

# **Review of Health Services for Children Looked After and Safeguarding in Torbay**

# Children Looked After and Safeguarding

## The role of health services in Torbay

<b>Date of review:</b>	19 <sup>th</sup> May 2014 – 23 <sup>rd</sup> May 2014
<b>Date of publication:</b>	18 <sup>th</sup> August 2014
<b>Name(s) of CQC inspector:</b>	Jan Clark and Lynette Ranson
<b>Provider services included:</b>	Torbay and South Devon Health and Care NHS Trust South Devon Healthcare Foundation NHS Trust Devon Partnership NHS Trust
<b>CCGs included:</b>	South Devon & Torbay CCG
<b>NHS England area:</b>	Devon & Cornwall
<b>CQC region:</b>	South
<b>CQC Deputy Chief Inspector, Primary Medical Services and Integrated Care</b>	Ms Ruth Rankine

## Contents

<b>Summary of the review</b>	<b>3</b>
About the review	3
How we carried out the review	4
Context of the review	4
The report	6
What people told us	6
<b>The child's journey</b>	<b>8</b>
Early Help	8
Children in Need	13
Child Protection	16
Looked After Children	21
<b>Management</b>	<b>25</b>
Leadership & Management	25
Governance	29
Training and Supervision	31
<b>Recommendations</b>	<b>33</b>
<b>Next Steps</b>	<b>36</b>

---

## Summary of the review

---

This report records the findings of the review of health services in safeguarding and looked after children services in Torbay. 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 the Clinical Commissioning Group (CCG) and NHS England Area Team (AT).

Where the findings relate to children and families in local authority areas other than Torbay, 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 well-being.

In total we took into account the experiences of 69 children and young people.

---

## Context of the review

---

*Commissioning and planning of most health services for children are carried out by South Devon and Torbay Clinical Commissioning Group.*

*Commissioning arrangements for looked-after children's health are the responsibility of South Devon and Torbay Clinical Commissioning Group and the looked-after children's health team. The Torbay and South Devon Healthcare Foundation Trust provides a designated doctor to carry out initial health assessments, the operational looked-after children's nurse/s, are provided by Torbay and South Devon Health and Care NHS Trust. This trust is an integrated health and adult social care organisation also providing community health services in Torbay and Southern Devon. The trust operates several Minor Injuries Units (MIUs) including one based at Brixham hospital, and another based at Paignton hospital.*

*Acute hospital services including an emergency department are provided by South Devon Healthcare Foundation NHS Trust at Torbay Hospital. The Trust's maternity service is facilitated through an integrated team midwifery model with in-patient facilities for ante / postnatal women. The Trust provides level 1 neonatal care. Any baby requiring more intensive level 2 or level 3 care, are stabilised and transferred. The nearest level 2 neonatal unit is Exeter, level 3 unit is Plymouth. The paediatric ward, Louisa Cary Ward, cares for children under the age of 18 with any medical, surgical or psychological conditions that require inpatient care, or day patient care. The ward has two high dependency beds.*

*The acute trust also operates the child development centre; a service for pre-school children who have complex difficulties and who may be having difficulties in meeting their developmental milestones; the children's specialist community team providing outreach nursing and psychology service in children's homes; outpatient service for children with medical, behavioural, emotional and/or developmental problems, speech and language therapy and general paediatric outpatient clinics.*

*Specialist Public Health Community Nursing, that is, school nurses and health visitors, are commissioned by Public Health (Torbay Council) and NHS England respectively, and provided by Torbay & Southern Devon Health and Care NHS Trust. The Trust also provides Child and Adolescent Mental Health Services (CAMHS), a specialist substance misuse health visitor and the Family Health Partnership health visiting team.*

*South Devon Healthcare NHS Foundation Trust and Torbay and Southern Devon Health and Care Trust are currently working to become one integrated care organisation by the beginning of the next financial year.*

*The Torbay Sexual Medicine Service (TSMS) is an integrated service providing genito-urinary medicine (GU), contraception and pregnancy advice.*

*Child substance misuse services are commissioned by Torbay Council (Public Health) and provided by the Children's Society.*

*Adult substance misuse services are commissioned by Torbay Council (Public Health) and provided jointly by Devon Partnership Trust and Torbay and Southern Devon Health and Care Trust. Adult mental health services are provided by Devon Partnership NHS Trust.*

*The last inspection of health services for Torbay's children took place in September 2010 as a joint inspection, with Ofsted, of safeguarding and looked after children's services. At that time, joint inspections did not give judgements for health's contribution to safeguarding and the Being Healthy outcome for looked-after children. Recommendations from that inspection are covered within the lines of enquiry for this review programme.*

---

## 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

---

### Young people said;

"A&E staff are really good, they are always really busy but they look after you whatever you're there for."

"We have done a lot of interviews of staff for CAMHs, particularly IAPT and have 50% of the weighting in the decision making. We had some training to help us in this."

"Every service has room to improve. We know how we want to be talked to. We don't want complicated words but don't want to be talked to like a child. They need to listen to us."

"We are looking forward to teaching schools and GPs about how to help young people with mental health problems"

"Being part of the *Have your Say Group* (for young people with emotional health issues) has given me confidence. I really feel that I have achieved something but not all young people are being told about the group and that's a problem"

"There can be a very long wait in A&E. It is ridiculous. One night, I was bounced between the out of hours GP service and A&E and in the end had to ring them to get help."

### Parents told us;

"Keeping things familiar is really important to her as she had so much disruption in her life. She has had this CAMHs worker for some time now, who is really helpful. My daughter likes her a lot and it's helped her to develop social skills."

