The Rotherham NHS Foundation Trust

Community health services for children and young people

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Ratings

Overall rating for this service

Are services safe?	
Are services well-led?	

Summary of findings

Community health services for children and young people

Summary of this service

The Rotherham NHS Foundation Trust was awarded foundation status in 2005 and provides a wide range of acute and community health services to the people of Rotherham (population approximately 261,000). The trust provides the full range of services expected of a district general hospital including urgent and emergency care, maternity, paediatrics, surgery, medicine, critical care and community services for both children and adults.

Previous reports relating to this trust can be found here: https://www.cqc.org.uk/provider/RFR

We carried out a focused inspection at The Rotherham NHS Foundation Trust on 7- 10 July 2020 to review the processes, procedures and practices for safeguarding children and young people. We looked at parts of the safe and well-led domains.

We did not rate services because this was a focused, short notice inspection in response to specific areas of concern. We inspected safeguarding processes in community services for children and young people and in urgent and emergency care, the children's ward and children's assessment unit, and maternity services. We also looked at the wider oversight and management of safeguarding children and young people across the trust.

Following our inspection, we put our concerns formally in writing to the trust and asked that urgent actions be put in place to mitigate the risks to children and young people.

The trust provided a detailed response including improvement actions already taken or planned, all actions were due for completion by November 2020. This provided assurance that sufficient action had been taken to mitigate any immediate risks to patient safety. We will continue to monitor this information through our routine engagement with the trust.

We found:

- Staff understood how to protect patients from abuse. Most, but not all staff had training on how to recognise and report abuse and they knew how to apply it, but the systems and processes they used made this difficult.
- Leaders did not operate effective governance processes throughout the service and with partner organisations. Staff did not always take opportunities to meet, discuss and learn from the performance of the service.

Detailed findings from this inspection

Is the service safe?

Although staff understood their responsibilities in relation to safeguarding children and young people, the trust's safeguarding children processes, procedures and practices did not support the identification and protection of children and young people who may be at risk.

Safeguarding and protection from abuse

During our last inspection of this service in 2018, we found that the recording of children and young people's voice was variable, and that the service's Safeguarding Level 3 training did not meet intercollegiate guidelines. The looked after children team was not adequately staffed to undertake their duties and, as a result, statutory assessments were not being completed when needed. We did not find any recurrence of these issues during this inspection.

At this inspection we found that record keeping had improved. For example, the use of flags to alert practitioners that a child or young person was subject to a safeguarding plan was well used in the 0-19 service. We reviewed 10 sets of records, all of which were correctly flagged.

However, fathers were not routinely considered by the 0 -19 service. Details of fathers were not consistently recorded in the electronic record. Recording of wider family members such as grandparents living with a child was poor and genograms (family diagrams) were not routinely used. This demonstrated a lack of consistent learning from national cases such as baby Peter where it was recognised that it was important to identify all those adults who lived in the same household or had a role in a child's life. It also meant that the opportunity to identify risk and offer intervention as early as possible was sometimes missed.

Assessment of parental risk was variable in the 0 -19 service and was dependent on individual practitioners. A new template had been introduced and standard operating procedures were being developed to support better understanding of the correct use of the template; however, these were not in place at the time of our inspection.

Antenatal home visits were not universally offered to families and were targeted to first time mothers and vulnerable families. However, we found two cases in the records we reviewed where people known to social services, including an unborn child on the child protection register, did not receive an antenatal visit. This meant the service was not operating a robust system to identify the most vulnerable families and target antenatal contacts to those who required them.

Electronic systems did not always support practitioners to help them to do the right things. For example, we saw that a vulnerable young person had attended the emergency department and should have been followed up by the 0 -19 team. Details of the young person's attendance were visible in the electronic record, but without a task set to alert the practitioner that they should review this record, a 0 -19 practitioner would not know that this person required a review. This person was not offered support from the team following their visit to hospital and meant there was a missed opportunity to promote the welfare of the child or young person.

Safeguarding referrals were not always comprehensively recorded. A known issue with the electronic referrals system (outside the trust's control) meant that referrals were not visible in the record. This was on the risk register and workarounds had been put in place but in two records we checked, the workaround had not been added to the record, so it appeared that a referral had not been made.

There had been notable improvements in capturing the voice of the child since our last inspection. In three sets of records we noted a new template prompted practitioners to record the voice of the child, and this had been successfully completed.

We checked five referrals to the local council's safeguarding team, all of which had been made by midwives or health visitors. These contained enough detail about the incident the professional was concerned about and included relevant information about other people living with the child.

Detailed findings from this inspection

Staff training levels in Safeguarding Children Level 3 was 63.4% compliance for medical and dental staff, and 88.7% for non-medical staff. These were not meeting the trust target levels of 95%. The Trust had been unable to access Safeguarding Children Level 4 training due to circumstances relating to Covid-19, and therefore only three of five people requiring Level 4 training as part of their role had received this.

