

Review of health services for Children Looked After and Safeguarding in Rotherham

Children Looked After and Safeguarding

The role of health services in Rotherham

Date of review:	23 rd February – 27 th February 2015
Date of publication:	14 th July 2015
Name(s) of CQC inspector:	Lea Pickerill Jan Clark Lynette Ranson Pauline Hyde
Provider services included:	Rotherham Doncaster & South Humber NHS Foundation Trust The Rotherham NHS Foundation Trust
CCGs included:	Rotherham CCG
NHS England area:	North of England
CQC region:	North East
CQC Deputy Chief Inspector, Primary Medical Services and Integrated Care:	Sue McMillan

Contents

Summary of the review	3
About the review	3
How we carried out the review	4
Context of the review	4
The report	5
What people told us	5
The child's journey	6
Early help	6
Children in need	10
Child protection	13
Looked after children	16
Management	19
Leadership & management	19
Governance	21
Training and supervision	23
Recommendations	25
Next steps	27

Summary of the review

This report records the findings of the review of health services in safeguarding and looked after children services in Rotherham. It focuses on the experiences and outcomes for children within the geographical boundaries of the local authority area and reports on the performance of health providers serving the area including Clinical Commissioning Groups (CCGs) and NHS England Local Area Teams (LATs).

Where the findings relate to children and families in local authority areas other than Rotherham, cross-boundary arrangements have been considered and commented on. Arrangements for the health-related needs and risks for children placed out of area are also included.

About the review

The review was conducted under Section 48 of the Health and Social Care Act 2008 which permits CQC to review the provision of healthcare and the exercise of functions of NHS England and Clinical Commissioning Groups.

- The review explored the effectiveness of health services for looked after children and the effectiveness of safeguarding arrangements within health for all children.
- The focus was on the experiences of looked after children and children and their families who receive safeguarding services.
- We looked at:
 - the role of healthcare providers and commissioners.
 - the role of healthcare organisations in understanding risk factors, identifying needs, communicating effectively with children and families, liaising with other agencies, assessing needs and responding to those needs and contributing to multi-agency assessments and reviews.
 - the contribution of health services in promoting and improving the health and wellbeing of looked after children including carrying out health assessments and providing appropriate services.
- We also checked whether healthcare organisations were working in accordance with their responsibilities under Section 11 of the Children Act 2004. This includes the statutory guidance, Working Together to Safeguard Children 2013.
- Where we found areas for improvement in services provided by NHS but commissioned by the local authority then we will bring these issues to the attention of the local public health team in a separate letter.

How we carried out the review

We used a range of methods to gather information both during and before the visit. This included document reviews, interviews, focus groups and visits. Where possible we met and spoke with children and young people. This approach provided us with evidence that could be checked and confirmed in several ways.

We tracked a number of individual cases where there had been safeguarding concerns about children. This included some cases where children were referred to social care and also some cases where children and families were not referred, but where they were assessed as needing early help and received it from health services. We also sampled a spread of other such cases.

Our tracking and sampling also followed the experiences of looked after children to explore the effectiveness of health services in promoting their wellbeing.

In total, we took into account the experiences of 84 children and young people.

Context of the review

Commissioning and planning of most health services for children are carried out by Rotherham CCG.

Acute hospital and community based services are provided by The Rotherham NHS Foundation Trust.

Adult mental health and child and adolescent mental health services (CAMHS) are provided by Rotherham, Doncaster and South Humber NHS Foundation Trust (RDASH).

School nursing is commissioned by Rotherham MBC Public Health Department and provided by The Rotherham NHS Foundation Trust.

Adult substance misuse services are commissioned by Rotherham MBC Public Health Department and provided by RDaSH with the service locally being known as "Clearways".

The Ofsted inspection of services for children in need of help and protection, children looked after and care leavers and review of the effectiveness of the Local Safeguarding Children Board carried out between 16 September 2014 and 8 October 2014 (report published 19 November 2014) all found services to be inadequate.

The Rotherham NHS Foundation Trust was inspected under the new CQC inspection methodology at the same time as this review and the report is available on our website [here](#).

The report

This report follows the child's journey reflecting the experiences of children and young people or parents/carers to whom we spoke, or whose experiences we tracked or checked. A number of recommendations for improvement are made at the end of the report.

What people told us

We heard from

A 15 year old girl was an in-patient on the children's ward. She said that being on the ward was *"alright most of the time"* and that she *"liked the student nurses because they talk to me"*. She said that the staff *"never shout and are always smiling"*.

"'cos I have social services and CAMHS everybody gets told everything". "when one person is on the phone and talking about me, everyone else is sitting around and listening in and talking about me".

She also said that she wasn't given any information about what was happening to her. She gave an example of waiting for results from blood tests: *"I only found out from the doctor after 4 days when the doctor told me"*.

With regard to her involvement with CAMHS she said that she liked the worker because *"she comes to talk to me. It's nice to talk to someone and not be shouted at."*

One mother of a school age child told us about the school nurse, *"She wants me to do well and gives me advice. I don't see her very often but my eldest has bowel problems and she helped to get things sorted – I was lazy and she helped move things on."*

A parent who was attending the substance misuse service, Clearways, told us *"They have helped me a lot, I used to use cannabis and I'm clean now and thankful to them. I'm better with the kids now"... "I was forced to go but to be honest otherwise I wouldn't have gone along but I wished I'd done it sooner."*

A foster carer told us that it was easy to contact the Health Visitor at other times, that there was a good messaging system in place and that she would always return a call within 48 hours. In any other more urgent situations the other Health Visitors would try to assist.

The foster carer told us that she had asked for some help with one of the children's sleeping but had been told that there were no services for that in Rotherham so they had "*muddled through themselves*".

Another foster carer told us that they had continually flagged the need for the health assessment with the Social Worker and it eventually took place two months later.

The child's journey

This section records children's experiences of health services in relation to safeguarding, child protection and being looked after.

1. Early help

1.1 Children and young people attending the emergency department (ED) at Rotherham Hospital have their safeguarding needs assessed, with appropriate actions taken to keep them safe.

1.2 ED receptionist staff routinely check whether a child or young person attending the department is looked-after or subject to a child protection plan and an alert is placed on the record; the next of kin and who is accompanying the child is recorded.

1.3 Receptionists demonstrated a good understanding of their safeguarding role and were able to cite several examples of when they had identified safeguarding concerns from their observation of the waiting room. These were reported promptly to the triage nurse.

1.4 The current children's waiting area is not observable by staff and not covered by CCTV and monitored by security. This poses a potential safeguarding risk to children.

1.5 Emergency department managers and safeguarding leads are aware of the difficulties posed by the current physical space. Children going to x-ray have to walk through the main ED and this is clearly undesirable and potentially detrimental to children. The trust is aware of this. There is a new emergency care centre planned and careful consideration is being given to ensure the new facility will meet the physical and clinical needs of children and young people.

1.6 Children's records contain a safeguarding questionnaire to guide practitioners in their safeguarding risk assessment. We saw good compliance with practitioners completing the questionnaire in the cases we reviewed. However, in some cases we saw no evidence of ED practitioners considering previous attendances of a child and how these related to the current presentation. In another case example, the practitioner had assessed there were no safeguarding concerns when these had been identified clearly within the assessment. (**Recommendation 4.1**).

1.7 A young person's substance misuse pathway is in place for under 16s. However, because of the capacity within the school nursing service we could not be assured that all young people were benefiting from an intervention. There has been no audit to confirm compliance with the policy. ***This issue has been brought to the attention of public health within Rotherham Metropolitan District Council England.***

1.8 Paediatric liaison review all attendances of children and young people under 18 to identify any child or young person needing community follow up. Provision of this role is positive, providing an additional strand of governance to oversight of cases. However, we did identify a number of cases where issues had been missed by ED practitioners and paediatric liaison. These had not been identified through existing quality assurance or operational management oversight. Governance and quality arrangements are not sufficiently robust. (**Recommendation 4.12**).

1.9 Paediatric liaison does not routinely have adult with children presentations passed over to her for review. This is a gap, as there is significant risk that other cases will have been missed as risk assessment of adults for safeguarding is not robust or well supported through documentation. (**Recommendation 4.2**).

1.10 Adult ED documentation has no prompt questions to ensure that practitioners are considering the presence and wellbeing of any children within the situation that has resulted in the adult attendance. This means that there is no systematic risk assessment and consideration of potential hidden harm, with an over reliance on the knowledge and safeguarding expertise of the clinician. (**Recommendation 4.2**).

1.11 It is recognised that young people do not always find it easy to access the full range of contraceptive and sexual health (CASH) services across Rotherham because many satellite clinics are held in schools and colleges and are not available in school holidays. The CASH and genito-urinary medicine (GUM) service recognises the need to increase service take-up by minority communities but plans are not yet in place to drive this forward. ***These concerns have been brought to the attention of the public health within Rotherham Metropolitan Borough Council.***

1.12 Young people are starting to benefit from the integration of CASH and GUM and are increasingly able to access a full range of services in one appointment.

1.13 Young people have access to emergency contraception from the local walk-in centre and pharmacies but pharmacies do not have a clear pathway linked into screening for sexually transmitted infections and safeguarding. This is a missed opportunity to keep young people safe. (**Recommendation 2.5**).

1.14 Vulnerable and hard to reach young people are well supported by the CASH outreach worker who works in the community, including making home visits to provide contraceptive services to those young people who will not attend a local clinic. The outreach nurse has an innovative approach to using social media to maintain contact with some of her clients to good effect.

1.15 There is an expectation that all young people accessing CASH and GUM services will have a risk assessment completed to identify vulnerability, including potential exploitation. Risk assessments for those young people accessing GUM services were significantly more robust than those seen in CASH. In cases examined, we found some assessments were incomplete and limited attention was paid to the young person's cultural and language needs. (**Recommendation 4.3**).

1.16 Most women in Rotherham book their pregnancy early and are seen by their community midwife at the local GP Practice before 12 weeks. Community midwives across Rotherham are attached to GP practices; this provides continuity of care to expectant women and promotes close working relationships between GPs and midwives.

1.17 When a woman is referred into midwifery service, part of the initial information collection is to contact the GP to establish if there are any medical or social concerns that the midwife needs to consider as part of the risk assessment. This did not happen in all cases we reviewed and therefore there is the opportunity for important information to be missed when reviewing risk and vulnerability. (**Recommendation 4.5**).

1.18 Social vulnerability is risk assessed during the booking and although there is an expectation that this risk assessment is repeated during pregnancy it does not always take place. This means that sometimes there is no formal record of discussion taking place to explore emerging issues around domestic violence, mental health or other potential concerns. (**Recommendation 4.3**).

1.19 Midwives do not use pre-CAF and the current risk assessment is basic. Midwives are not routinely instigating CAFs to provide a co-ordinated package of support to expectant women at the earliest opportunity. (**Recommendation 4.3**).

1.20 Good arrangements are in place to ensure timely follow up of those expectant women who do not attend their antenatal appointments. Midwives are tenacious in ensuring women are seen regularly during the antenatal period, therefore protecting the health of the woman and the unborn child.

1.21 There is a need for closer working between midwives and health visitors. Notifications of pregnancy from midwives to health visitors, via the IT system, are often missing important information. Midwives are not making best use of the IT system to alert health visitor colleagues of any significant development during the antenatal period. (**Recommendation 4.4**).

1.22 We did not see examples of good joint working between midwifery and health visiting teams to support vulnerable families. There is little opportunity for joint visits and we were told that these happened by exception. This is a missed opportunity to provide and demonstrate a co-ordinated approach to vulnerable and complex families. (**Recommendation 4.4**).

1.23 A protocol is in place to ensure safe and timely handover from the midwife to health visitor, however, no audit has taken place to assure managers or commissioners of services that these handovers are taking place effectively. Good arrangements are in place to provide support to new families with children under five who come to live in Rotherham. We saw evidence of how a vigilant health visitor identified potential safeguarding concerns on a transfer-in visit and the children in this family now benefit from a child protection plan to keep them safe.

1.24 Arrangements to transfer children from the health visiting service to the school nursing service are well established. However, the capacity within the school nursing service means that the availability of support from school nurses is restricted. This has significant impact as children get older and there is no capacity for the school nursing service to identify or meet the need for support unless a child or young person has a child protection or child in need plan in place. **These concerns have been brought to the attention of public health within Rotherham Metropolitan Borough Council.**

1.25 Families needing early help can access support from the network of local children's centres. Partners have worked collaboratively to develop the local "Best Start Programme" which is a joint approach between health, early years and education. We have seen evidence of vulnerable families being well supported by the Family CAF process with positive change that has improved the outcomes for children and young people living in the family.

1.26 The recent development of the Together Project, a partnership involving police, youth support and adult mental health, is positive. Early indications are that this is working particularly effectively for young people.

1.27 The Clearways substance misuse service has a worker attached to every GP practice but one in Rotherham and this is commendable as it provides quick access to adults seeking support in a familiar environment.

2. Children in need

2.1 Children and young people who present at the Rotherham Hospital emergency department in mental health crises and those who self-harm or take overdoses are admitted to the paediatric ward for observation, until specialist CAMHS assessment can take place. Recent improvements in processes means that most young people are now assessed within 24 hours of being deemed medically fit. This is a significant improvement.

2.2 The paediatric ward can use agency staff to provide one-to-one support for young people with mental illness who are being cared for on the ward but this may not always be possible or appropriate. The local CAMHS do not have the capacity to provide this specialist support. Paediatric staff are not currently sufficiently trained and equipped to support these young people while also minimising the impact on other children on the ward. (**Recommendation 2.1**).

2.3 There is an expectation that CAMHS services work with the paediatric ward to develop a clear, written risk management plan for each individual child to best support paediatric staff. This is not currently established practice in Rotherham creating significant risk. (**Recommendation 2.1**).

2.4 Children and young people access CAMHS through a single point of access. There is now improved access to CAMHS through the new provision of the “out-of-hours” rota. Young people aged over 16 access out-of-hours Consultant Psychiatrist, through the Adult Access Team. However, there is no access to an “out-of-hours” consultant CAMHS psychiatrist and this is not best practice.

2.5 Two practitioners triage referrals into CAMHS for urgency and families can expect to receive a letter to inform them of the outcome of the referral within five working days.

2.6 CAMHS accept self-referrals and operate an age specific drop in for young people aged 13+ with Youth Start. Managers have identified that access to this could be publicised more effectively.

2.7 When engaged with the CAMHS service, young people experience beneficial outcomes from the intervention and we saw case work that demonstrated this.

2.8 CAMHS practitioners routinely give young people the opportunity to be seen alone and this is good practice. CAMHS practitioners are not routinely ensuring that they speak to GPs directly about young people about whom there are concerns. Lack of interprofessional information sharing and direct communication is a feature of serious case reviews (SCRs). (**Recommendation 3.1**).

2.9 CAMHS practitioners are not always clear on who else is working with a child and who has case responsibility. In a service where there is a significant degree of staff movement and service redesign, this presents the potential that a young person may “fall through the net.” (**Recommendation 3.1**).

2.10 There is currently no intensive home treatment team in CAMHS to facilitate early discharge from inpatient provision or to support young people in mental health crisis at home and therefore prevent the need for admission or reduce the length of inpatient stays.

2.11 CAMHS told us there have been a number of cases where young people who had been in tier 4 provision have been discharged back to Rotherham without local CAMHS being informed. This is unacceptable, putting highly vulnerable young people at serious risk of harm. In each case CAMHS have notified NHS England. (**Recommendation 3.2**).

2.12 There is a gap in services to support children with autistic spectrum disorder (ASD). The local community, through Healthwatch, have expressed concerns about support to families and the CCG has recently completed a gap analysis to identify where services are not compliant with NICE guidance. RDASH has an action plan in place to address delays in families accessing care and discussions are taking place across the partnership on how to address gaps in service.

2.13 We were told that transitions of young people from CAMHS into adult mental health service is improving and is starting to work well in the adult access service.

2.14 Managers and practitioners within adult mental health demonstrated good awareness of their responsibilities in regards to safeguarding children while working with the adult. However, rather than adopting the Think Family model, the RDASH adult mental health service is working to establish an “Holistic” model of practice based on think family principles. Documentation and assessment templates in use in the service are not supporting this approach and identification of children within some of the assessment documentation is not consistent or readily accessible. (**Recommendation 3.3**).

2.15 Good progress is being made to support young carers of parents with mental health illness. Practitioners identify families where there are young carers and make appropriate referrals to Barnardos who provide support to this vulnerable cohort. Barnardos are also providing training to adult mental health on the impact of parental mental health on young carers.

2.16 Expectant women with perinatal mental illness accessing maternity services from The Rotherham NHS Foundation Trust, are referred to the midwife with specialist interest for initial assessment and advice. The midwife supports the weekly mental health antenatal clinic, where the care of these expectant women is overseen by an obstetrician with special interest. There is no named consultant psychiatrist within RDASH with responsibility for perinatal mental health. The current pathway does not provide clarity to practitioners working with these vulnerable women and does not identify the local offer available to women in the postnatal period. Plans for birth that we reviewed did not always explore trigger factors, how a woman who is relapsing may present, how staff could best support the woman and when to seek specialist advice. (**Recommendation 2.2**).

2.17 Expectant women with a known substance misuse problem are supported well by specialist substance misuse midwives, who work closely with a consultant obstetrician with a special interest and also the adult substance misuse team. The specialist midwives support a local “women’s group” run by the adult substance misuse team where pre and post conception advice is often accessed and is very popular within this community of women.

2.18 All teenage girls are referred to the teenage pregnancy midwife who will see them at least once in the pregnancy and outline what support she can offer. This includes the opportunity of a co-ordinated package of care through CAF, where the young person consents. Teenage expectant mothers can also access support from GROW (Giving Real Opportunities to Women). Health visitors told us that mothers who were supported by GROW appreciate the individual support and befriending which often continues beyond pregnancy.

2.19 The Family Nurse Partnership is well established in Rotherham and is successful in working with those young mothers-to-be who traditionally are difficult to engage and have complex and often chaotic lifestyles. There is evidence of improved outcomes for child and parent. Family nurses work closely with other health and social care professionals to provide a co-ordinated approach to supporting their clients, with joint visits being commonplace. This is good practice.

2.20 Health visitors are able to refer new families, where they identify concerns around attachment between mother and their baby, to the early attachment service. This is a well-regarded service but is currently vulnerable as it is over reliant on one practitioner.

3. Child protection

3.1. Health practitioners across Rotherham are familiar with the threshold descriptors for safeguarding and child protection concerns and all referrals seen during this review were appropriate. We saw some examples of good quality multi-agency referrals completed by health practitioners across all areas where the risks to the child and/or others were set out clearly and succinctly and the expectations of the practitioner in making the referral were also identified.

3.2. However, we saw many other examples where the risk of harm to the child was not set out clearly and it was not entirely evident what the purpose of the referral was. This makes it difficult for a children's social worker to sometimes understand the significance of the content of the multi-agency referral form (MARF). This has the potential to lead to confusion and delay in putting in place appropriate plans to protect children. (**Recommendation 2.3**).

3.3. In the primary care settings visited, all were able to demonstrate strongly that there was good awareness of their roles and responsibilities to refer cases promptly to children's social care. We heard about cases in practices where this had been done recently, including some very diligent work by reception staff to find out what information was known about a child about whom there were concerns. However, GPs do not routinely retain copies of any safeguarding referrals they are making. This reduces their ability to quality assure and drive improvement. It does not ensure a good audit trail in cases of any professional disagreement or need to scrutinise actions taken by professionals retrospectively. (**Recommendation 1.1**).

3.4. In one practice, child protection plans were analysed by the safeguarding lead GP together with the designated lead receptionist and appropriate alerts put onto the patient records. In another practice, no clinician reviewed minutes of child protection conferences or child protection plans, this being mainly an administrative task. This is unacceptable. The lead GP acknowledged that this was not best practice and we were assured that practice would change immediately. (**Recommendation 1.1**).

3.5. In neither practice were child protection plans loaded onto the patient record. This is a significant gap as clinicians working with families and children, where there are known to be risks, must have these plans readily available to them when they present at the surgery, with or without the child, in order to monitor parental compliance. One practice was under the misapprehension that information governance precluded them uploading the plan and other key documents intended to help protect children at risk of harm. (**Recommendation 1.1**).

3.6. All health practitioners routinely attend child protection conferences and prepare reports where needed. In all cases seen, practitioners are sharing conference reports with families and this is best practice.

3.7. When midwives identify the need to safeguard the unborn child, they create a set of green notes to record all safeguarding activity. However, child protection conference reports, minutes and referrals to children's social care are all scanned onto the IT system and not contained in the paper record. The paper record is the full record and therefore the patient record is incomplete. (**Recommendation 2.4**).

3.8. No regular opportunities exist for multi-agency discussion around expectant women with identified social vulnerability. The absence of a joint protocol between midwifery services and the local authority with clear timescales for key child protection processes is contributing to delays in creating timely pre-birth plans. (**Recommendation 4.6**).

3.9. An unacceptable culture has developed over time where it has become routine for some expectant mothers, where child protection concerns have been identified, to have a planned stay on the postnatal ward of five days or even longer when there is no clinical need for the mother or baby. This is poor practice; healthy babies should not have extended stays in hospital environments and the delay in discharge has considerable impact on the emotional wellbeing of mothers who face extended waits for decisions on whether they will be leaving hospital with their babies. Midwives are being asked to pass messages on to new mothers from social workers around extending their stay. This is not the responsibility of a midwife. (**Recommendation 4.6**).

3.10. Health visitors are proactive in working with families where child protection plans are in place. We saw evidence of enhanced visiting for those families in Partnership Plus, with notes reflecting the voice of the child. In cases seen, health visitors are good advocates for the children, challenging parents and other professionals appropriately to ensure the best outcomes for the children on their caseload.

3.11. The potential role for CASH and GUM in contributing to child sexual exploitation (CSE) and child protection enquires is not well understood by the service or partners and as a result multi-agency risk assessments may be incomplete. Neither CASH nor GUM staff could recall being asked to contribute to a Section 47 enquiry. (**Recommendation 4.7**).

3.12. We have found a lack of clarity over the role of the partnership's CSE team, in particular the operational role of sexual health services in contributing to CSE work is an area for development. The place of sexual health services in CSE identification is not yet fully understood internally, with systems not yet developed to ensure that intelligence about risk is appropriately captured and utilised on an ongoing basis. (**Recommendation 4.7**).

3.13. CAMHS practitioners are aware of the clinical decision tree model which has been developed in CAMHS to steer practitioner assessment and identification of safeguarding risk, however, it was not clear that this is routinely used by practitioners in their day-to-day practice.

3.14. We did not see in all cases that clear service care plans are being developed by CAMHS to reflect the aims of intervention appropriately and underpin child protection plans where these are in place. We understand that this is a clear managerial expectation but is not embedded practice. (**Recommendation 3.5**).

3.15. A regular multi-agency complex and dangerous service users' meeting is held. Attendees include mental health social worker and the police vulnerable person's unit. The purpose of the meeting is to discuss individual cases in a multi-agency forum to provide guidance to practitioners engaged with the case. Where cases are identified as having children, the RDASH child safeguarding named professional will attend as an expert advisor. This ensures the group has an additional focus and expertise on children's safeguarding and hidden harm issues.

3.16. Clearways managers and practitioners have a clear understanding of their responsibilities in prioritising the safety and wellbeing of children while working primarily with the adult. However, there is no embedded Think Family model in the adult substance misuse service and the service's information and case recording system does not support practitioners in undertaking their safeguarding role to best effect. (**Recommendation 3.3**).

3.17. Where a patient self-refers to Clearways on the direction of a social worker, this does not prompt the substance misuse practitioner to seek information from the social worker to ensure they are fully informed as part of their risk assessment. Social workers also do not routinely inform Clearways of concerns for child safety which may be key factors in the case.

3.18. Practitioners working in Clearways and in adult mental health are not routinely sharing indicators of relapse with health visitors and midwives and there is a lack of direct liaison with health visitors and other health professionals outside of formal child in need or child protection forums. This is a common feature in SCRs. Where service users may not always be a reliable source of information, it becomes even more important that practitioners involved with the family maintain a professional scepticism and have regular direct communication to ensure children are protected. We did not see this demonstrated. (**Recommendation 3.6**).

3.19. Most health practitioners across Rotherham are not using chronologies of significant events to help them identify emerging concerns. Chronologies are particularly useful to help practitioners working with complex families to quickly identify significant events and can help identify trends and drift. The lack of chronologies is a common feature of serious case reviews. (**Recommendation 2.4**).

3.20. We have found many examples of healthcare practitioners working well within their own areas of expertise to protect children, however, we have also found professionals reluctant to challenge colleagues in other disciplines and an over-reliance on escalation to senior managers. The LSCB recognises this problem and has revised the professional disagreement policy to try and encourage and support practitioners to resolve concerns early. LSCB training on the role of professionals at key child protection conferences and core group meetings is also available to all practitioners across Rotherham.

3.21. Some practitioners told us of the positive impact of the new way of working by children's social care. They described how the child protection plans were now being used by some social workers and conference chairs to keep the child at the focus of discussion at review conferences and core groups. This is encouraging.

Mother A is a single parent of two school age children had been engaged with treatment from the assertive outreach team for more than 12 months. She was receiving drug therapy for schizophrenia. The children had increasingly poor school attendance as A was not letting them go to school when she was ill. They were malnourished and unkempt with head lice. They were both placed on child protection plans.

The adult mental health worker together with the social worker worked on relapse prevention with A. Alongside this, the two professionals worked with the children to identify simple relapse indicators which would alert the children when A was becoming unwell. Agreements were put into the plan for the children to inform a teacher or grandparent or trusted adult as soon as they identified that A might be relapsing.

This helped Mum to parent more effectively as there were appropriate safeguards in place to obtain help quickly and decrease the pressures and stresses within the family. As a result, the case has been able to be safely stepped down as risks have decreased and the case is now being managed as a CAF.

4. Looked after children

4.1 Children who are brought into the care of Rotherham Children's Social Care are not receiving timely initial health assessments (IHA). It is reasonable to suggest that there will be children who come into care and are returned to either their parents or other family members who never benefit from an IHA. It is well recognised that the health of children who become looked after is often poorer than their peers. Subjecting these children to further and unnecessary delay in having their health needs assessed is not acceptable. (**Recommendation 4.8**).

4.2 Files reviewed demonstrated good attention being paid to the inclusion of the child's legal status, the date they entered the care system and the reason for them becoming looked-after. We also saw evidence in some cases where birth history and parental health history had been gathered and included in IHA documentation, however, this was much less consistent and is an area for development for the partnership. This is important information to secure at the point the young person first becomes looked-after, as it facilitates the health team to ensure the information goes with the child on their journey through the care system. Young people who have recently left care tell us how important this information is to them as they leave the care system and enter adulthood. (**Recommendation 4.8**).

4.3 Appropriately qualified paediatricians carry out all IHAs and record their findings on the British Association of Adoption and Fostering forms. This is compliant with statutory guidance. The designated doctor completes the health summary and the health plan.

4.4 Health plans resulting from IHAs and review health assessments (RHA) are not SMART. Those reviewed were task focused rather than setting out measurable health objectives. Timescales were loose and actions not always clearly attributed to facilitate effective follow-up to ensure actions had been taken. This was responsible for drift in some provision of healthcare. (**Recommendation 4.9**).

4.5 All children and young people who come into care are registered quickly with a local GP and this is good practice. However, GPs we spoke to acknowledged that they have little understanding of the looked-after child system despite the CLA health team providing training in the past.

4.6 Health practitioner's already working to support a child new into care or looked after, including the child's GP and CAMHS are not routinely contacted and asked to contribute to IHAs or health reviews. (**Recommendation 4.8**).

4.7 In some cases we saw how the school nurses engaged well with the young people generating a wide ranging discussion about the young people's health needs, queries and concerns. However, often case recording was all in the third person, making it less easy to get a good sense of the young person as an individual and the language was professional and clinical rather than reflective of the actual voice and individuality of the child. This observation equally applies to the content of the IHAs seen. (**Recommendation 4.8**).

4.8 The school nurses who carry out health reviews for the older children do not use any screening tools to help identify substance misuse or risk taking behaviour. (**Recommendation 4.8**).

4.9 Outcome scores from Strengths and Difficulties Questionnaires (SDQs) completed by foster carers are available to school nurses, although not routinely commented on as part of the health review. Young people are not being given the opportunity at RHAs to use the SDQ to track their own emotional growth and journey during their time in care, which could help to engage the young person in their own health and wellbeing. (**Recommendation 4.10**).

4.10 This lack of information and holistic approach to reviewing the child or young person's health is resulting in reviews and health plans that do not reflect the health needs of the child. It is not acceptable to complete sections of the review with comments such as "no concerns." The health reviews we saw were often episodic with no link to previous reviews and health plans. This means that it was not always possible to chart the child's health journey and to evaluate the impact of previous health intervention and demonstrate progress made. (**Recommendation 4.8**).

4.11 Effective arrangements are in place to secure and monitor the health reviews and quality of health plans for those children and young people placed out of area. The CCG is responsive in commissioning specialist health care where the receiving health economy is unable to meet identified need. This is helping to ensure that Rotherham's children and young people who are looked after and placed out of area are not disadvantaged in accessing health care.

4.12 Young people are given choices about where they have their RHAs with most opting either for at school or at their foster home. Although we were told that young people are routinely given the opportunity to see the nurse on their own for part of their RHA, this is not well evidenced through the case record.

4.13 It was not always clear whether young people had been given the opportunity to sign their own consent when it was likely that they were competent to do so. Young people are not currently sent a copy of their health assessment or health plan, even when they have been asked to give their consent to the health assessment or review taking place. (**Recommendation 4.10**).

4.14 Children and young people, looked after who require additional support around their emotional health and wellbeing are supported effectively through the Local authority looked after and adopted children service therapeutic team.

4.15 Young people who are looked after are able to access the local CASH and substance misuse services held in the local youth hub and across Rotherham. Currently there are no dedicated named workers within CASH and substance misuse to provide specialist advice or consultation to professionals working within those teams on LAC. **This has been brought to the attention of Public health within Rotherham Metropolitan Borough Council.**

4.16 Young people, looked after, who become pregnant and wish to continue with the pregnancy are prioritised within the Family Nurse Partnership if they meet the criteria. For those that do not meet the criteria, support is available from the teenage pregnancy midwife and GROW. There is close working between FNP, teenage pregnancy midwife and the LAC health team to co-ordinate care for these vulnerable young women.

4.17 The care leavers' health offer is underdeveloped overall, although there are positive features. The service is commissioned only until the young person is 19 although school nurses do continue to provide support for young people at college. Where individuals are particularly vulnerable, the looked-after child health team will continue to offer some support where capacity allows. Young people are encouraged to engage with Youth Start, which offers help and advice on a range of issues up to the age of 25. Work is in hand to develop a local care leaver's icon to be entered onto SystemOne to enable health providers to identify young adults who may have additional vulnerabilities as a care leaver. The service recognises there is more to do to support care leavers well beyond the health summary they are given currently. (**Recommendation 4.11**).

Management

This section records our findings about how well led the health services are in relation to safeguarding and looked after children.

5.1 Leadership and management

5.1.1 Leaders and managers across the CCG and providers of health care across Rotherham demonstrate a clear commitment to safeguarding children and young people. The CCG are appropriately represented at the LSCB and feel that they are listened to and have a “voice.” The LSCB chair told us that in particular he welcomes the challenge provided by the TRFT’s chief nurse who now chairs the board’s performance sub-group.

5.1.2 NHS England has recently reconfigured local area teams into larger regional groups. It is reassuring to note that the Yorkshire and Humber team are committed to retaining representation on local safeguarding children groups and continue to contribute regular safeguarding briefings to the South Yorkshire and Bassetlaw Quality Surveillance Groups.

5.1.3 It is of concern that previously children have not featured as a priority of the Rotherham Health and Wellbeing Board and children’s needs are not included in any meaningful way in the Joint Strategic Needs Analysis. The relationship between the previous Health and Wellbeing Board and its partners was poor. These issues are now being addressed.

5.1.4 The CCG is an active participant of the NHS South Yorkshire and Bassetlaw Safeguarding Group who together have developed and implemented safeguarding standards, underpinned by key performance indicators and incentives to drive the improvement agenda and ensure that safeguarding children is now a priority across Rotherham.

5.1.5 Performance is regularly scrutinised at monthly contract performance monitoring meetings. Further incentives are available through carefully constructed CQUIN and Quality Outcomes Framework which have been developed and introduced to improve those areas of practice that require a more targeted approach.

5.1.6 Primary care is supported well by the CCG; the practice manager forum is embedded and safeguarding is a standing agenda item. In addition, the CCG facilitate protected learning time and safeguarding children is featured as part of a rolling programme. The “Top Tips” for primary care in safeguarding and on services provided by CAMHS have been well received by GPs and their colleagues. The named GP is part of a developing local named GP network across South Yorkshire and Bassetlaw.

5.1.7 GP Practices visited held regular practice meetings with safeguarding as a standing item, although neither GP practice held a vulnerable families meeting which would provide a good forum to invite the substance misuse worker, health visitor, domestic violence worker and relevant others to attend and facilitate good information sharing about families where there are vulnerabilities.

5.1.8 Other than a very good sense of when to refer concerns and how, there was little further development of primary care practice structures to drive improvement and monitor internal safeguarding practice in both surgeries. Work is ongoing to standardise READ coding to ensure that if families transfer between practices and across local boundaries vital information on risk is not lost because of differing coding protocols.

5.1.9 Rotherham has been subject to intense scrutiny over child sexual exploitation and the partnership is working together to create a new more focused plan. What we found during this review is that there was still a lack of understanding about roles and responsibilities in CSE and that closer partnership working is needed at an operational level in some key areas to protect these vulnerable children. The partnership is aware of these concerns and work is ongoing to redraft and implement a new strategy.

5.1.10 The CCG and its partners are committed to the development of the multi-agency safeguarding hub (MASH) and key professionals are now in place to take forward a recently agreed model.

5.1.11 The CCG and local authority are starting to work together more closely; a joint commissioning post has been agreed to look at how services can better support families for “whole life.”

5.1.12 High numbers of the Rotherham population access emergency and urgent care. A new integrated centre has been commissioned and the new ED will have a designated area for paediatrics. There are specific task and finish groups to develop children’s care pathways which are compliant with national requirements and recommendations.

5.1.13 Concerns around CAMHS services have been the subject of an external review commissioned by the CCG. A number of working groups at strategic and operational level are now in place. Managers in RDASH CAMHS have a good understanding of the areas requiring practice improvement and service development. A significant improvement plan is in place and a process of service modernisation and redesign is in train. However, progress is being impeded due to high levels of vacancies in the service and resistance to cultural change. Operationally, the impact of this new work is less evident and there remain significant areas of concern that need urgent response. We have seen evidence of unallocated cases, high rates of agency staff and low staff morale.

5.1.14 There is no shared vision across Rotherham about the role of the school nurse. The ability of the school nursing service to provide the commissioned service is compromised by high levels of activity in supporting children and young people who have child protection or child in need plans. **This has been brought to the attention of public health within Rotherham Metropolitan Borough Council.**

5.1.15 The designated nurse and named nurse for children looked after attend the Corporate Parenting Board which has had a number of different chairs over the recent past. The CCG and its partners are not able to identify the health needs of the cohort of looked after children and the impact of the work of the children looked after health team. It has been acknowledged that this has not been within the priorities of previous health and wellbeing strategies and joint strategic needs analysis.

5.1.16 Work is ongoing to improve the preceptorship of newly qualified midwives, health visitors and school nurses, although the current programme requires strengthening to include more robust competencies in safeguarding and child protection practices. One health visitor who was newly qualified told us how the increase in health visitor numbers had meant her mentor had been able to offer direct support and mentoring which she had found invaluable.

5.1.17 The named safeguarding professionals in both NHS trusts have been working under significant pressure with increased and unexpected sickness and absence. Both trusts have responded well to the opportunities that this has created to look at how front line practitioners can be better supported to be more confident and competent in working with vulnerable families.

5.1.18 There are seven paediatric nurses employed within the ED (including one being an advanced Nurse Practitioner). They are currently rostered for duty between 8am and 11pm. This means that there is no paediatric nurse on duty overnight. To mitigate the risk the majority of adult ED staff have undertaken additional specialist life support for children training.

5.2 Governance

5.2.1 The RFT does not use the NHS identifier number and is working to address the challenge presented by the child protection information sharing (CPIS) project which has been rolling out nationally since March 2014.

5.2.2 The disparate legacy systems and IT between CASH and GUM presents barriers to effective safeguarding practice.

5.2.3 GPs are working across Rotherham to standardise READ codes, however, in GP practices we visited this remains a key area for development. Inconsistency and variability in coding and protocols in storing important child protection documentation means that the electronic patient record does not always assist the GP in informing their consultation with vulnerable families. GPs we visited do identify CIN, looked-after child and child protection on their IT systems and can identify the cohort of children. Family members are linked and this is important and supports the GP in understanding any social vulnerability when consulting with their patient.

5.2.4 Use of SystmOne is not consistent between staff across healthcare teams so information is lodged in different folders or coded differently which impacts on the ability to find reports and ensure that workers are able to make fully informed decisions. (**Recommendation 2.4**).

5.2.5 There is unresolved confusion/ concern about the extent of consent and share across health practitioners using SystmOne even within the same trust. This means that practitioners do not have access to routine information to inform their work. (**Recommendation 2.4**).

5.2.6 CAMHS, adult mental health and adult substance misuse services are unable to identify what cohort of cases may have children subject to CIN or child protection plans. This does not facilitate effective operational management oversight of safeguarding practice within the services or help to inform caseload management. (**Recommendation 3.4**).

5.2.7 Overall, there is not a robust operational performance management system in place across RDASH to ensure that practitioners are compliant with both organisational expectations and effective practice demonstrably protecting children. This is a key area for development. (**Recommendation 3.4**).

5.2.8 CAMHS managers' operational oversight of practice through case records is made more challenging as practitioners file documentation in different sections of the electronic case record. For example, one practitioner will file their MARFs under referrals and another practitioner will file their MARFs under safeguarding. This necessitates managers potentially searching through the whole record to review safeguarding documentation. (**Recommendation 2.4**).

5.2.9 In Clearways, we were told that supervisors undertake a record keeping check of three cases in each supervision session with a practitioner. However, in both tracked cases reviewed, the service care plans were not on the electronic case record but were being held in hard copy by the case worker. As a result it is not clear how effective recording practice and record keeping oversight is. (**Recommendation 2.4**).

5.2.10 All health reviews and health plans are reviewed by the LAC named nurses using the national checklist for the health of looked after children audit tool. However, the tool is not held as part of the patient record, which means that practitioners completing the health review are not able to use this as part of their self-evaluation and the LAC health team are not able to evidence their findings and include these as part of the health record. (**Recommendation 2.4**).

5.3 Training and supervision

5.3.1 The CCG and partners recognise the importance of having an appropriately qualified workforce and have prioritised the improvement in uptake of mandatory training in safeguarding children. We are assured that both NHS trusts are on trajectory with their training and recognise the issues around data quality, especially in relation to Level 2 training.

5.3.2 The named GP has been successful in securing slots in the local GP trainee programme to provide safeguarding training to doctors in the first two years of their training, rather than the current offer which is to wait until the doctors are in their final third year. We heard from GPs how they would benefit from having more awareness about children looked after, the processes, documentation, and expectations for the GP practice in working to support the health needs of a child looked after registered with their practice.

5.3.3 The LAC named nurses deliver regular training to health visitors and school nurses on the health needs of looked after children and the health review process. They have also designed bespoke training for teams across the hospital on health of looked after children.

5.3.4 Paediatric staff have received no specific mental health training. It has not been offered to them by CAMHs but neither has it been sought by the ward manager. Given the high number of young people in mental health crisis being admitted to paediatrics while waiting mental health assessment or waiting for T4 assessment or identification of an appropriate inpatient bed, this is a significant gap. The paediatric ward manager told us that mental health training would be extremely welcomed by staff. (**Recommendation 2.1**).

5.3.5 Practitioners working in CASH and GUM have good awareness about abuse, what constitutes CSE and the system for referrals when new safeguarding information comes to light. However, they lack confidence in understanding their role in relation to CAF, CIN, CP status, the thresholds, the CSE service and its interfaces with child protection. This makes them reluctant to challenge when outcomes are not improving. (**Recommendation 4.7**).

5.3.6 A TRFT trust-wide female genital mutilation (FGM) policy has just been finalised. Not all staff working with potential victims have received any FGM training though they are aware of the new policy. We were assured that the trust has a plan in place to roll out training to support the new policy.

5.3.7 Plans are well advanced to commence a programme of training health visitors in perinatal mental health. It is intended to roll out implementation of an enhanced model of support to new mothers with mild to moderate perinatal mental health concerns. In the near future and this new offer should be incorporated into the perinatal mental health pathway. (**Recommendation 2.2**).

5.3.8 Supervision of staff across TRFT has been compromised by the recent absence of the named nurse and named midwife. However, both providers report difficulty in recording practitioners accessing supervision and this is a key area for development and is recognised by both NHS trusts.

5.3.9 The lead safeguarding clinician for ED does not receive any safeguarding supervision from the designated doctor to help support him in this role. Other than the paediatric liaison nurse, who has good, regular supervision from the named nurse which she values, safeguarding supervision arrangements for staff in ED are weak and ad-hoc.

5.3.10 Three years ago there were changes to the model of supervision used in child protection practice within health visiting teams. Safeguarding supervision is now provided as part of case management supervision, with notes made on the patient electronic record. Some practitioners felt that there was now no opportunity for restorative reflection and support within the new model. This is important when practitioners are working with complex families to ensure that practitioners remain emotionally resilient.

Recommendations

- 1. NHS England & Rotherham CCG should:**
 - 1.1 Work with GPs to ensure that they fully understand the local child protection processes, including their responsibilities around record keeping, information governance and information sharing.

- 2. NHS England, Rotherham CCG, Rotherham, Doncaster and South Humber NHS Foundation Trust and The Rotherham Foundation NHS Trust should:**
 - 2.1 Ensure children and young people who have attended the emergency department following an episode of self-harm or other mental health care need and admitted on to the trust's paediatric ward are looked after by appropriately trained practitioners and that there is a clear, written risk management plan in place for each child.
 - 2.2 Develop a perinatal mental health pathway that is compliant with NICE guidance and reflects all services that are available to support women with perinatal mental health needs.
 - 2.3 Ensure that health practitioners are completing referrals to children's social care that clearly assess and articulate the risk.
 - 2.4 Ensure effective governance around record keeping, including use of chronologies, case note entry, sharing of information and understanding of consent.
 - 2.5 Ensure that pharmacists and practitioners working from the local walk-in centre are aware of their role in referring young people for local screening for sexually transmitted infections or in raising safeguarding concerns and that clear pathways of care are in place.

- 3. Rotherham CCG and Rotherham, Doncaster and South Humber NHS Foundation Trust should:**
 - 3.1. Ensure that children and young people who are working with CAMHS practitioners have a clearly identified lead professional and that regular communication takes place with the child's GP where there is concern.
 - 3.2. Ensure that children and young people engaged with CAMHS have access to a clear pathway of care that includes arrangements for stepping up and down from Tier 4 services.

- 3.3. Improve the emergency department documentation and assessment templates to ensure safeguarding processes are robust and support practitioners in the identification and recording of children of adults who are accessing services.
 - 3.4. Implement a clear operational performance management system to demonstrate compliance with organisational requirements and effective safeguarding and child protection practice.
 - 3.5. Ensure that CAMHs practitioners develop clear service care plans for individual children. These should explicitly underpin child protection plans where these are in place.
 - 3.6. Adult mental health and substance misuse practitioners should, where appropriate, share relapse indicators with other professionals working with vulnerable families.
- 4. Rotherham CCG and The Rotherham Foundation NHS Trust should:**
- 4.1. Ensure that previous attendances at the emergency department by children or young people are routinely considered as part of the safeguarding triage assessment.
 - 4.2. Improve the identification and recording of children who are cared for by adults who attend ED following risk taking behaviours or mental health concerns and that these children are brought to the attention of paediatric liaison.
 - 4.3. Improve the risk assessment for vulnerability in midwifery services, CASH and GUM to ensure that vulnerability is being identified and responded to at the earliest opportunity.
 - 4.4. Ensure a robust communication process is in place to facilitate joint working between midwives and health visitors.
 - 4.5. Ensure that midwives are routinely including information from general practice as part of the initial risk assessment.
 - 4.6. Work with partners to develop a clear pre-birth protocol for expectant women to include robust plans for timely discharge of mother and baby.
 - 4.7. Ensure that practitioners working in CASH and GUM are clear about their contribution to local arrangements for child sexual exploitation and child protection.

- 4.8 Ensure that children looked after receive timely, comprehensive and child centred initial health assessments and review health assessments that reflect the voice of the child and the child's health journey whilst they have been looked after. Assessments should include information from other health professionals working with the child and every attempt should be made to include parental health histories.
- 4.9 Ensure that health plans developed from initial health assessments and health reviews are SMART.
- 4.10 Improve opportunities for young people who are looked after to participate in their health reviews.
- 4.11 Improve the arrangements to support young people with their healthcare as they prepare to leave care and ensure that they are provided with comprehensive health care summaries.
- 4.12 Improve the quality assurance process of paediatric liaison within the emergency department so that the trust and the CCG are confident that practitioners are remaining vigilant to potential safeguarding and child protection concerns.

Next steps

An action plan addressing the recommendations above is required from Rotherham CCG within **20 working days** of receipt of this report.

Please submit your action plan to CQC through childrens-services-inspection@cqc.org.uk. The plan will be considered by the inspection team and progress will be followed up through CQC's regional compliance team.