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09 September 2010

Mr A Buck  
Chief Executive  
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Dear Mr Buck

### **Outcome of integrated inspection of safeguarding and looked after children's services in Rotherham**

I am writing about the recent joint inspection by Ofsted and the Care Quality Commission (CQC) in Rotherham to provide you with more detailed feedback on the findings from the CQC's component of the inspection. Thank you for your contribution to the inspection and for accommodating the requests for interviews and focus groups with your staff and those of partner agencies at relatively short notice.

As you will be aware, the team led by Ofsted colleagues provided feedback to your local Director of Children's Services at the end of fieldwork and the report to the authority is now published.

This letter sets out more detail of the underlying evidence which relates to your organisation and the provider units for which you commission services. It incorporates the findings from the overall inspection report, but provides greater detail about what we found, in order that your organisation can consider and act upon the specific issues raised.

### **The Inspection Process**

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The inspection was conducted between 19 July 2010 and 30 July 2010 and was conducted under the [framework for inspection](#) of safeguarding and looked after children's services published by Ofsted.

Ofsted's inspection principle takes account of the extent to which service providers have sought and acted on the views of children, young people, family and carers when reviewing and improving services and outcomes generally. Inspectors will also

consider the views of those users and stakeholders they speak to during on-site evidence gathering. Details of the organisations involved are listed at the end of this letter.

The findings contribute to Ofsted's annual reviews of the performance of each local authority's children's services and its annual performance rating for each authority and will also feed into the joint commissions Comprehensive Area Assessments. The specific findings about health services' performance may also be used by the Care Quality Commission as a part of the assessment of NHS provision, registered health providers and PCT performance in delivering commissioning outcomes.

## **CQC's Involvement**

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As part of the overall inspection, CQC examined the effectiveness of the Commissioning PCT's delivery of outcomes for children and young people. We looked at the PCT and its health providers as follows:

- the role of the board: how boards assure themselves in relation to safeguarding and the health of looked-after children
- whether staff have the right skills and experience to recognise concerns, share information and escalate problems where necessary

The points discussed during meetings with the PCT commissioning board members were further explored with staff and, where possible local children across the Primary Care Trust, its providers, GPs, and community health teams.

## **Joint Inspection Report**

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The integrated inspection focused upon health and social care services in relation to implementing child safeguarding procedures and delivering appropriate outcomes for 'looked after' children. It looked at outcomes for children and young people and practices to improve children's life experience. [The joint inspection report](#) was published within 20 working days of completion of the inspection.

From the aggregated findings from the inspection, it was concluded that the overall effectiveness of the safeguarding services in Rotherham was **Adequate** and capacity for improvement was **Adequate**.

Overall effectiveness of services for looked after children and young people in Rotherham was judged to be **Adequate** the council and its partners were also judged to have **Adequate** capacity for improvement

## **Inspection Findings for Health Partners**

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The following sections provide details of CQC's findings which contributed to the overall inspection report. These are separated into two sections: safeguarding and looked after children. Where possible, evidence is attributed to a specific organisation.

CQC used a range of documentary evidence in advance of and during this inspection, and interviewed individuals and focus groups of selected staff and,

where possible, children and young people, their parents and carers in order to provide a robust basis for the findings and recommendations.

## **Key findings – Safeguarding and health**

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Extract from Inspection report of safeguarding and Looked after Children Services – Ofsted **August 2010**

*Planning and commissioning of health services for children are led by the council and NHS Rotherham (NHSR) the latter of which commissions acute hospital and maternity hospital services from The Rotherham NHS Foundation Trust. Rotherham Community Health Services (RCHS) are commissioned by NHSR to provide children and young people's community health services (including health visiting and school nursing), are co-located with council services in locally based communities and schools. NHS Rotherham are the lead commissioners of Child and Adolescent Mental Health Services (CAMHS) services which are provided by Rotherham, Doncaster and South Humber Mental Health NHS Foundation Trust (RDaSH) Rotherham community health services [and two other providers not inspected here]*

*The overall effectiveness of safeguarding services is adequate. Statutory requirements are met and there have been recognisable improvements in safeguarding over the last seven months since the Government issued a Notice to Improve in December 2009. The strong corporate ownership of the improvement plan, involving the leader of the council, lead member for children's services, the chief executive and the chief executive officer of NHS Rotherham has ensured that there is robust leadership and clear strategies in place to support the improvement process.*

*Local partnership working is good; health agencies, South Yorkshire police service and the voluntary and community sector contribute well to strategic development and improvements. The RSCB works effectively and is well led by the independent chair The Rotherham Safeguarding Children Board operates effectively. A new independent chair was appointed in September 2009 and is providing good leadership and direction to ensure that all statutory requirements in respect of the board's work are met. There is good challenge with all partners; in particular, health agencies play a key role in the CYPTB and the RSCB. Challenge has been further enhanced since the improvement notice was served and following the inspection of fostering services. For example, the chief executive of NHS Rotherham reviewed all placements of looked after children.*

*Partnership work, including performance management, between safeguarding board members is sound. The links between the child death overview panel and the serious case review panel are effective. The safeguarding unit provides good assistance to partner agencies to support their contributions. A wide range of high quality multi and single-agency safeguarding training takes place and is well attended, including by general practitioners and the voluntary and community sector. This training is valued by stakeholders spoken to as part of this inspection. The RSCB does not currently evaluate training for impact on practice. However, designated health professionals have undertaken review and evaluation of training and changes to provision have occurred as a result of this. For example, there has been increased access to training for practice staff, including practice managers,*

receptionists and GPs. Training data shows that all staff within NHSR and Rotherham Community Health Services have completed level 1 safeguarding training and nearly 90% of all other staff have completed levels 2 and 3 training as appropriate to their post.

There is no electronic flagging system in the Accident and Emergency department (A&E) at Rotherham Foundation NHS Trust (TRFT) for children and young people known to social care. Previous A&E attendances of children and young people known to services are only held on the A&E system for the past six months. This system does allow A&E staff to record parental concerns, however this is not accessible by other health professionals across Rotherham as StsymOne and this has the potential to inhibit sharing of safeguarding information. The health visitor liaison post ensures that all children and young people's attendance at A&E is reviewed. There is a lack of qualified nursing staff or staff with enhanced children competencies employed within the A&E department. All nursing staff reported to be trained in advanced paediatric life support; however no staff were neonatal advanced life support trained.

The Teenage Pregnancy Strategy is well implemented and provides a more localised approach to data collection with improved access to contraception. Targeted interventions are provided which supports parents to talk to their children about relationships. The Maltby Linx Young Women's project is an effective partnership which works with vulnerable young women who may be at risk of sexual exploitation, or have a number of high risk behaviours. In the project's first year, only one young woman out of 96 participants became pregnant. The project works closely with the Long Acting Reversible Contraception nurse (LARC), which the young people find to be of great benefit.

The Family Intervention Project (FIP), and Families and Schools Together (FAST), which include support from parenting support advisors, have all had a positive impact in helping children, young people and their families feel safe. There has been effective and creative joint agency work to prevent sexual exploitation and young people seen confirm that they have been well supported with regards to this issue.

Social workers, health visitors, school nurses and community midwives work in co-located teams in children's centres. Primary mental health workers are also being co-located within these teams, and these services are particularly targeted on those at risk of becoming children in need. Communication between partners is strong and partnership working is good at an operational level. A multi-agency Common Assessment Framework (CAF) resource team has very recently been established to support and develop the implementation of CAF, with an increasing focus on prevention and early intervention. The CAF is now being used by agencies including health and education to provide earlier assessment of children and young people and coordinated support to meet their needs. To date, 608 multi-agency professionals have been trained in the use of CAF and 372 CAFs have now been completed. These developments have been welcomed across children's services and by partners, although it is too early to assess the impact of this work as it is not yet sufficiently embedded.

According to the council's latest data, the timeliness of initial assessments is considerably improved from 73% in December 2009 to 80% in July 2010. In most initial assessments, other agencies are appropriately involved and joint assessments are undertaken with health professionals. Assessments are routinely shared with

families, and children are usually seen. Flexible and responsive inter-agency support is provided to children with disabilities across the spectrum of need and there is good transition planning.

Health professionals report good safeguarding supervision with increasingly flexible approaches which include some joint supervision with social workers. The designated nurse has been seconded to the RSCB and held the role of safeguarding manager for an interim period until a replacement safeguarding manager was appointed. During this time she had responsibility for overseeing the work of three serious case reviews and two individual management reviews, which has strengthened health partners understanding of their role in safeguarding children and young people. Members from both boards are also represented on the improvement panel and play a vital role in driving forward the improvement agenda.

Safeguarding policies and procedures have been updated and comply with statutory requirements. There is a newly developed joint commissioning strategy and a joint commissioning partnership which meets quarterly to direct commissioning arrangements. There have been a number of recent new appointments to key senior management posts and there is a new lead member for children's services and these changes have contributed to an increasing momentum of change across the area, which all staff report on positively. The Director of Children and Young People's health reports to the Strategic Director as well as the chief operating officer of the community health services and is also a member of the Directorate Leadership Team. This joint post is enabling a clearer and focused approach to be taken when commissioning services, particularly when reviewing joint commissioning. Multi-agency work with the Roma migrant community and their children is effective and has improved access to health provision and education and this is a particular strength of the council. The specialist nurse for unaccompanied asylum seekers and homelessness works closely with other health colleagues and social workers.

A Continuing Care Panel has been recently established between the Council and NHS Rotherham to determine partnership contributions to care costs. This is illustrated through the close working of the locality teams with aligned area assemblies, police safer neighbourhood teams and co-location of health professionals. Joint commissioning is well established with the voluntary and community sector's Consortium for Children's Services.

### **Leadership, management and performance management.**

There is strong senior leadership within NHR and across all provider organisations. Health commissioners have invested financially into children's services, to continue to improve services; budgets are aligned and not pooled.

Co-location of health and social care teams, including primary care mental health workers, child and adolescent mental health services (CAMHS), complex needs team and the child development centre teams has improved the effectiveness of practitioners, enabling good communication and information sharing, including links with allocated police officers. This continued integration of services and partnership working is well supported by senior managers.

Health partners are fully involved on the Children Trust Board and local safeguarding children board (LSCB) and partnership work and challenge has been strengthened since December. The chief executive of NHS Rotherham acts as critical friend to the LSCB and the council cabinet, which includes regular monitoring and challenge of key priority areas, including progress against action plans from SCRs. The LSCB's new independent chair has introduced clear role definitions for members and holds regular 'one-to-one' meetings with the chairs of the LSCB sub groups, some of which include health directors and the designated and named health professional staff. This is helping to improve working relationships and understanding of organisations' roles and remits. There are plans in place to introduce a "dashboard" to monitor the performance indicators and actions from section 11 audits which are currently not being effectively monitored by the LSCB.

Reporting and governance structures within The Rotherham NHS Foundation Trust (TRFT) have recently been redefined and this is now starting to show improvements in monitoring of serious case review action plans and the communication of actions required.

Non executive directors from NHSR visit all General Practitioners (GP) practices and front line services to assure themselves that robust systems are in place and staff are aware of their safeguarding responsibilities. Participation of GPs in safeguarding activities and training events is very good. The outcome of this is being seen through greater involvement of GP in making safeguarding referrals and attending case conferences all of which is contributing to the improvement of safeguarding for children and young people.

Rotherham Doncaster and South Humber Mental Health NHS Foundation Trust (RDaSH) contributes to 5 LSCBs with appropriate staff attendance. The named staff and directors are taking robust action to ensure that lessons and good practice are shared both within the trust as well as with other health providers to improve safeguarding practice. There is now a dedicated named nurse for Rotherham, which has improved local working and integration. There is a clear review and benchmark process for national reports which contributes to the relevant trust boards, but there was little evidence to show how this is improving outcomes for children and young people. Transition services have been reviewed following a SCR and adult services have now started to focus on the family as a whole which includes the safety of children. Whilst examples were provided of how this was becoming standard practice, including adult general and mental health services, and the service commissioned by the voluntary sector, it is too early to measure the impact of this progress.

The information technology (IT) system is fit for purpose according to staff however they are unable to access the social care IT system, which is preventing the quick sharing of information and often results in duplication of records. New clearer templates are improving communication with GPs all of which is helping to increase sharing of case information and ensure that safeguarding procedures are fully and appropriately utilised. Currently midwives have to use 3 IT systems to find information related to women and any previous pregnancies and children which is time consuming and has the potential for key information to be missed.

Service specifications are closely monitored, with commissioners visiting service areas and shadowing front line staff to review the quality of provision, embedding of policies and value for money. Performance management, data and intelligence

arrangements have been strengthened with improved use of data to inform contract performance monitoring and metrics such as monitoring of immunisations, vaccine and breast feeding rates. Consequently service specifications are being revised, improving the way that services are being delivered.

Several jointly commissioned services with Rotherham Metropolitan Borough Council (RMBC) have aligned budgets, including teenage pregnancy, substance misuse, CAMHS (Tier 2 and 3), equipment for disabled children and short breaks. NHSR act as specialist commissioner for tier 4 CAMH services and also commission specialist children's services at Sheffield Childrens hospital, including cancer, neonatal and paediatric intensive care and a range of low number high cost services, improving the range of high quality services available to children, young people and their carers in Rotherham.

There are good multi disciplinary audits involving co-located health providers and the each police. One example is a review of the number of children and young people admitted to A&E as a result of a trauma and violent episodes. This has resulted in a change of practice with all admissions deemed as appropriate by staff now reported to the police to follow up, ensuring that the child, young person and family remain safe.

### **Workforce, training and supervision**

Staff have good access to a wide range of safeguarding training, including multi agency sessions and dedicated themed training sessions and reported being up to date with training. The scheme is designed locally and uses 6 levels which are mapped to "Working Together to Safeguard Children". All staff have received level1/group 1 training, with an overall compliance rate at 89% for all other levels/groups of training.

There are now robust systems of child protection clinical supervision for all practitioners and examples show that the wider health team i.e. porters and receptionist staff are also able to access supervision and some have taken the opportunity. There is highly valued joint case supervision for co-located health and social care staff, which ensures casework work is consistent and move effectively through the safeguarding system; this is maintained if a child or young person becomes looked after, as the same staff are involved.

There is a dedicated school nurse for each special schools, working alongside educational staff, conducting health reviews and participating in special education needs (SEN) reviews which are undertaken jointly. This minimises anxiety for young people, and information from the assessments is fully shared and used by all parties involved. This service is highly rated by carers and staff.

Recruitment difficulties in the health visitor teams have been addressed following a skill mix review, with additional posts in place at advanced practitioner level, (band 7), staff nurse (band 5) and nursery nurse level as well as support workers. Assessment timeliness and quality is consequently improving. The same approach is currently underway within the school nursing service; the age range of the universal service is now 0 to 19 years to maintain consistency for the child, young person and their families however it is too early to show the impact of this review. There is good use of the community practice teachers to develop safeguarding competencies within the new teams which is ensuring safe working practices.

Safeguarding Supervision is provided for community staff including GPs through the Safeguarding Unit with joint casework supervision undertaken with social workers in localities. This has improved joint working and facilitated resolution for children and young people and their families or carers.

The designated dentist and named dental nurse for safeguarding and looked after children provide good on going support for community and private dentists, which includes discussing safeguarding concerns before referrals are made or the case escalated. This approach is starting to promote an increased awareness of safeguarding throughout dental services. The common assessment framework (CAF) is used as the referral tool to community dentist services for looked after children and young people or for a child with dental anxiety. This ensures that the dentist is fully appraised of the medical and social history before treatment commences. Community dentists have access to SystmOne (the health information technology/electronic clinical record system) including the alert 'flags' indicating parental responsibility, what information can be shared, and with whom, safely. This information is further used if there is a concern about a child, to identify the professionals already involved and therefore ensure that any concerns are shared correctly.

### **Child death overview panel**

The child death overview panel (CDOP) is working well through a participative approach. A dedicated paediatrician provides expertise to the panel, with good engagement of GPs. All sudden infant deaths and serious untoward incidents are discussed in order that lessons can be learnt and shared. Following one recent child death investigation CDOP have reissued sleeping guidance to staff which has been fully implemented, however the impact of this has not been measured. There is good use of national and regional reviews outcomes and sharing of lessons learnt within the health sector which is promoting good practice, however the implementation is not monitored.

### **User feedback**

User feedback ensures that services for children and young people with disabilities and complex needs are responsive to their needs. Commissioning of services through aiming higher, equipment provision, respite services and a DVD produced by young people through all the special schools has been used to inform the commissioning strategy. The outcome of this was the co-location of the Under-8s and Over-8s teams to better meet the needs of users.

Information from the Lifestyle survey, the youth cabinet, children in care council and the healthy school enhancement survey are all being used to commission services to meet the needs of young people. User views were used in the teenage pregnancy contract specifications and these have been successfully used with the refocused contract by the teenage pregnancy partnership. 'You're Welcome' standards are only just being implemented so too early to measure impact.

The Tier 2 CAMH service is now offering two Saturday mornings clinics a month in response to a request from young people and their families/carers which is enabling easier access and has therefore reduced the 'do not attend' rates. There is a well embedded 'do not attend and disengaged' policy in place. This policy was recognised as good practice by the national conference on child deaths (as the policy was revised following a child death). If a child misses/does not attend an

appointment, letters are sent to the GP, Health Visitor and School Nurse, ensuring that the whole primary care team is aware and a risk assessment is undertaken to ensure that the child is not at risk of harm. The development and design of the new Kimberworth development, which will co-locate CAMHS tier 2 and 3 services, has been shaped by the young people who will be using the services

There is good interagency working between the co-located Police Constable for Children and Young People, (which is highly valued by school nurses and health visitors), the Youth Offending Service and Youth Offending Teams in restorative justice. This police constable, alongside health staff, has been able to work within schools to reduce the risk of vulnerability. A recent case involving a primary school demonstrated an immediate joint response to ensuring two children who needed to be in a place of safety immediately were placed successfully.

### **Mental and emotional well being services**

The CAMH service has a low number of black and ethnic minority groups accessing the service. However low levels of referrals especially from black and ethnic minority group referrals are being monitored and a CAMHS worker has been seconded to work with community support development workers to ensure that all those children and young people from black and ethnic minority groups that should be referred are referred. As yet it is too early to measure the full impact of these initiatives. The MIND service has the same low rates including a low number of boys accessing school based services, but there has been no action to review the reasons for this.

Specialist mental health nurse practitioners working with homeless and unaccompanied asylum seekers have recently increased the age range of children and young people seen; this appears to be working well and working with other partners they have successfully reduced the vulnerabilities of some of these young people, however it is too early to measure the full impact in the change of service thresholds.

Adult mental health services are now focusing on hidden harm, think family and changes to admission and assessment documentation that now requires staff to ascertain if the adult is a carer for children and young people, as a result the referrals from adult services for child in need cases to social care teams have increased. There are good links with RDaSH and adult safeguarding teams which have improved working relationships. For example, adult drug workers are now involved with the 'team around the child', to ensure that hidden harm is minimised.

### **Children with disabilities**

Community children nurses in the disabilities team have laptops to remotely access information about/for children, young people and their carers immediately. They provide the latest health related materials, translated into an appropriate format as required to ensure that young people and their carers can make informed choices and consent.

There is good access to social care referral teams and staff that are co-located have a good awareness and understanding of the thresholds for referral. Health staff rated social care support as excellent, and having a dedicated social worker on the disabilities team has improved communication and swifter action for the child and carers.

## **Unscheduled care**

There is no flagging system used in the A&E department at The Rotherham Foundation NHS Trust (TRFT) for children and young people known to social care. Staff are unaware of any child already subject to child protection proceedings and, in the case of looked after children and young people, they cannot determine who has consenting responsibilities and what, if any, information can be shared with family members and carers.

Referrals to social care out of hours remain a concern for accident and emergency (A&E) staff, at TRFT. Staff reported a number of differing responses from a risk register check requests as some are being taken as referrals. Not all referrals are being taken verbally in line with the social care procedure and some social care staff will not accept referrals when the young person is aged 16-18 years even if deemed vulnerable or are teenage parents and their child is vulnerable. The lack of timely response to check the 'at risk register', (which can take anything from 10 minutes to over an hour,) may result in the person having left the A&E department, and therefore the staff cannot discuss the course of action agreed upon with the parent/carer. A&E staff escalate these cases however they feel that the young people are not safeguarded adequately and this continuing situation may put children and young people in a more vulnerable position. A&E staff reported that they very rarely receive feedback on referrals made to social care and therefore are not aware if their referral was appropriate and what action has been taken. Designated and named professionals had identified this as an area of concern and have recently started to work with health and social care teams to address this; however this is too early to show impact.

There are no children-qualified nursing staff on each shift, nor are staff with specific children training competencies on each shift. All nursing staff are however reported to be trained in advanced paediatric life support. Staff have training in pain assessment for children within three weeks of commencing post, however this is not updated and there is no other child related competency training.

There is good health visitor liaison in A&E monitoring referrals to social care and to school nursing/health visiting services.

## **Sexual health**

Teenage conception rates are higher than both England and Yorks & Humber SHA, with in 2008, only a 1.4% reduction on the 1998 baseline. February 2010 data showed a 15% reduction in the conception rate, which is the largest reduction to date. This is attributed to the change in focus of the teenage pregnancy partnership, and the embedding of new pathways. Maternity services introduced a 'green pack' for pregnant women, known to be at risk, vulnerable or whose baby maybe or is at risk, the green pack forms part of the hospital records rather than the patient held records. Chronology records follow from booking onwards and identify any risk issues. At the time of the inspection an audit to ascertain how well used these are, and the impact on safeguarding was being undertaken, and therefore the impact of this could not be measured at this time.

There is an effective one stop self referral system in place for terminations of pregnancy. The service, along with maternity services, is supporting young woman and provides long acting reversible contraception (LARC) which is believed to be one of the reasons why the pregnancy rate has reduced.

There is a care pathway for young mums identified at risk of post natal depression which is mapped to the substance misuse services and ensures that the high risk period from birth to 3 years is closely monitored. All referrals are accepted and assessment occurs within 8 weeks. There has been no formal measure of impact of this pathway.

The condom care scheme known as 'C card' has had 736 contacts per year within one youth centre since it moved to new location which is much improved, as the new venue is seen by young people as more friendly. However there is no formal audit to demonstrate the changes in these services and the drop in teenage pregnancy rates.

There are two full time substance misuse midwives who identify the needs of parents misusing substances/alcohol. There is a dedicated adult alcohol specialist worker who, together with the dedicated midwives, is working well in addressing hidden harm. Since the 2 midwives have been in post there has been a reduction in the number of newborns with substance misuse conditions on the special care baby unit with withdrawal from 50% to none in the last 18 months. All pre-birth referrals are now accepted by social care, and protocols have now been changed to ensure this happens. The Primary Care Screening Tool for Alcohol has been introduced; as a result, referrals from GPs to substance misuse services and social care have increased.

Young people reported that they did not feel safe in their local communities, citing issues with gang cultures and estates rivalry. Some were involved in this culture before becoming involved with the youth scheme LINX. An early Intervention multi agency project which includes the LARC nurse, has targeted a number of young women who were being sexually exploited, some of whom stated if they had not been involved in this project they would either be 'dead, pregnant or in prison'. The young women like this service and feel this enables them to feel safe when they are out; they develop an understanding of their own vulnerability and what they can do to remain safe. The LARC specialist practitioner has set up a face book page to share information with young people and this has a high 'hit' rate. The page contains a range of information, such as clinics and drop in session location and times, which has increase attendance at the sessions. The evaluations show that young women involved with the Maltby LINX project all have improved aspirations, reduction in teenage conceptions and sexually transmitted diseases and an increased aware of their own risk and vulnerabilities.

### **Key findings – Looked after children and health**

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Extract from Inspection report of Safeguarding and Looked after Children Services – Ofsted **August 2010**.

*The overall effectiveness of services for looked after children and young people are adequate. Outcomes are at least satisfactory and in some cases good, particularly in relation to the health of looked after children and their opportunity to make a positive contribution. Health needs are well met and looked after children are appropriately safeguarded in their placements.*

*Health assessments are of a good quality and there is a good contribution from children and young people to service design and evaluation of services, including the plans to re-configure the service.*

*Services to promote the health needs of looked after children and young people are good. All looked after children's health assessment files seen during the inspection were comprehensive and of good quality with clear action plans in place. Foster carers receive copies of children's health plans and this enables them to monitor the health needs of children in their care.*

*There is a good track record of increasing the proportion of children, young people and care leavers who receive an annual health assessment. In 2009, 85.5% had an assessment, which was significantly improved from previous performance. The service is now on track to exceed the current target of 90%. The designated nurse and doctor ensure that any Rotherham child placed out of the area receives their health assessment, and that any follow up actions are completed. The designated doctor provides well received advice to social care staff when placing children and young people in care settings as well as undertaking adoption health assessments, to ensure that the most suitable placement is found. Looked after children have good access to dentists with 91.3% receiving dental assessments and this is better than statistical neighbours and the England average. The community dentist teams support children and young people until their 18th birthday which is good practice. Immunisation rates are good.*

*Multi-agency health promotion is good. The 'Design for Life' programme involves all looked after children and their carers, including those living in foster homes. The programme offers valuable support to carers and enhances their skills. Looked after children have good access to timely CAMHS through the Looked after and adopted children's team (LAAC) which is improving their emotional well being and placement stability.*

*The CAMHS team also provides effective assessment for looked after children from other authorities placed in the borough. The designated nurse and the Long Acting Reversible Contraceptive (LARC) nurse undertake joint assessments within each of the children's homes which are promoting a better understanding of sexual health and relationships. These sessions provide young adults with an opportunity for direct access to contraceptive services and sexual health tests, in a familiar environment. Care leavers receive good support from the LAC specialist nurse during the transition period and into independence. She works flexibly and creatively to ensure that care leavers are able to maintain contact with health services and become increasingly able to manage their own health needs as they move towards independence. The transitions team for disabled children and looked after children is a highly motivated inter-professional and interagency team who demonstrate good, close and young person focused working relationships.*

*There is a dedicated school nurse for special schools who works with educational staff, undertakes any looked after children and young people health reviews and*