Is the service well-led?

Governance and Management

At the previous inspection of community health services for children and young people in 2018, we found that there was no oversight of referrals and no quality assurance or mechanisms for regular audit.

Audits were not always embedded, and actions signed off in a timely way. For example, an audit of child sexual exploitation assessments completed in February 2020 still had a number of actions relating to dissemination of learning outstanding at the time of our inspection.

Minutes of the last five strategic safeguarding groups, held quarterly, showed that these meetings were not quorate during the period July 2019 to April 2020. Attendance ranged from six to 12 people, including some external agencies. During this time, no trust medical staff had attended.

Minutes of the last year's safeguarding operational group showed that this meeting had not been quorate since August 2019. One member of medical staff had attended in March 2020, and two in May 2020. No other medical staff had attended in the previous year. Minutes of meetings were not always available when needed, with one set of minutes (April 2020) described as 'missing' (it was later confirmed that the meeting had been cancelled) and June's minutes not available as they had not yet been completed when requested by CQC three weeks later.

The safeguarding operations and strategic groups fed into the trust's clinical governance group. We reviewed the minutes of this group for the previous 12 months. Safeguarding was a standing agenda item every quarter and featured on the November 2019 and May 2020 agendas. Discussion recorded in the minutes focused on staff training levels.

It was not recorded in the clinical governance group minutes that there were any concerns about the efficacy, quoracy or format of either safeguarding group, nor did the clinical governance group escalate any concerns regarding safeguarding to either the quality assurance committee or board of directors. As a result, there was no 'ward to board' oversight of safeguarding, and issues of quoracy and poor engagement from medical staff was not brought to the attention of the executive team or board through governance mechanisms.

Three risks relating to safeguarding were on the trust risk register at the time of this inspection. These were; social care referrals were not generating receipt emails, poor evidence of implementation of the Mental Capacity Act (this does not apply to children under the age of 16), and staff training levels. However, there were also identified risks such as antenatal contacts, delivery on mandated contacts and safeguarding supervision that did not feature on the risk register.

The trust was required to submit a Rotherham partners self-assessment document as evidence of their effectiveness once every two years. The trust's last document, submitted in December 2019, did not match our findings; for example the trust self-assessed at the highest level for 'effective supervision for staff relating to their safeguarding responsibilities' when there was no regular, minuted and structured safeguarding peer supervision in place for medical staff.

Culture of the organisation

"The culture surrounding safeguarding children in the community was positive. However, the culture surrounding safeguarding children in the hospital generally was poor. Staff did not prioritise keeping their skills and knowledge up to

Detailed findings from this inspection

date and safeguarding children was not 'everybody's business'. Staff universally told us they felt well supported and managers and leaders were visible. While they acknowledged that systems and processes did not make things as easy for them as it could be, they spoke of strong links with other services, both in the acute hospital and community, and gave examples of teamworking they had instigated across services having positive safeguarding outcomes for children.

Areas for improvement

Action the trust MUST take to improve

- The trust must ensure that formal supervision and peer review processes for safeguarding children are in place. (Regulation 13 (2).
- The trust must ensure that staff complete safeguarding training in line with trust policy. Regulation 13 (2).
- The trust must ensure that records used for safeguarding children are accessible by all who need to do so. Regulation 13 (2).
- The trust must ensure that records used for safeguarding children are complete and contemporaneous, including sufficient information about everyone living in the household. Regulation 13 (2).
- The trust must ensure that safeguarding processes and systems keep people safe 24 hours a day, seven days a week. Regulation 13 (2).
- The trust must ensure that records used for safeguarding children are stored in such a way that they are easy to access and enable a practitioner to quickly build up a complete picture of a child's care. Regulation 17 (2) (c).
- The trust must ensure that records used for safeguarding children are regularly audited for quality and completeness. Regulation 17 (2) (a).
- The trust must ensure that there is sufficient audit activity to monitor the quality and effectiveness of safeguarding processes against current national guidelines and quality standards. Regulation 17 (2) (a).
- The trust must ensure the risk register captures all service risks and appropriate mitigation is in place. Regulation 17 (2) (a).
- The trust must ensure that safeguarding governance systems and processes are effective and monitor this regularly. Regulation 17 (2) (a).
- The trust must ensure that meetings where information about safeguarding children is shared are appropriately attended and effective. Regulation 17 (2) (a).
- The trust must ensure that learning from incidents takes place in a timely manner and that this has been embedded. Regulation 17 (2) (a.)

Our inspection team

The team included five inspectors, two inspection managers and a specialist in safeguarding children and young people. The inspection team was overseen by Sarah Dronsfield, Head of Hospital Inspection.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Maternity and midwifery services Nursing care Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

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Maternity and midwifery services Nursing care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance