23/24)	Q1 Position (24/25)	Q2 Position (24/25)	Q3 Position (24/25)	Q4 Position (24/25)	Key actions from the last period / identify achievements	Any risk, including mitigation
UEC MS 1	Review and delivery of a revised falls offer	Q4 23/24						This scope has been expanded to support 2 out of 4 of Rotherham's high impact projects including frailty and ambulatory care. Cross system MDT workshops have been held. Outputs include a directory of services created along with identifying what is working well, challenges, opportunities and risks. To be sessions held to inform 24/25 priorities. Developing and delivering the model has been incorporated into the frailty workstream in order to provide an integrated offer	Risk in developing, delivering and embedding sustainable change due to the size and complexity of the offer. Impact/mitigation: this was an issue in practice. A mapping exercise was completed which will inform a holistic review of community services to be conducted in 2025-6
UEC MS 2	Community frailty model: Review and streamline the current frailty and falls offer to provide a more holistic and integrated approach within an affordable resource envelope, including enhanced access to physical activity, self help, signposting, and self referral to appropriate pathways	Q4 24/25						The Moving Rotherham partnership secured a Place Expansion development grant from Sport England in April 2025. This includes piloting an Active Hub with health coaches to support people with long-term conditions into physical activity opportunities. This will include opportunities to embed physical activity into daily lives locally. A new post will work to identify opportunities to sustain physical activity for children and young people linked to the Children's Capital of Culture. A new falls /deterioration pathway has been developed for care homes to reduce avoidable conveyances/ admissions and circulated as part of a comprehensive care home support pack as part of the winter plan. A wider piece of work to review community services has been specified for 2025-6 which will include reviewing the Place falls and frailty offer.	

Milestone		Target for Delivery	Q4 Position (23/24)	Q1 Position (24/25)	Q2 Position (24/25)	Q3 Position (24/25)	Q4 Position (24/25)	Key actions from the last period / identify achievements	Any risk, including mitigation
UEC MS 3	Implement proactive care	Q3 24/25						<p>Primary care led a proof-of-concept proactive care model between December 2024 – March 2025 with the aim of enhancing quality of life for the frail and reducing unplanned admissions/attendances. PCNs risk stratified patients based on frailty scores and risk of admission and conducted an MDT review working across physical and mental health, social care and the VCS. A consultant community geriatrician trialled a high acuity pathway for those potentially in the last year of life, conducting a comprehensive geriatric assessment (CGA). Initial evaluation is positive with 288 patients having undergone an MDT, 576 patients having their care optimised and 100 patients receiving a CGA. 88% of Primary Care colleagues felt that patient/care experience will improve through this programme which is demonstrated through a 37% reduction in hospital admissions for patients on the high acuity pathway, when compared to a control group. Ongoing evaluation will allow the benefits of this programme to be fully realised.</p>	<p>There is a risk to timescales if collective action impacts on this work. Impact/mitigation There was no significant impact on this piece of work in practice, with positive engagement from primary care.</p>
UEC MS 4	Develop an integrated MDT offer to support acute frailty	Q4 24/25						<p>Development of an integrated acute frailty pathway to support frailty identification, intervention, admission avoidance and discharge, further strengthening the link between acute and community care. Benchmarked against the national frailty strategy as part of the TRFT quality initiative and ambulatory care workstream. Additional resource to support Comprehensive Geriatric Assessment/ holistic approach in place which has increased the numbers being completed, particularly upstream in the pathway.</p> <p>TRFT have been successful in securing £7m capital funding to expand urgent and emergency capacity to facilitate flow. The build is scheduled to be completed in July 2025 with full implementation for winter 2025/6 (see below)TRFT are reviewing the frailty offer and new ways of working</p>	

Priority 2: Ambulatory Care

Lead Officer: Steph Watt \ SROs: Kirsty Littlewood & Jodie Roberts

Milestone		Target for Delivery	Q4 Position (23/24)	Q1 Position (24/25)	Q2 Position (24/25)	Q3 Position (24/25)	Q4 Position (24/25)	Key actions from the last period / identify achievements	Any risk, including mitigation
UEC MS 5	Ensure signposting and navigation directs to the most appropriate pathway according to need focusing on out of hospital pathways wherever possible	Q2 24/25						Implementation of the multi-disciplinary Transfer of Care Model facilitates knowledge transfer of health, social care and VCS community pathways and alternative pathways to ED/ right care for hospital admission and discharge. Co-location with Yorkshire Ambulances Services reduces avoidable conveyances by accessing alternative pathways. 111/999 directory of services reviewed and updated as new work streams come on board.	
UEC MS 6	Enhance ambulatory care offer through focussed review of top presenting conditions and implementation of alternative pathways	Q4 24/25						£7m national capital award is funding replacing the current medical SDEC, an old ward in the middle of the hospital, to a new expanded space next to ED. There will be direct access for Yorkshire Ambulance Service and Primary Care. In addition, there will be improved facilities including the fracture clinic and sexual health. 35 teams & 600 staff have been moved to facilitate the build whilst running all services. Clinical standards, clinical pathways and processes and workforce are all being reviewed to maximise efficiency and effectiveness. The SDEC design will prevent this space being bedded in future to ensure consistent streaming, thereby reducing ED pressures. A mobile Xray pilot has been developed to be implemented in Q1 2025 which will enable radiographers to take x-rays in people's homes (according to level of risk) to improve the patient experience and reduce avoidable conveyances. This is ground-breaking as there are very few other areas currently doing this.	
UEC MS 7	Implementation of hot clinics	Q3 24/25						De-prioritised due to SDEC capital project. Re-working of the fracture clinic has been incorporated into the programme.	

Priority 3: Integrated Discharge to Assess **Lead Officer: Steph Watt \ SROs: Kirsty Littlewood & Jodie Roberts**

Milestone		Target for Delivery	Q4 Position (23/24)	Q1 Position (24/25)	Q2 Position (24/25)	Q3 Position (24/25)	Q4 Position (24/25)	Key actions from the last period / identify achievements	Any risk, including mitigation
UEC MS 8	Review and recommission community bed base	Q4 24/25						Extension of existing nursing intermediate care community bed base contract is in place to enable a wider review of the commissioned bed base as part of the community services review	Dependency with the home based pathway review and discharge to assess model.
UEC MS 9	Agree and implement escalation process for place and out of area	Q3 24/25						A revised whole system escalation process has been established in Rotherham with new national acute, community and mental health OPEL requirements embedded. This has enabled barriers to be addressed on a case by case basis and learning which has informed new ways of working to improve system flow. Updated repatriation policy and streamlined out of area processes for SY placements and the wider system is in place. Re-purposed funding has been used to support an acute flow Matron and Place system capacity manager to identify and address barriers to system flow and support complex cases.	
UEC MS 10	Support for care homes: i. to reduce avoidable conveyances ii. support time to including Trusted Assessor pilot	Q4 24/25						Two new trusted assessor roles hosted by the TRFT care homes team conduct discharge assessments on behalf of care homes, providing expert knowledge to identify appropriate placements to support the needs of the individual and family wishes. Initial evaluation indicates a positive impact with excellent qualitative feedback from care homes and discharge teams alike. The role holders have also worked in ED to reduce avoidable admissions, supporting people to return to their care home in a timely way, reducing risk of harm and supported care homes post complex discharges to reduce the risk of re-admission. A steering group is meeting to review multidisciplinary support to care homes and the effective implementation of the Enhanced Health in Care Homes pathway.	

Milestone		Target for Delivery	Q4 Position (23/24)	Q1 Position (24/25)	Q2 Position (24/25)	Q3 Position (24/25)	Q4 Position (24/25)	Key actions from the last period / identify achievements	Any risk, including mitigation
UEC MS 11	Implement a community patient tracker and enhance visibility and oversight of community pathways	Q4 24/25						In 2024-5 there was no evidence that a real time community patient tracker was on the market. This is due to complexities arising from the need to draw on data sources from different record systems across multiple organisations and extracting real time data. The workstream scope was therefore reduced to provide interim solutions which provide greater transparency and maximised capacity. In pathway 1, RMBC are implementing a new electronic system to allocate enablement resource and support case management. There has been a technical delay due to single sign in which is currently being resolved.	
UEC MS 12	Update capacity and demand tool	Q2 24/25						In year delay due to recruitment. Information has been collated and analysis will be conducted through the community services review.	

Priority 4. Cross cutting workstreams

Lead Officer: Steph Watt SROs: Kirsty Littlewood & Jodie Roberts

Milestone		Target for Delivery	Q4 Position (23/24)	Q1 Position (24/25)	Q2 Position (24/25)	Q3 Position (24/25)	Q4 Position (24/25)	Key actions from the last period / identify achievements	Any risk, including mitigation
UEC MS 13	Develop and embed the TOCH D2A model	Q3 24/25						TRFTs community base at Woodside has been adapted to enable the co-location of the TOCH call centre, Yorkshire Ambulance Service, integrated discharge team, urgent community nurses and therapists, reablement and voluntary and community services from Q4. A therapy D2A model is embedded with 758 assessments conducted at home in the period Apr 24 – Feb 25] A pilot of ring-fenced enablement resource to increase the numbers who can be assessed at home will be conducted from May.	Previous risk of lack of identified space for TOCH is now resolved. Potential for D2A pilot to impact on timeliness of enablement assessments in community if D2A are prioritised. This will be mitigated by expansion of enablement workforce through ongoing recruitment.

Milestone		Target for Delivery	Q4 Position (23/24)	Q1 Position (24/25)	Q2 Position (24/25)	Q3 Position (24/25)	Q4 Position (24/25)	Key actions from the last period / identify achievements	Any risk, including mitigation
UEC MS 14	Out of Hospital Pathways. Targeted community pathways to reduce avoidable conveyances/admissions and in-reach to deflect from the front door. Including implementation of Virtual Ward remote monitoring, growing push pathways and reaching 80% virtual ward occupancy.	Q2 2024/25						<p>Rotherham's virtual ward has been nationally recognised as an area of good practice. There were 2817 admissions to virtual ward 01/04/24 to 31/03/25, equivalent to nearly 8 admissions per day. This has saved in the region of one third of an acute ward of admissions every day of the year, or, based on an average LoS of 8 days, 22,536 acute bed days across the year. Virtual Ward now has a frailty, respiratory and heart failure pathway and has supported 65 % step up/admission avoidance and 35 % step down/discharge between 01/04/24 and 31/03/25</p> <p>Mental health and Community Respiratory Exacerbation Push pathways have been implemented to provide alternative responses to ambulance conveyances, thereby reducing wait times for patients and the risk of harm. This extends the push pathways from two to four, with 258 accepted referrals 1/04/23-29/1/24 and 573 accepted referrals, 1/04/24-31/04/25, representing a 122% increase.</p>	<p>Remote technology may not be appropriate to support all pathways. Mitigation: The technology will only be applied where appropriate to support care according to the individual's needs.</p> <p>Impact/mitigation: A remote tech solution has been procured in partnership across SY. There has been a delay in implementation in Rotherham due to funding, which has been resolved, with a planned pilot in Q1/2 2025.</p>
UEC MS 15	<p>Review Falls offer</p> <p>Delivery of revised model incorporated into frailty work stream</p>	Q4 2023/24						<p>Review of the falls offer is complete and included in frailty directory of services. Strengths and opportunities of the offer have been identified through whole system workshops.</p> <p>Now incorporated into the wider high impact frailty and ambulatory care workstreams</p>	<p>Risk in developing, delivering and embedding sustainable change due to the size and complexity of the offer.</p> <p>Mitigation: Partnership and programme approach, supported by Frailty /ambulatory care being identified as a high impact priority for 2024/25.</p>

Metric		2024/25 Target	Q4 Position (23/24)	Q1 Position (24/25)	Q2 Position (24/25)	Q3 Position (24/25)	Q4 Position (24/25)	Comments if off track	Any risk, including mitigation
UEC KPI 1	% of 2-hour UCR referrals that achieved the 2-hour standard <i>Data from Care Group 4, TRFT</i>	70%	73% March 24 (Validated position)	75% April 24	75% July 24	80% Oct 24	72% Jan 25	Project completed and work transitioned into business as usual. Performance continues to be monitored through the UEC meeting for benefits realisation/impact on whole system flow. The service has met or exceeded 70% threshold consistently since launch.	
UEC KPI 2	Virtual Ward trajectory and capacity (occupancy rate) <i>Data from Care Group 4, TRFT</i>	Q4 100 beds with 80% occupancy	76% March 24	76.1% June 24	69% Sept 24	73% Dec 24	68% Feb 25	Project completed and work transitioned into business as usual. Performance continues to be monitored through the UEC meeting for benefits realisation/impact on whole system flow. The quality of service is high as validated by patient feedback and requests to speak at national conferences and hosting subsequent good practice meetings. Acuity levels are high reflecting genuine admission avoidance and early discharge. Occupancy has been varied due to increased demand across all unplanned pathways, ongoing staff sickness and vacancies resulting in some resourcing challenge.	
UEC KPI 3	Improve A&E waiting times, compared to 2023/24, with a minimum of 78% of patients seen within 4 hours in March 2025 <i>Data from 6 key indicators – Source: NHS Digital</i>	78% of people treated, referred or admitted within 4 hours of arrival	63% March 24	68.7% June 24	68.6% August 24	62.1% Nov 24	65.04% Mar 25	This standard is nationally challenged due to sustained increases in demand. Rotherham has seen unprecedented levels of demand throughout winter with regularly over 300 attendances per day. This has masked the impact of some of the service improvements made to date. Activity includes streaming at the front door, development of Same Day Emergency Care, alternative pathways to ED including virtual ward and 2 hour urgent response and workforce/cultural change. The four-hour standard is measured and reported across all types of A&E department. When broken down by type 1, it is reflective of the performance comparison for services operating 24-hour consultant led care with full resuscitation capability. Rotherham continues to perform well for type 1 attendances when compared regionally. For week ending 01/04/25, Rotherham ranked 24/126 for type 1 performance and 80/126 for all performance.	A rapid action plan has been developed with daily oversight and monitoring.

Metric		2024/25 Target	Q4 Position (23/24)	Q1 Position (24/25)	Q2 Position (24/25)	Q3 Position (24/25)	Q4 Position (24/25)	Comments if off track	Any risk, including mitigation
UEC KPI 4	<p>Improve ambulance response times</p> <p><i>Data from 12 Additional Measures – Source: NHS Digital</i></p>	Cat 2 30 mins	29:28 March	30:43 June	26:11 August	37:18 Nov	28:45 Mar 25	<p>A single national target to improve category 2 ambulance response times to an average of 30 minutes across 2024/25 has been set. TRFT, YAS and Place partners are working together to reduce avoidable conveyances including Project Chronos to identify new ways of working. Unprecedented levels of attendance in Q3/4 have impacted on performance</p> <p>SYICB has the best cat 2 response times of all Y&H ICBs</p>	
UEC KPI 5	<p>Ambulance handover times</p> <p><i>Data from UEC Alliance report</i></p>	18:50 (SY target)		16:32 June	19:00 YTD to October	22:09 YTD to Dec	23:57 YTD to Mar	Year to date figures from SY Alliance show that the target is just off track, but Rotherham continues to perform well when compared across the wider ICB – broadly in line with Barnsley and 7-10 mins quicker than Doncaster and Sheffield	
UEC KPI 6	<p>Reduction in people with no criteria to reside</p> <p><i>Data from 6 key indicators – Source: NHS Digital</i></p>	NCTR % occupancy of ≤10.8% Local target 10%		16.2% June	18% August	17.9% Nov	19.1% Mar 25	<p>Unprecedented levels of attendance in UECC/industrial action in the early part of the year and impact on admissions has resulted in unplanned escalation beds being used in the acute in addition to planned escalation beds which impacts on demand for discharge pathways. Additional escalation meetings have been held to facilitate de-escalation of the unplanned beds which impacts / exceeds capacity in the discharge pathways. Additional investment has been provided for enablement and spot purchase community beds.</p>	System pressures may be higher than impact of changes. A new escalation framework and operational /performance reports helped manage resource across pathways to maximise impact.
UEC KPI 7	<p>Reduction in long lengths of stay in Acute bed base at 7, 14 and 21 days</p>	Acute: 7 days 40%	7 days 55%	45.6% June 24	46.5% August 24	45.9% Dec 24	56.8% Feb 25	As above Escalation meetings were increased including daily Executive escalations across Place at peak times.	As above
UEC KPI 8	<p>% of acute bed occupancy for NCTR by LOS</p>	Acute: 14 days 25%	14 days 27%	22.7% June 24	24.8% August 24	22.4% Dec 24	28.7% Feb 25	As above	As above
UEC KPI 9	<p><i>Data from UEC Performance Report – Source: TRFT</i></p>	Acute: 21 days 12%	21 days 16%	12.8% June 24	14.4% August 24	11.7% Dec 25	15.9% Feb 25	As above	As above

Metric		2024/25 Target	Q4 Position (23/24)	Q1 Position (24/25)	Q2 Position (24/25)	Q3 Position (24/25)	Q4 Position (24/25)	Comments if off track	Any risk, including mitigation
UEC KPI 10	Reduction in long length of stay for community beds	TBC	TBC	TBC	TBC	TBC	TBC	Baseline being established to set target reduction Additional escalation meeting added for commissioned beds and new review meeting for spot purchase beds. Successful go live of the updated Community Daily Discharge SitRep / Intermediate Care Data Collection. Working with business intelligence and applications team to support a system solution to enhance performance monitoring.	
UEC KPI 11	Proportion Discharged to Usual Place of Residence Data from 12+ indicators, Local data – Source: SUS	94%	95.5% March 24	96.1% June 24	94.9% August 24	95.2% Nov 24	94.5% Mar 25	The target continues to be met despite increased demand and complexity. Better care funding has been used to increase capacity to support more people to remain/return home. However, capacity is challenged due to levels of demand, staff sickness and vacancies. Service improvement work continues to grow capacity.	Due to the aging population there is greater complexity of requirements which cannot always be supported at home Mitigation: Rotherham has prioritised and invested in supporting people at home wherever possible. The majority of people receive a period of rehab/recovery before final decisions are made.
UEC KPI 12	Reduce adult general and acute (G&A) bed occupancy to 92% or below. Data from 6 key indicators – Source NHS digital	92% (NHS National Objective)	95.3% March	93.2% June	93% August	96.2% Nov	94.3% Mar 25	Unprecedented levels of attendance in UECC and impact on admissions has resulted in unplanned escalation beds being used in addition to planned escalation beds which impacts on flow. Additional escalation meetings are stood up to facilitate de-escalation of the unplanned beds.	System pressures may be higher than impact of changes. A new escalation framework and operational /performance reports will help manage resource across pathways to maximise impact.

Any further comments:

Operational pressures, including industrial action, and staffing (sickness and vacancies) poses a risk to engagement and successful delivery.

7 Transformation Workstream: Palliative and End of Life Care

<p>Priorities covered by the milestones and metrics below are:</p> <ol style="list-style-type: none"> 1. Enhance personalised palliative and end of life care 2. Implementation of ReSPECT across Rotherham 3. Benchmark against the Ambitions Framework 4. Inform future commissioning through patient and Carer experience 	<p>Lead Officer: Emma Royle</p>
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Milestone		Target for Delivery	Q4 Position (23/24)	Q1 Position (24/25)	Q2 Position (24/25)	Q3 Position (24/25)	Q4 Position (24/25)	Key actions from the last period / identify achievements	Any risk, including mitigation
PEOLC MS 1	Undertake work to identify Rotherham patients and carers experience to inform future commissioning	Q3 24/25						Engagement sessions have taken place with Speak-up (Self Advocacy for people with LD and autism), The Rainbow Project (LGBT), and The One Voice & Life Groups (run by and for BAME women). Healthwatch have also carried out SY wide consultation work with patients, families, and carers. Next steps – to undertake engagement sessions focused specifically on Rotherham. We have engaged with the public and have heard the experience of 52 people, including information that they would like to see on the new PEoLC website. Also connected with Community Outreach Worker at The Rotherham Hospice and to take part in one of the radio programmes. Feedback will be used to help inform future commissioning work.	
PEOLC MS 2	Implement ReSPECT across Rotherham, including relevant training	Q4 24/25						ReSPECT went live in Rotherham 1 st October 2023. A multi-agency implementations meetings continue every 2 months. Level 1, 2 and 3 training videos, ECHO training sessions etc developed. Positive feedback re use from the Training session to continue. Audit and evaluation is taking place and feedback from this will go to the UK Resuscitation Council. A SY wide policy progressing.	
PEOLC MS 3	Repeat Benchmark against the ambitions for PEOLC framework annually (by March 2025)	Q4 24/25						The results from Rotherham, Sheffield, Barnsley and Doncaster to form a SY wide action plan. This will be monitored by the SY ICB PEoLC Board. The repeat benchmarking has commenced, starting with Childrens PEoLC. Benchmarking against the ambitions has been completed for childrens services across Rotherham.	

Milestone		Target for Delivery	Q4 Position (23/24)	Q1 Position (24/25)	Q2 Position (24/25)	Q3 Position (24/25)	Q4 Position (24/25)	Key actions from the last period / identify achievements	Any risk, including mitigation
PEoLC MS 4	Develop a Rotherham Place Action Plan working with the SY wide Implementation Group to respond to the SY PEoLC Strategy	Q3/4 24/5						This will take into account the actions within the new SY PEoLC Strategy and also the Rotherham Benchmarking against the national ambitions framework. The action plan is in place and the areas relating specifically to Rotherham are discussed at the Rotherham Place Group.	
PEoLC MS 5	Develop Rotherham PEoLC Dashboard.	Q2 24/25						This has been completed on a SY wide basis and is available on the SY ICB intranet. Information from this is exportable and is shared with Partners at the Rotherham Place PEoLC Group for discussion. Further discussion is taking place regarding SY wide trajectories. Rotherham Dashboard has been completed by Public Health as part of the JSNA work. It will be added to the RMBC website and discussed at the monthly Rotherham Place PEoLC meetings. (NB: Work is taking place with the SYICB Business Intelligence Team to develop a common activity and monitoring process to measure Rotherham performance against the SY PEoLC strategy.) This is completed and reported on through the Rotherham Place Group.	

Metric		2024/25 Target	Q4 Position (23/24)	Q1 Position (24/25)	Q2 Position (24/25)	Q3 Position (24/25)	Q4 Position (24/25)	Comments if off track	Any risk, including mitigation
PEoLC KPI 1	Maintain the proportion of people on end of life care registers at 0.7%	0.7%	0.72%	0.71%	0.74%	0.77%	0.77%	Note that this is the best rate across South Yorkshire and is above average nationally.	
PEoLC KPI 2	Increase the number of ReSPECT plans in place.	1000 by March 25	485	626	792	919	1100		
PEoLC KPI 3	Increase number of people who have completed training in end of life care	250	56	55	56	56	58		

Any further comments:

The South Yorkshire ICB Palliative and End of Life Care Board has been established. There are 3 sub-groups under the Board – Children and Young People, Patient Engagement and Clinical Reference Group. A SY PEoLC Strategy is in place. ICB Place PEoLC leads meet weekly. A Rotherham Place PEoLC group meets every 6 weeks.

Rotherham Place Partnership Update: March/April 2025

Park Rehabilitation Centre Community Appointments Day

In November the Musculoskeletal (MSK) Physiotherapy service ran a new approach to delivering physiotherapy assessment and interventions. The team invited over 100 patients to attend the day which provided patients with a holistic, person centred approach and the opportunity to have 'one stop shop' for all their needs. Community based providers were invited to attend including Rotherham Healthwave, the Improving Access to Psychological Therapies Service, Working Win and Places and Leisure.

The day was a fantastic success. 100 patients were assessed and received person centred conversations, the patient feedback received was amazing.

Park Rehab's Community Appointment Day

Thank you to all the amazing colleagues who gave their time to support Park Rehab's Community Appointment Day!

Patients were surveyed for their feedback about the event. The early results of the survey are excellent, meaning Community Appointment Day was a big success for Becky, Gemma (pictured) and the colleagues who supported the event.

Three patients surveyed - Kim, Jane and Lesley - chose to share their experience of the day. Here, they tell you why changing how we worked helped improve their experience.



I was first offered a group appointment with a physio, but I have anxiety. I was glad to be offered an appointment today instead.

"At first, when I arrived, it all felt a little bit open which I was worried about because of my anxiety. But as soon as I saw Eleanor (physiotherapist), I felt absolutely fine - the appointment still felt very one-to-one and intimate.



Jane

"She looked at me in a holistic way - she didn't just focus on my physical problem. She asked me about different things - like lifestyle changes - which could contribute as well. She was really knowledgeable and very positive.

"I've definitely got peace of mind now about my problem and about what comes next."

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"I've definitely got peace of mind now about my problem and about what comes next."



Kim

"I didn't realise this is what I was coming to today. I didn't expect any of this - everybody's been so nice. I've actually felt like a person and not a number.

"Sarah (physiotherapist) has looked at my scan with me. She's shown it to me and explained what the cause of the problem is. I didn't expect that somebody was going to explain everything. I know Sarah's going to be back in touch with me before I have an MRI.

"I'm also struggling with anxiety and stress. I've been struggling with not knowing where to turn and feeling there's no help there at all.

"I wouldn't have known where to go for help or support with any of that. I didn't even know it was there. Today, I've learned about the help I can access that I need."



Lesley

The **Voluntary and Community Sector (VCS)** has a three- staged approach to responding to the cost-of-living crisis, in 2022/23:

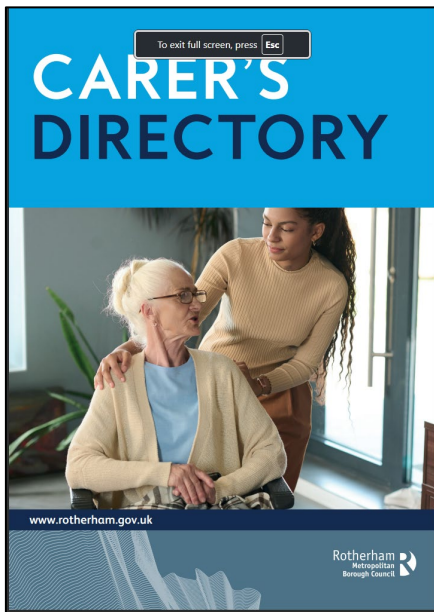
- **Warm Welcome** – 27 groups accessed funding of up to £5k to deliver a 'warm welcome' and critically to serve as connectors to financial inclusion hubs
- **Financial Inclusion Hubs** - core partners: Rotherfed, Citizens Advice Bureau, Laser Credit Union - delivered One Stop Shops including Energy KnowHow, low cost loans and debt advice in 10 targeted locations
- **Community engagement** - events held to drive footfall, seed funding supported 9 groups, identified through hubs



- 400 one-stop shop sessions
- 2,400 people attending sessions
- 300 socially excluded people engaged
- 10 community venues supported
- 10 community events held
- 500 people attending events
- 12 VCS organisations supported
- 5 new groups established
- 50 volunteers

**Continuing to
over-achieve!**

RMBC has launched a new Carers Directory



Produced to provide comprehensive information and support for carers.

Aiming to empower carers with knowledge about their rights, available support services, and practical advice to help them in their caregiving roles. The directory includes navigational links to relevant websites, making it easier for carers to access the information they need.



CARERS INFORMATION

A carer is someone who provides unpaid care and support to a family member or friend who has a disability, illness, mental health condition, addiction or who needs extra help as they grow older. It isn't someone who volunteers or is employed to provide support.

Caring for someone you love will not always be easy, but you can be helped by the right support services.

There are lots of organisations and activities in Rotherham for carers that provide support and advice on:

- Dementia
- Mental Health and Wellbeing
- Bereavement
- Suicide Prevention and Support
- Community Transport
- Banking support and discount cards.

For more information, help and support, visit our website below or scan the QR code.



www.rotherham.gov.uk/carers

A digital copy of the directory can be accessed via visiting www.rotherham.gov.uk/carers

Investing £7 million into services for Rotherham Patients



Sally Kilgariff, Chief Operating Officer, said 'Our success in securing this funding is great news for Rotherham and the patients we care for'

'The expansion and improvement of emergency primary care, minor injuries and medical same day emergency care will go a long way to help reduce our UECC waiting times and overcome capacity challenges that many trusts face'

The Rotherham NHS Foundation Trust has been successful in its bid to secure £7 million from the Governments Additional Capacity Targeted Investment Fund (ACTIF).

ACTIF is ring-fenced funding specifically to be used to expand urgent and emergency care capacity.

The money will be used to expand Rotherham's Urgent and Emergency Care Centre (UECC) creating additional capacity for urgent primary care, minor injuries and the medical same day emergency care (SDEC).

This additional capacity will support the Trusts improvement journey working towards achieving the national four hour emergency care standard.

Domestic Abuse and Suicide Awareness Training

Following a Domestic Homicide Review in 2024, The Crisis Team Service Manager and Clinical Lead at RDASH considered how they could enhance understanding and learning internally around domestic abuse and suicide. They subsequently developed a training session around suicide and domestic abuse and invited a Senior Project Worker from Hopian (who provide support for adults, young people and children affected by Domestic Abuse and Child Sexual Exploitation in Rotherham) to join the session to provide an overview of domestic abuse services in Rotherham. The session was attended by members from across teams and was well received by the attendees.

Following the initial session, Hopian requested delivery of the same session - adapted to provide an overview of the Rotherham Crisis Team to improve their understanding of services. There was a real sense that Hopian were confident in contacting the Rotherham Crisis Team if they have concerns for the people who access their service and understand how working in a collaborative way, providing wrap around support to individuals in crisis can enhance care. Staff mentioned that they felt reassured following speaking to members of the team.

Suicide and domestic abuse are not easy matters to talk about, many of the people who experience this adversity are equally vulnerable to health inequalities and find it difficult to access or receive the support they need. It is hoped that ongoing collaborative pieces of work such as this with our third sector partner agencies will seek to improve the care for those that require it in Rotherham.

New Medical Centre at Olive Lane, Waverley

Practical completion took place on 12th December 2024 and the lease agreements are close to being agreed and completed. Services will be delivered from the premises in Spring 2025 and the adjacent retail properties are now being fitted out.



Successful Capital Bids for Mental Health Out of Area Placements

The national 2025/26 capital guidance awarded £75m in capital funding to reduce Mental Health Out of Area Placements (OAPs), for those admitted to mental health inpatient hospitals out of area, which includes autistic people, and people with a learning disability.

The successful RDASH proposal is to open a 16 bedded mixed sex Adult Mental Health Rehabilitation Unit to serve patients across Doncaster, Rotherham and North Lincolnshire. The needs of patients with autism or a learning disability will be built into the environment with sensory needs being addressed such as sight/visual, smell/olfactory, hearing/auditory, body awareness/proprioception, internal awareness/interoception, touch/tactile, balance/vestibular, taste/gustatory, communication, sensory space, and awareness. They will also ensure that staff are trained in caring for people with autism and/or a learning disability as well as mental health. This will also include the provision of advocacy for these patients.



The Zen Den at Rotherham Hospice

As part of the patient experience team, Katy Dickson, is the new clinical complementary therapist at Rotherham Hospice. She has worked at the hospice for many years. Combining her palliative experience with her holistic therapy skills she has set up a new service for patients and to support their families and carers.



She offers advanced aromatherapy, in combination with conventional medicine to help with pain, anxiety, nausea and tension. Working alongside an amazing multi-disciplinary team she can offer these treatments safely.

Treatments are offered to inpatients, outpatients who are well enough to travel in and home visits are available for patients who cannot travel. A bathing service for outpatients who need that support is proving to be an amazing part of the service.

The Hospice has also introduced a new room called the Zen Den; the name was picked by patients. It has been designed to help people on their journey after being diagnosed with a terminal illness. The hospice plans spa days for loved ones and helps create memories they can treasure, with treatments such as luxury facials, hot stone massages, manicures, pedicures, head massage, swedish massage and aromatherapy massage. Focussing on a person's physical, spiritual, social and emotional wellbeing.

The hospice invites patients to come in and experience the complementary therapies before they need the inpatients unit. This gives them the chance to meet the staff and have a look around meaning that when they do need to come into the hospice for pain management, symptom control or end of life care they have built a relationship with members of the team and feel more relaxed and prepared.

Within three months of the service having been established there are over 50 people on complementary therapy caseloads and over 120 treatments have been offered. Those who have used the Zen Den have stated that they feel they have been transported to a luxury spa and that they are no longer in a hospice. Families have also expressed how much the service is making a difference to their time in the hospice.

Top Tips for Reducing Your Risk of Dementia

In collaboration with the South Yorkshire Integrated Care Board, Rotherham Memory Services have produced a poster highlighting top tips to reduce the risk of dementia.

The poster is based on the Lancet Commission: Dementia Prevention, Interventions and Care, 2024, **which estimates that around 45% of all dementia cases worldwide could be prevented or delayed by addressing 14 modifiable risk factors at different stages during the life course.**

Over the next couple of weeks, the poster will be distributed to every GP practice in the Rotherham area. The poster includes QR codes directing people to services and support within the Rotherham area to help people address risk factors.

Further information about the Lancet Commission: Dementia Prevention, Interventions and Care, 2024, can be found at:

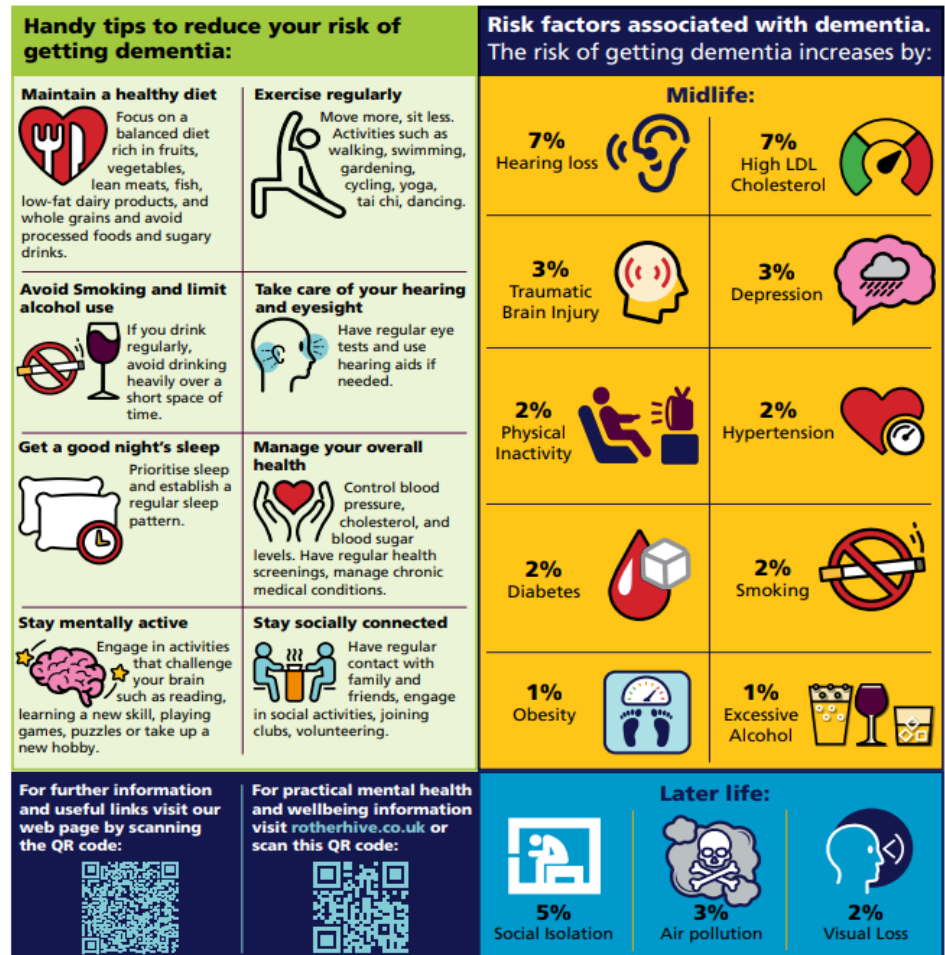
<https://www.thelancet.com/infographics-do/dementia-risk>

Top Tips for Reducing Your Risk of Dementia



Rotherham Doncaster and South Humber
NHS Foundation Trust

Medical research suggests that your risk of developing dementia could be reduced by up to 40% if you lead a healthy lifestyle



Produced in collaboration between Rotherham Memory Services RDASH and the NHS South Yorkshire Integrated Care Board.

RDASH nurturing the power in our communities

Rotherham Prescribing for People with Dementia Forum (in primary, secondary, acute and community care) took place in February 2025:

The forum, which is a collaboration between TRFT (Rod Kersh, Consultant Community Physician) and RDASH (Allie Singer, Nurse Consultant) aims to foster collaboration and provide support in prescribing decisions for individuals with dementia. It presents an opportunity to:

- Share best practices
- Review current evidence and guidelines
- Engage in thoughtful discussions to enhance patient safety and outcomes
- If the inaugural meeting and subsequent work is a success, there is opportunity for this to be rolled out across the wider RDASH footprint and South Yorkshire.



Healthwatch Rotherham

Our statutory duties

- 1. Promoting and supporting the involvement of local people** in the commissioning, provision and scrutiny of local care services.
- 2. Enabling local people to monitor the standard of provision of local care services** and whether and how local care services could and ought to be improved.
- 3. Obtaining the views of local people** regarding their needs for, and experiences of, local care services and importantly to make these views known.
- 4. Making reports and recommendations about how local care services could or ought to be improved.** These should be directed to commissioners and providers of care services, and people responsible for managing or scrutinising local care services and shared with Healthwatch England.
- 5. Providing advice and information** about access to local care services so choices can be made about local care services.
- 6. Formulating views on the standard of provision** and whether and how the local care services could and ought to be improved, and to share these views with Healthwatch England.
- 7. Making recommendations to Healthwatch England to advise the Care Quality Commission to conduct special reviews** or investigations (or, where the circumstances justify doing so, making such recommendations direct to the CQC); and to make recommendations to Healthwatch England to publish reports about particular issues.
- 8. Providing Healthwatch England with intelligence** and insight to enable it to perform effectively.

What were our priority topics for 2024–2025?

Our priority topics 2024–2025

The health and social care experiences of people with **learning disabilities** and/or **autism**



Healthcare views of **young people**



The health and social care experiences of **asylum seekers** or **refugee communities**



Homeless people's experiences of health and social care




All of our work has Rotherham at its heart, whilst shining a light on people in communities facing health inequalities.





All Rotherham people deserve great health outcomes.


healthwatch
Rotherham

What else is in our work plan?

Providing a high-quality information and signposting service - including developing information resources 

 Use the opinions and feedback provided by Rotherham people to look into themes - highlighting issues coming through our enquiries

Working with our community partners to amplify more people's views and experiences 

Developing and strengthening our partnerships in the health and care system in South Yorkshire and Rotherham - including collaborative work with other South Yorkshire Healthwatch 

Our reach in Q4



From Jan – Mar 2025:

331

People have **shared their experiences** of health & social care with us, helping to raise awareness of issues and improve care.

2898

People have come to us for **information and signposting services** (both directly and via our website).

653

People seen through **34 outreach** engagements & events

46

People have attended one of our **Let's talk** events

385

People received our monthly **Newsletter**

12145

People reached through **social media** (Facebook & X)

Our reports in Q4



From Jan – Mar 2025, we have produced:

- 2** Targeted project reports:
 - Living in the shadows – homelessness in Rotherham
 - What young people in Rotherham told us about their wellbeing in 2025
- 1** Enter & View report
- 3** Let's Talk reports on:
 - Oral health
 - Healthy eating and lifestyles
 - Menopause
- 3** What we heard reports / Spotlight shares
- 1** Quarterly insight report that is shared at stakeholder board level
- 1** Young People's directory resource

What we've heard in Q4



Hospital services

We have heard from **49** people about their hospital care.

Key concerns:

- **Waiting times for appointments and procedures**
- **Waiting times in UECC**
- **Parking**
- **Poor communication**

Positives:

- **Some people receive excellent care**
- **Radiology, ICU, Coronary care, Day surgery, Orthopaedics, Fracture clinic & Breast cancer care all received positive feedback**

"I have been waiting about a year now for a hospital appointment for surgery and I was told I'd have an appointment by now. Everytime I try to contact the reception for orthodontics, they don't answer. I've left voicemails but they haven't got back to me"

"My child was admitted to hospital for two days due to severe gallbladder pain. However, they were discharged without the underlying issue being resolved. There was no communication provided to explain the reason for the discharge or any follow-up plan"

"I waited 24 hours in A&E at Rotherham Hospital before being seen"

"I was admitted to hospital in November 24 with a life-threatening condition. I would like to thank the ICU department for saving my life"

"I've been in Rotherham hospital several times over the last few years and it's been an excellent experience"

What we've heard in Q4



GP services

We have heard from **60** people about their GP services.

Key concerns:

- Difficulties getting appointments
- Poor communication – results and follow up appointments
- Issues with referrals

Positives:

- Some excellent examples of quality care provided by specific doctors

“I get fed up trying to book appointments at my GP practice. When you call, you can be 15 in the queue and often I put the phone down and don't bother. It's off putting”

“I have submitted a report from a physiotherapist re my hip [as] a recent hip x ray indicated 'need to discuss with gp'. I hadn't heard from the surgery, so I contacted them...”

“My GP said they'd refer me to Rotherham hospital over Christmas but the referral wasn't sent until February”

“The mental health support I've had at my practice is excellent! [My doctor] is so good. She is kind, she listens to me, I get plenty of time with her and never feel rushed. I can always get in to see her too”

“I am writing to say about the excellent, quality patient centred care I have had at my surgery and in particular, my doctor....She has always listened, is prepared for my entering her room having read up on what is happening....The consistency of seeing one GP, saves so much time in me trying to go through my whole history...”

What we've heard in Q4



Dental services

We have heard from **18** people about dental services.

Key concerns:

- **16** people have been unable to register with an NHS dentist

Positives:

- **Fantastic treatment provided by one dentist for a patient with learning disabilities, allowing them to access dental treatment with respect and understanding**

"I can't get treatment at an NHS dentist. I attend a practice that does have NHS patients but I'm on a waiting list for NHS treatment with them. In the meantime I have to pay private prices"

" I have become a wheelchair user due to chronic illness and now can't access the local dentist I have used for over 40 years. They don't provide a ramp , not even a removable one. This is disgraceful, people with all kinds of mobility issues should not have to struggle with basic access"

"...the difference in [my relative] is remarkable. He looks forward to the visit and can comfortably stay in the chair for a good twenty mins or so. This is all down to the interaction of the dentist and her colleague with my relative. Outstanding! I understand not all healthcare professionals are trained in dealing with Learning disabilities but the importance of having them cannot be underestimated"

What we've heard in Q4



Mental health services

We have heard from **23** people about mental health services.

Key concerns:

- **Lack of support waiting for assessment**
- **Waiting times for ADHD/Autism assessments**
- **Lack of treatment options**

Positives:

- **Community support groups can make a difference**

"I've been referred for an autism assessment but waiting times to be assessed are so long, so what in between now and then?"

"I recently tried Talking Therapies but this didn't suit me and I told the therapist I needed to stop the sessions. My doctor was made aware of this and I have not been offered any further treatment or signposting. I've just been left"

"I have been waiting for an ADHD and autism assessment for around 3 years now. I'm concerned I will fall under adult services now I'm 18 and I've had no updates from anyone to say where my referral sits now"

"My partner has gone two weeks without medication even after constant calls from my partner and myself regarding this. Asked to speak to a manager...and still no communication"

"Mental Health support isn't great! I rely on meeting people at groups and places like this. People I've met make all the difference to how I feel"

What we've heard in Q4



Positive praise for other services:

- Breathing Space
- RNID drop-in clinics
- Patient transport
- Ambulance services
- Community Health Centre services
- Physiotherapy

"We cannot speak highly enough of the rehabilitation treatment that breathing space provides and the staff members"

"I use patient transport for my hospital appointments - it's a great service..."

"The RNID drop-ins are fantastic! I don't know what we'd do without the service..."

"The Community Health Centre services are great... I was able to self refer and was offered a range of times for my appointment and then they said they'd leave my referral open for 6 months in case I needed another appointment in that time"

"When using an ambulance for the 1st time in my life due to a heart attack both were friendly efficient and put me at my ease even came to see me in resus to see how i was which i thought was lovely"

"The physio service at the moment is really good! I was given a number to call and I was offered an appointment locally within a couple of days."

What we've heard in Q4



Negative feedback for other services:

- Healthwave
- Child social care
- Adult social care

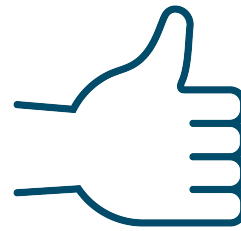
"I wanted chair based exercise classes near to where we live for myself and my husband. Healthwave told me they have nothing in our area and the nearest one to us is at Rotherham Hospital. There aren't even any buses that could get us there. There are a lot of elderly people and services should cover all areas"

"Social is supposed to pay door to door to take my child to Sense a few times a week. They have awarded me the money but after 9 weeks, I'm still paying for it out of my own pocket. I can't afford it anymore but if I don't pay she doesn't go to the day centre and I don't get a break"

"I've had a social worker for my youngest child, she only worked 2 days and was never around when I needed her. Useless"

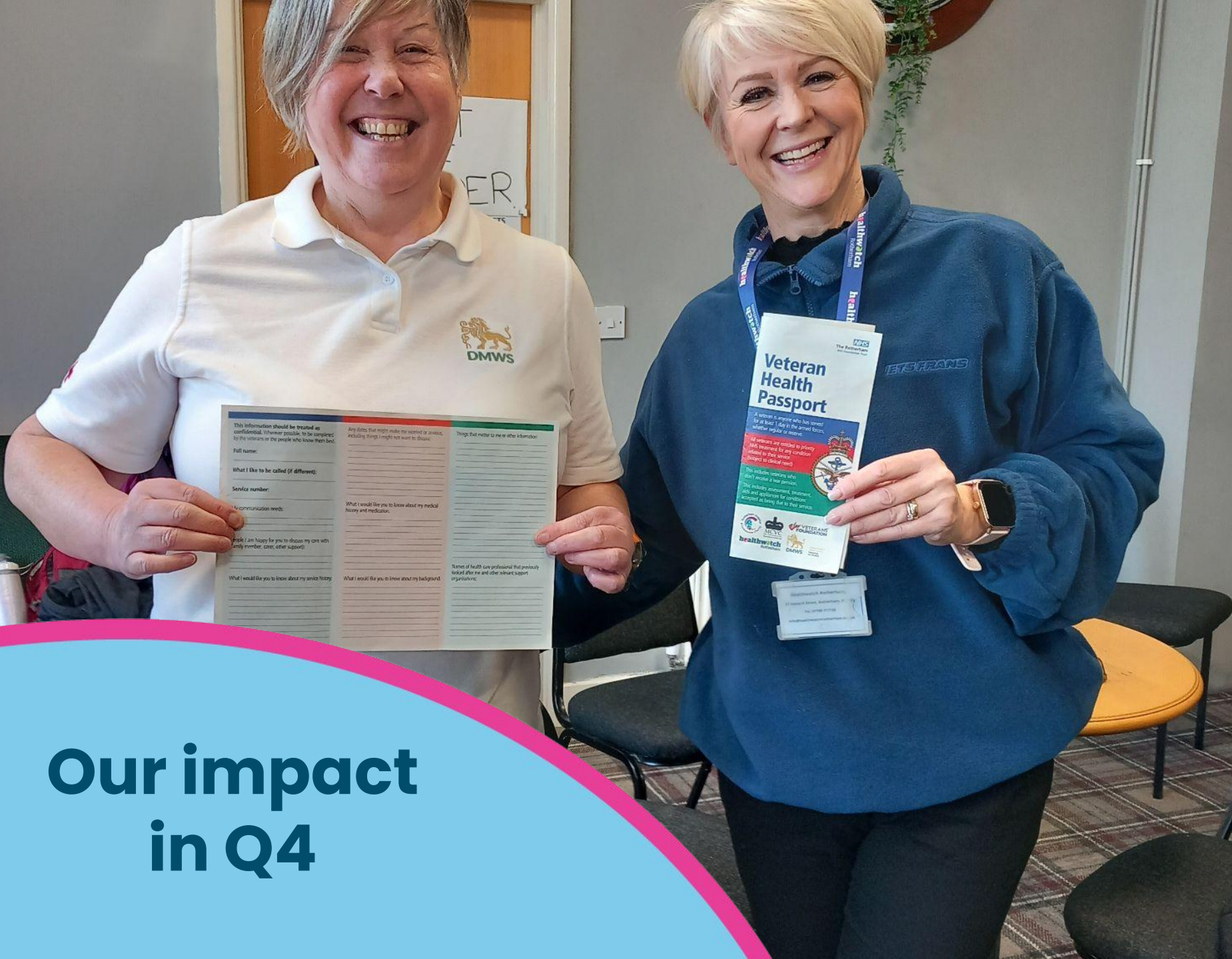
"I go into care homes as part of my role... Normally the staff work really hard and are dedicated and caring. However without exception all the homes are chronically understaffed and it breaks my heart to see residents distressed because they have to wait so long for attention"

Recommendations Q4



Following the feedback we've received in Q4, our recommendations are:

- **Information to be provided to patients in a person centred way using their preferred method of communication**
- **Improve the transparency of the process surrounding referrals both GP and TRFT**
 - Be clear on timescales surrounding how long it takes to send the referral and whether the waiting time starts from the referral being sent or being received
 - How do patients access the process to wait well if they're non digital
- **Improve communication between GP's and patients following test results**
 - Transparency over timescales
 - Be clear if patients should access their results via the NHS App or if the practice will call the patient
 - For non digital patients, be clear at the point of referral on how they access their test results



Our impact in Q4

Living in the shadows – homelessness in Rotherham



We have been working hard over the last 8 months, strengthening our relationships with homeless support services in Rotherham and have been speak to those using the services to find out more about their experiences of healthcare. We also worked closely with Michael* who was willing to provide an in-depth case study for us.

Our report highlighted 4 key themes:

- Mental health issues
- Problems with physical health
- Addiction and attitudes
- Access to healthcare and digital exclusion

"...[If] you have addictions and mental health issues, you can feel that people look down on you and speak to you in a way that is quite patronising"

"How come they can call you to tell you you've missed an appointment but they can't call you to tell you when an appointment has been made? There can't just be me in this situation!"

IMPACT: The power of our case study was picked up by the SY ICB and we were asked to liaise with Michael* for him attend an ICB board meeting to tell them his story.

Young People's directory



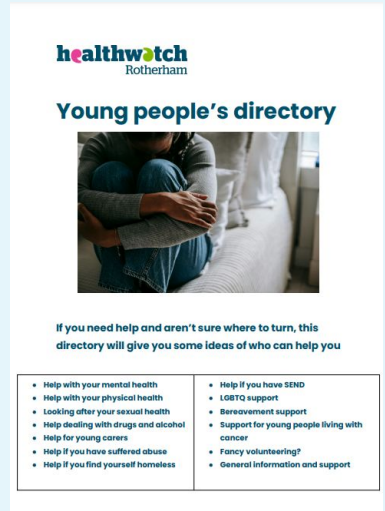
Through our engagement work with young people throughout the year, we have heard how they often struggle to know where to turn when they have a problem.

Our Mental Health directory is consistently one of the most visited pages on our website and so it was identified that producing something similar for young people, could help them find the support they need all in one place.

The directory was produced in conjunction with our two Sheffield University medical placement students, who helped compile the information. It covers many aspects of support including; mental, physical and sexual health, drugs & alcohol, bereavement, young carers, abuse, homelessness, SEND, LGBT, cancer, volunteering, as well as general information and support.

IMPACT:

- **The Young People's directory has been picked up by the Rotherham Advertiser and they have published an article on it.**
- **CARD have put posters up in the office so that it is accessible to clients.**
- **The poster has been sent to all secondary schools/sixth forms/colleges in Rotherham to ensure it reaches those it is designed to support.**



Communication cards



My Communication Card
My communication needs are..

What best describes me..

- I am deaf
- I use a hearing aid
- I use British Sign Language (BSL)

I need a BSL interpreter at every appointment

I need to lip read

Face me and speak clearly

I may need extra time

I need things written down

We have been working with the deaf community over the past 2 years and have continuously highlighted the problems that they are facing in accessing health and social care services. One of the requests that has come out of our work, was for a communication card that they could show to services to ensure they get the reasonable adjustments they need.

The work we did on the health care experiences of people with learning disabilities also showed that this community would also benefit from a similar card.

Working collaboratively with both communities, we designed 2 communication cards that we have had printed for them to use.

IMPACT:

- **Both communities are delighted with the cards and can't wait to use them**
- **We have been approached by other services and LHW to ask if they can use the cards**
- **We have been approached by other groups to ask if we can design a card for their needs (visual impairment, autism, brain injury)**



I have a learning disability
You can help me by.....

- Providing reasonable adjustments, ask me what I need
- Reading my health passport
- Speaking clearly and using simple words
- Being patient and giving me extra time to understand
- Talking to me and not the person I'm with
- Giving information in Easy Read

healthwatch
Rotherham

Other impacts this year



Our transport report featured in a [Healthwatch England article](#) about barriers patients face getting appointments, it was also featured in a [Rotherham Advertiser article](#) on parking and transport at TRFT. The report was used as part of the Health & Wellbeing Strategy refresh. As a result of our recommendations, appointment times have been moved to take into consideration travel issues and extra stops have been added to bus routes serving Badsley Moor Lane.



Through our work on people with learning disabilities and autistic people, we are collaborating with TRFT to change all initial appointment letters to an Easy Read format. TRFT are also looking to link with organisations who produce Easy Read to improve their patient information. Our report has improved awareness of the entitlement to reasonable adjustments, health passports and annual health checks, and has led to our communication card being produced.



We have made **32** recommendations across **3** Enter & View visits. Improvements adopted include: Increasing the diversity of the PPG to make the group more representative of the patient population; Improving signage and patient information on entrances and waiting areas; Introducing dementia friendly signage; Ensuring complaint procedures are clearly displayed; Providing information in other languages where possible. We have also delivered dementia training via one of our SAB members and our report style has been adopted as best practice with other local HW.

Other impacts this year



Collaborative work between Healthwatch Rotherham, TRFT and Military Community Veterans Centre (MCVC) to produce a brand new Health Passport for Veteran's to use when attending healthcare appointments.



Easy Read section added to the website to make health information accessible to all. The Easy Read guides we have produced have been shared with other local Healthwatch for them to adapt. SY ICB have also requested to adapt our 'How to get help with your health' guide to put on their website.



The feedback we have provided to the Health & Wellbeing board is helping to shape the Health & Wellbeing strategy refresh.




We were commissioned by ADASS to conduct a mystery shopper exercise of RMBC's Social Care services to assess how easy it is to access high quality information and support. Our findings and recommendations will help RMBC improve their service ahead of their peer review with the Care Quality Commission (CQC).

Our new work plan priorities for 2025–2026



Our priority topics 2025–2026

The health and social care experiences of people who are **addicted** or in **recovery** from addiction 

 Understanding the **communication difficulties** experienced by people using health and social care


Investigating the experiences of people using **Social Care** services 


All of our work has Rotherham at its heart, whilst shining a light on people in communities facing health inequalities.


All Rotherham people deserve great health outcomes.




What else is in our work plan?

Providing a high-quality information and signposting service - including developing information resources 

Use the opinions and feedback provided by Rotherham people to look into themes - highlighting issues coming through our enquiries 

Working with our community partners to amplify more people's views and experiences 

Developing and strengthening our partnerships in the health and care system in South Yorkshire and Rotherham - including collaborative work with other South Yorkshire Healthwatch 

For more information:

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Let's stay connected:



www.facebook.com/healthwatchrotherham



[@HWRotherham](https://twitter.com/HWRotherham)



We are committed to the quality of our information. Every three years we perform an in depth audit so that we can be certain of this.

Minutes	
Title of Meeting:	PUBLIC Rotherham Place Board: Partnership Business
Time of Meeting:	9.30am – 10.30am
Date of Meeting:	Wednesday 16 April 2025
Venue:	John Smith Room, Rotherham Town Hall
Chair:	Ian Spicer
Contact for Meeting:	Lydia George: lydia.george@nhs.net/ Wendy Commons: wcommons@nhs.net
Apologies:	Wendy Allott, Director of Financial Transformation - Roth, NHS SY ICB Anand Barmade, Clinical Director, Connect Healthcare Rotherham Mat Cottle-Shaw, Chief Executive Officer, Rotherham Hospice Chris Edwards, Rotherham Place Director, NHS South Yorkshire ICB Richard Jenkins, Chief Executive, The Rotherham NHS Foundation Trust Sharon Kemp, Chief Executive, Rotherham Metropolitan Borough Council Bob Kirton, Managing Director, Rotherham NHS Foundation Trust Toby Lewis, Chief Executive, Rotherham, Doncaster and South Humber NHS Foundation Trust Gordon Laidlaw, Head of Comms - Rotherham NHS SY ICB Dr Jason Page, Medical Director, Rotherham Place, NHS SY ICB
Conflicts of Interest:	General declarations were acknowledged for Members as providers/commissioners of services. However, no specific direct conflicts/declarations were made relating to any items on today's agenda.
Quoracy:	Confirmed as quorate.

Members:

Ian Spicer (**IS**), Rotherham Metropolitan Borough Council
 Alex Hawley (**BA**), Acting Director of Public Health, Rotherham Metropolitan Borough Council
 Shafiq Hussain (**SH**), Chief Executive, Voluntary Action Rotherham
 Andrew Russell (**AR**), Director of Nursing – Rotherham & Doncaster, NHS SY ICB
 Jodie Roberts (**JR**), Rotherham NHS Foundation Trust (deputising)
 Claire Smith (**CS**), Director of Partnerships Rotherham Place, NHS SY ICB (deputising)
 Victoria Takel (**VT**), Deputy Chief Operating Officer, Rotherham, Doncaster and South Humber
 NHS Foundation Trust (deputising)

Participants:

Cllr Joanna Baker-Rogers (**JBR**), Health & Wellbeing Board Chair, RMBC
 Kym Gleeson (**KG**), Service Manager, Healthwatch Rotherham
 Shahida Siddique (**SS**), Non-Executive Member, NHS SY ICB
 Lydia George (**LG**), Transformation & partnership Portfolio Manager, NHS SY ICB

In attendance:

Jude Archer (**JA**), Assistant Director of Transformation, NHS SY ICB
 Sue Panesar (**SP**), Public Health Specialist, RMBC
 Debbie Stovin (**DS**), Dental Programme Lead, NHS SY ICB
 Kate Tufnell (**KT**), Mental Health & Dementia Transformation & Delivery Lead, NHS SY ICB
 Sue Turner (**ST**), Public Health Specialist, RMBC
 Sam Watt (**SW**), Registrar in Dental Public Health, Y&H Deanery

Minute Taker:

Wendy Commons, Business Support Officer (Rotherham), NHS SY ICB
 4 Observers

Item Number	Discussion Items
01/04/25	Public & Patient Questions
There were no questions from members of the public.	
02/04/25	Oral Health Needs Assessment
<p>Samantha Watt, Specialty Registrar in dental public health advised members that the oral health needs assessment was being updated as the previous version dated back to 2018. In response to a request by the Rotherham Oral Health Improvement Group to take account of new national and local data, changes to organisational roles and responsibilities for improving oral health and reducing health inequalities whilst also building in a system approach in Rotherham Place.</p> <p>SW outlined what the new OHNA will cover and advised Place Board that:</p> <ul style="list-style-type: none"> - The 2023-4 national dental epidemiology survey found 23.5% of 5 year olds in Rotherham had visually obvious dentinal decay which was 22.4% higher than the national average. - In 2022-3 23.4% of year 6 children surveyed in Rotherham had experience of tooth decay in a least one permanent tooth – similar to SY ICB and Y&H regional average, but higher than England value of 16.2%. - Rotherham consistently has one of the highest levels of hospital tooth extractions nationally with tooth decay still the most common reason for hospital admission in children aged between 5 and 9 years. - Data on the oral health of adults at Rotherham place level is limited. - Head and neck cancer incidence and mortality are increasing nationally with South Yorkshire higher than the national average with the incidence and late/emergency presentation of head and neck cancer. <p>SW outlined the dental services including primary, community and secondary care dental service commissioned in Rotherham by South Yorkshire Integrated Care Board. In March 2024, access to primary dental care in Rotherham for adults and children was higher than nationally with 51.9% of Rotherham adults having seen an NHS dentist in the past two years compared with 40.3% nationally and 57.35 of children had seen an NHS dentist in the past 12 months compared with 55.4% nationally.</p> <p>Currently NHS dental practices in Rotherham support access to dental services through high delivery of commissioned units of dental activity (UDAs). To improve access and prevention for children and adults most in need of care it will involve changing how the dental contract is delivered to a flexible commissioning approach and swapping UDAs for sessions of care and prevention. There are currently 8 flexible commissioning practices in Rotherham.</p> <p>Going forward it is intended to look at improving oral health with more collaborative working with VCSE, partnership working with SY ICB, the development of links with other services, looking for further opportunities to work with schools etc, the expansion of water fluoridation and supporting the implementation of and utilising oral health needs assessment.</p> <p>In terms of next steps, SW asked Place Board to support the Rotherham Oral Needs Health Assessment for 2025 including its recommendations to have a system approach and a common risk factor approach.</p> <p>Place Board were also asked to consider the governance of the Rotherham Oral Health Improvement Group (OHIG) and review membership to ensure it has the right representation to deliver the recommendations.</p> <p>IS thanked SW and asked members for comments.</p>	

JBR asked what can be done at family hubs to get bigger impact with families rather than just with the children. It was acknowledged that more work could be done with training and resources. ST will look at how to roll out a family approach.

In terms of representation on the group, SS felt that strengthening representation from the voluntary sector and including faith representation would help. She also suggested looking at how hospitals connect with people whilst they are inpatients and where medical conditions impact on their oral health as well as looking at how prescribed medications can impact and how pharmacies can assist with oral health messaging in these cases.

Debbie Stovin interjected that the flexible commissioning programme will be about working with patients that don't have a regular dentist to develop pathways and link with Trusts and Dentists to give wider holistic approach. This is expected to grow the list of dental practices.

JR will provide the name of a trust representative to involve from an operational perspective.

SS suggested that getting economic leaders involved in supporting campaigns would be another approach to be taken forward via the local Chambers of Commerce. She also recommended contacting Doncaster to enquire about the work they have done with the drug and alcohol addiction services and had a profound impact.

SH advised that as a member of the Children and Young People's Forum Consortium, he would be happy work with and to link in the work from the OHNA.

Place Board is supportive of work and approach being undertaken recognising that the resource for Children and Young People and supporting vulnerable adults falls within the remit of Rotherham Council and acknowledging that for adults commissioning is the responsibility of SYB ICB which may prove challenging to achieve financially for partners.

Place Board supported the governance provided via the Rotherham Oral Health Improvement Group (OHIG) to deliver on the recommendations of the OHNA.

03/04/25 Prevention and Health Inequalities Update

Sue Panesar updated members on progress made with prevention and health inequalities:

Partner engagement is working well with all partners involved. Recent work has included:

- Engagement on the refresh of the prevention and health inequalities action plan for 2025-6
- Stronger links established with housing and neighbourhoods
- Approval of spend for Sport England Place expansion programme
- Rural health toolkit work undertaken
- Humanitarian Group Action Plan developed.

SP outlined a number of challenges and risks, ie the impact of poverty and the cost of living, the system financial position, organisational leadership across the system, maintaining momentum and data sharing and health inequalities single narrative.

Going forward:

- A health inequalities development session is being arranged for Monday 28th April – all partners will be invited.
- A new Action Plan will be developed which includes accountability
- Work around chronic pain and partnership working will be built on

CS mentioned that some of the work on the health accelerator programme, which is supported with some funding from the ICB would link in with local work and should be co-ordinated accordingly. CS to discuss with SP.

Action: CS/SP

Members thanked SP for the update.

04/04/25 Mental Health Update

KT gave update on work being undertaken:

- Primary/Secondary care Integrated Community Care Pathway and enhanced workforce established.
- stronger working partnerships are being built across Rotherham and South Yorkshire ICB.
- Community capacity, patient voice and personalisation is being developed.
- a wide range of suicide prevention and self-harm training is being delivered across the borough.
- There is strong partnership working across SYICB and the 4 Local Authorities.
- the Mental Health Crisis offer (YAS MH Vehicle, Crisis Grants, Text Lines, Expansion of Crisis Team) is being improved
- A review/transformation of social care pathway is underway.
- Rotherham Dementia Network has been established
- Adult ADHD Physical Health Checks/Medication pathways take place
- Mental Health communication is strong via Rotherhive, Carers Directory, Dementia Prevention posters.

The challenges and risks were outlined:

- Demand and Complexity of individual continues to increase.
- Embed the primary / secondary care community pathway (Cultural, Recruitment and Retention).
- Improve the support available for those individuals who have attempted suicide due to a life event.
- Improve Dementia pathway (prevention, post-diagnostic and end of life).
- Improve Eating Disorder pathway across SYICB.
- Alignment of the various Mental Health Strategies and Action Plans to be refreshed over the next 9 months.
- Adult ADHD Physical Health Check / Medicine Monitoring Pathway Delayed to drug shortages.
- Lots of activity planned for 2025-26 versus capacity to deliver

Going forward the intention is to continue to embed the Primary/Secondary care Integrated Community Care Pathway and workforce in primary care (25/26), consult and mobilise the SYICB Community Eating Disorder Pathway, complete the All Age Neuro engagement plan, launch the Rotherham Vista Project, refresh of the suicide prevention and self-harm Action Plan, Better Mental Health for All and Loneliness Plan, refresh the RMBC Mental Health Strategy and undertake the Rotherham Dementia Pathway Review.

SH commented that from a voluntary sector perspective Rotherham mental health services offer worked well.

AR said that although challenging, the increase in complexity and demand also highlighted successes and showed that focussing on supporting people from the start rather than when they are in crisis is beneficial.

JBR thanked for all work being done and offered to support advising that she had a personal and professional interest in mental health.

Noting the amount of consultation taking place in Rotherham across a variety of services and the importance of co-ordinating an approach to address consultation fatigue as well as partners sharing resources already in place to avoid duplication, it was agreed to share with the Communication and Engagement Team for discussion and to consider how this can be achieved

Action: IS/LG

IS thanked KT for the update and she left the room.

05/04/25	Communications to Partners/Promoting Events & Consultations
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- UEC Alliance event tomorrow.
- Prevention and Health Inequalities Development Session- 28 April 2025

06/04/25	Draft Minutes and Action Log from Public Place Board
<p>The minutes from the meeting held on 19 March 2025 were agreed as a true and accurate record.</p> <p>The action log was reviewed. There were no outstanding actions.</p>	
07/04/25	Risks and Items for Escalation to Appropriate Board
<p>There were no new risks to note and nothing for escalation at this time.</p> <p>However, Members noted the risk from the recent announcements made around cost reductions for NHS SY ICB and will review and determine what needs to be placed on register at a later stage when more detailed guidance allows the local impact to be assessed.</p> <p>KG advised that Healthwatch had received feedback from the public about impact on NHS services. Discussion turned to acknowledge the difficulty of discussing mitigation in the absence of further clarity and guidance. It was agreed that a standing item will be added to future PLT going forward to allow for partners to be updated on any information received and decide how it can be communicated and risk assessed.</p> <p style="text-align: right;">Action: CS/LG</p>	
08/04/25	Future Agenda Items:
<p>Standing Items</p> <ul style="list-style-type: none"> - Updates from all groups (as scheduled) - Bi-Monthly Place Partnership Briefing - Feedback from SY ICP Meetings – Bi Monthly - Place Achievements (as and when) 	
09/04/25	Date of Next Meeting
<p>The next meeting will take place on Wednesday 21 May 2025 in the John Smith Room, Town Hall, Rotherham.</p>	

Members

Chris Edwards (Joint Chair)	Executive Place Director/ICB Deputy Chief Executive	NHS South Yorkshire Integrated Care Board
Sharon Kemp (Joint Chair) Quarterly attendance)	Chief Executive	Rotherham Metropolitan Borough Council
Ian Spicer	Strategic Director, Adult Care, Housing and Public Health/Deputy CE	Rotherham Metropolitan Borough Council
Ben Anderson	Director of Public Health	Rotherham Metropolitan Borough Council
Richard Jenkins	Chief Executive	The Rotherham NHS Foundation Trust
Bob Kirton	Managing Director	The Rotherham NHS Foundation Trust
Shafiq Hussain	Chief Executive	Voluntary Action Rotherham
Toby Lewis	Chief Executive	Rotherham, Doncaster and South Humber NHS Foundation Trust
Dr Anand Barmade	Medial Director	Connect Healthcare Rotherham (GP Federation)

Participants

Cllr Joanna Baker- Rogers	Chair of H&WB Board	Rotherham Health and Wellbeing Board
Claire Smith	Director of Partnerships, Rotherham Place	NHS South Yorkshire Integrated Care Board

Andrew Russell	Director of Nursing, Rotherham & Doncaster Place	NHS South Yorkshire Integrated Care Board
Dr Jason Page	Medical Director, Rotherham Place	NHS South Yorkshire Integrated Care Board
Wendy Allott	Director of Financial Transformation Rotherham Place	NHS South Yorkshire Integrated Care Board
Shahida Siddique	Independent Non-Executive Member	NHS South Yorkshire Integrated Care Board
Nicola Curley	Director of Children's Services, RMBC	Rotherham Metropolitan Borough Council
Matt Cottle-Shaw	Chief Executive	Rotherham Hospice
Kym Gleeson	Service Manager	Healthwatch Rotherham
Lydia George	Transformation and Partnership Portfolio Manager (Rotherham)	NHS South Yorkshire Integrated Care Board
Gordon Laidlaw	Head of Communications	NHS South Yorkshire Integrated Care Board
Julie Thornton	Care Group Director	Rotherham, Doncaster and South Humber NHS Foundation Trust

DRAFT

PUBLIC ROTHERHAM PLACE BOARD ACTION LOG - 01 April 2025 - 31 March 2026

Mtg Date	Item No.	Agenda Item Title	Action Description	Timescale for Completion	Lead Officer	Action Status	Date Completed	Comments
16.04.25	03/04/2025	Prevention and Health Inequalities Update	CS to discuss the work on the health accelerator programme that is being funded by the ICB with Sue Panesar to link and co-ordinate it with local P&HI work.	21.5.25	CS	Green	18.04.25	
16.04.25	04/04/2025	Mental Health Update	Noting the amount of consultation taking place in Rotherham across a variety of services and the importance of co-ordinating an approach to address consultation fatigue as well as partners sharing resources already in place to avoid duplication, it was agreed to share with the Communication and Engagement Team will be asked to consider how this can be achieved	21.5.25	IS/LG	Green	13.05.25	Forwarded to GL for Comms & Engagment Team to discuss
16.04.25	07/04/2025	Risks and Escalation Items	An item will be added to PLT agenda going forward so that partners can be updated on any further information received on the future ICB model and decide how it can be risk assessed and communicated .	21.5.25	CS/LG	Green	30.05.25	ICB Organisational change added as standing item on PLT agenda