*participates in special educational needs (SEN) reviews which reduces stress and repetition for young people. This service is highly regarded by all staff. Care leavers receive good support from a range of professionals, including a Bridges leaving care worker, a Connexion PA, and a dedicated looked after children nurse, and all have access to learning mentors*

*A variety of post- 16 provision is available within the borough, including a number of different vocational programmes. This ensures that young people can access a good range of further education programmes to suit their needs.*

*The LAAC, Get Real and the dedicated health teams undertake good direct work with individual children and young people and their carers. This is effective in supporting placement stability and ensuring children and young people have timely access to specialist services such as respite care or access to tier 1 and 2 CAMHS provision.*

*The chief executive of NHSR, in his role as a critical friend to the council, has reviewed all current placements and the speed with which plans for permanent placements are being developed to ensure that work is responsive to the needs of all looked after children and young people.*

*Partnerships are good. Participation in corporate parenting at a strategic level is satisfactory and most key partners are involved in delivering support for looked after children and young people. For example, the LAAC team which is funded by CAMHS and is co-located within a social work team provides effective support through individualised packages to promote health and emotional wellbeing and placement stability. Good partnership working between the council, health and voluntary agencies is successful in providing targeted services for looked after children and young people, including services to care leavers provided through action for children and the Barnardo's Junction project. Good multi-agency youth work is effective in reducing anti-social behaviour of looked after children, this has resulted in reduced rates of offending and re-offending behaviour.*

*Rotherham short breaks provision for disabled children has established good partnership working across the statutory and voluntary sectors with 319 children and young people accessing these services in the Rotherham area. The short breaks service has also taken effective action to include minority ethnic children, young people and families within its work, recognising that these groups may have less access to services and use services less.*

*Good partnership and multi-agency working between health, social care and education ensures that a good range of equipment is provided to disabled children and their families and is in the best location for the children and young people to use. During long school holidays, health equipment that is usually kept in school is transported home to ensure that the most appropriate and beneficial equipment is provided.*

*Scrutiny of special equipment provision for children and young people with disabilities and complex needs including those with life limiting conditions has been strengthened and is now robust with health, social care and education all contributing funding. This has resulted in most equipment being provided within eight weeks.*

*Overall Being Healthy grade – Good*

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## **LOOKED AFTER CHILDREN AND YOUNG PEOPLE**

The health needs of looked after children and young people is good. All looked after children health assessment files (11) seen during the inspection were of a good quality overall with evidence of actions being completed in some cases. There has been a reduction in the proportion of young people having an annual health assessment; this has been attributed to the recent office move and no access to the IT network. The 2008/09 rate for health assessments was 85.53% an improvement on the previous year by 15% and dental assessments and checks have risen again to 91.3 %, better than England average. Foster carers are now given copies of health plans, which is enabling actions to be completed fully and within an appropriate timeframe. Access to CAMH services is through the single point of access, (SPA), which gives a priority to looked after children and young people, to their own dedicated looked after and adoption team. Waiting lists times have recently reduced to 15 days. This service is able to provide access for young adults until they are 21 years, with an early psychosis service from 14 - 35 years. All of which are providing a good and improving service, which currently meets the needs of service users. Good databases are now in place for looked after children and young people which are enabling the sharing of information with partner agencies, health, social care, and Connexions. As a result of this staff know all young people who are going through transition and to ensures that there are no gaps in services due to lack of provision. The health disability team attend all relevant looked after children health reviews, and in some cases undertake health assessments in the special school with the dedicated school nurse for special school, which is reducing the number of assessments that held, and has improved timeliness of assessments and increased information sharing

### **Leadership and management**

Corporate parenting is strong and well understood within health strategic managers, non executive directors and senior teams. Systems have changed within organisations so that changes to policies and working practices are fully embedded and the boards receive assurance that children and young people remain safe within their organisation as well as within partnerships through improved reporting and governance arrangements. Partnership working is very good across health organisations and good partnerships between health and the council, which is ensuring that the needs of looked after children and young people are being addressed promptly.

### **Workforce and training**

All staff seen during the inspection have received training in the needs of looked after children and young people as part of the general range of safeguarding training courses. There is a wide range of training provided, coordinated by the LAC nurse and an ongoing programme for foster carers and new adoptive parents training which is maintaining looked after children and young people placement stability. Multi agency preventative work is undertaken both with foster carers and in children's homes through a programme entitled 'Design for Life' the aim being to support looked after children and young people and maintain placement stability as well as enhancing the skills of carers. This includes information related to sexual health and relationships which is delivered with the Fostering Team. The designated nurse for looked after children and young people and the Long Acting Reversible Contraceptive (LARC) nurse

are undertaking joint assessments within each of the children's homes which are promoting a better understanding of sexual health and relationships. These sessions provide young adults with an opportunity for direct access to contraceptive services and sexual health tests, in a familiar environment and therefore improve take up and reduce risk taking behaviours. Evaluations of the programmes held are positive and is helping to maintain placement stability.

The A&E Health Visitor (HV) liaison post ensures that all children and young people attending A&E are reviewed and that HVs (for under 5s) and school nurses (5-19 years) are informed of hospital or A&E attendances by looked after children and young people and action required. This ensures that all actions are followed up and the child and young person and carers are supported and any concerns are effectively monitored.

The dedicated school nurse for special schools who coordinates the transitions for young people with physical disabilities and life limiting conditions starts from 12 years onwards, this includes good individualised and targeted approaches, with joint adult and young people clinics that are starting to assist young people to take responsibility for their own health and develop independence. However the effectiveness of this intensive service has not been formally measured. School nurses report that if an out of authority child and young person is placed in Rotherham, that they are not invited to the Team Around the Child (TAC) or the common assessment framework (CAF) meeting. This is causing difficulties for these staff as the support they give to children and young people through school healthcare services may not be in line with the individual health assessment, or action plan.

Family support workers, who work with a preventative remit, are positively evaluated and highly respected by the health team. Case studies show good joint working and information sharing which has a positive effect on mothers and children and has enabled mothers to continue to look after their own children, reduce vulnerabilities and stop them going into care. Evaluation using the 'every child matters' outcomes is positive overall. One case study involved the use of NSPCC working with the family to support attachment, and another of how the Speech and Language Therapists had improved school attendance. The common assessment framework was used well to coordinate and record activity.

Good partnership and multi agency working exists between health, social care and education to ensure that equipment is provided and is in the best location for the children and young people to use. During longer school holidays, health equipment usually kept in school is transported home for the child to use this ensures that treatments can continue maximising the benefits for the children, young people and their families. All drivers and helpers used to transport the children and young people receive training based on the individual children and young people needs and care plan is given along with risk assessments and medical emergency training. This approach has ensured that all children and young people health needs are met and that their safety is maintained. Flexible approaches within the palliative care services and children's hospices ensure that young people can stay with these services depending on their needs, past 18 if required, resulting in the end of life experience of family/carers being as positive as possible in the circumstance and that the young person remains safe in a service which they know.

## **Areas of Strength**

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Co-location of teams, primary care workers, child and adolescent mental health services (CAMHS), complex needs team and the Child Development Centre team have all added value to the work of practitioners and the continued integration of services and partnership working is supported by senior managers. This is increasingly ensuring that safeguarding concerns of children in need are quickly addressed and children and young people are safeguarded quickly.

### **Recommendations for Improvement from joint report relating to health partners**

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#### *Within 3 months*

NHS Rotherham and Rotherham Foundation NHST must ensure that within the A&E services that there is access to suitably trained and qualified Childrens' nursing staff available when children and young people are being seen in the department.

NHS Rotherham must ensure that A&E staff at Rotherham Foundation NHS Trust have access to and use SystmOne to ensure that children and young people can be easily identified if they are already know to social care services.

### **Conclusion**

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Your CQC Regional Director is copied into this letter and will arrange follow up on any actions detailed. We have also copied in the Strategic Health Authority and CQC's Head of National Inspection, who has overall responsibility for this inspection programme. We also recommend that you share specific findings in this letter with your provider units. In respect of the recommendations, please complete an action plan detailing how they will be addressed and submit this to our regional director and your SHA Chief Executive within 20 working days of receipt of the final copy of this letter.

Yours sincerely

*Lynn*

Lynn Davison  
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Integrated Inspections of children and looked after children and young people

Cc

Mr Bill McCarthy - CEO Yorkshire and the Humber SHA  
Ms Jo Dent – CQC Regional Director, North Yorkshire and Humber  
Mr Anthony Deery – CQC Head of National Inspections  
Mr Chris Batty HMI – Ofsted Managing Inspections  
Mrs Marie McGuinness HMI – Ofsted Lead Inspector  
Ms Tina Welford - CQC Children services inspector

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Other organisations involved in this review

NHS Rotherham

Rotherham Community Health Services

Rotherham Foundation NHS Trust

Rotherham Doncaster and South Humber Mental Health NHS Foundation Trust