"The CAMHS worker is lovely. He is supportive and helped us by teaching us techniques to help manage our son's behaviour".

**Foster Carers told us;**

“We waited a year for CAMHS. In the end we got some private therapy for our foster child and then we were offered CAMHS.”

“We actually got CAMHS very quickly due the high risk of running away and serious self-harm.”

“The TSMS outreach worker is really good. She goes out to see the young person and has a nice relaxed approach.”

“Waiting in A&E when my looked-after child has self-harmed is just too long”

Clinicians in Torbay are very good. Once you get to the paediatrician it works. Waiting is awful.”

---

## 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 Overall, we saw and heard about practitioners working hard to ensure that children and families with vulnerabilities and needs are well supported. Health services link well with schools and children's centres as part of the offer for early help support.
- 1.2 Midwives are good at identifying vulnerability and risk at an early stage and make prompt and appropriate referrals to the Hub. The introduction of the interagency communication form (ICF) has been valued by other disciplines and is used effectively, with maternal consent, to facilitate the early engagement of children and vulnerable families with appropriate support. This routinely includes children's social care and housing. The fortnightly review of the ICFs by the public health midwife and named midwife provides robust managerial oversight to ensure all risks have been identified and appropriate actions taken. Good safeguarding practice and effective communication with other agencies by the midwifery service is ensuring effective multi-agency pre-birth planning and ensures adult services are fully engaged. Notifications of birth are sent promptly to the adult substance misuse when the mother is engaged with this service and pre-birth risks to the unborn have been identified.



- 1.3 The perinatal mental health service, developed 18 months ago is good and mothers are well supported both ante and post-natally, particularly helped by its location within the antenatal clinic. Midwives have received training on the early identification of mental health issues and the referral pathway is in place. Approximately 37% of all mothers-to-be engage with the service, a rate which is reflective of local demographics. Access to the service is good and women are seen within a week of the referral. Receiving up to 12 months support from the perinatal service, mothers requiring ongoing intervention are transferred into the mainstream mental health service through individually tailored handovers. Communication between the service and other professionals generally works well although we saw one complex case where the service had referred the case to children's social care for safeguarding concerns and the service had not been invited to the strategy meeting; the service had escalated the case as a result. With the woman's agreement, letters setting out the assessed needs and level of engagement are copied to children's social care, the woman's GP, midwife and health visitor. The service reports that it is rare for women to withhold consent to share information which facilitates a wrap-around support model operated across services. The adult mental health service also shares risk indicators for maternal emotional health problems with other services. This is good practice in alerting those services to potential relapse indicators. However, it was not easy to access information about how other professionals should respond if they observe these indicators in their dealings with the woman (**Recommendation 1.1**).
- 1.4 Torbay Hospital has a single emergency department with integrated services for paediatric and adult emergency treatment. Receptionists at the emergency department are able to observe an often crowded waiting area and are good at identifying safeguarding concerns. They were able to cite an example where they had alerted the triage nurse to a concern about parental interaction with a child awaiting treatment, as a result of which a referral was made to children's social care and the child was safeguarded.
- 1.5 The MIU, operated by Torbay and South Devon Health and Care NHS Trust, and South Devon Healthcare Foundation NHS Trust's emergency department at Torbay Hospital sit side by side with a shared waiting area which can become very crowded. All children attending either service go through a single point of triage. Without exception, all young people and parents we spoke to expressed concern about waiting times at the emergency department and the impact this has on them. The Have Your Say Group is a support and consultation group for young people with mental health issues who have contact with CAMHS. The group is supported and facilitated by Young Devon, a third sector organisation. To date, young people in the Have Your Say group have not been consulted on how services for children in the hospital and the waiting area for the emergency department and the MIU might be improved. The integrated nature of the paediatric and adult emergency department presents challenges in ensuring children are safeguarded while their clinical needs are met. However, there are designated areas within the emergency department for children to be seen separated from adult patients. (**Recommendation 2.6** and **3.13**).

- 1.6 Practitioners in the acute trust emergency department and MIUs are well supported in assessing risks to children by the assessment proforma in use for adults and children which include good risk assessment trigger questions. These are not always completed however (**Recommendation 2.1**). The pathway from the emergency department into the maternity service is well defined. We were told that cases where an adult with children attends the emergency department for mental health issues, domestic violence or self-harm, are routinely referred to the paediatric liaison nurse to ensure follow-up by community services.

**Case example 1:** *A 17 year old male of no fixed abode and with drugs and alcohol abuse issues was presenting at Torbay Hospital every other day with a range of medical concerns. He also had mental health issues and had been detained in psychiatric care under the Mental Health Act 1983 at one point.*

*The hospital paediatric liaison nurse co-ordinated a multi-agency response. A shared support plan was developed which ensured he had support which was consistent and addressed all his needs.*

*As a result of this co-ordinated approach, he continues to be well supported in the community and has not required emergency department treatment since February 2014.*

- 1.7 The provision of the paediatric liaison nurse service in the acute hospital trust is good and well established. The paediatric liaison nurse is diligent in ensuring required actions and communication with other disciplines and agencies happens promptly. In one case, effective multi-agency coordination by the paediatric liaison nurse had clear beneficial outcomes for a highly vulnerable young person. We saw examples of good identification of risk and the need for support by clinicians and appropriate referrals from both adult and paediatric cases to the paediatric liaison nurse. Over recent years, clinicians' awareness of safeguarding issues and the need to take action has increased. Referrals to paediatric liaison have also increased with 184 made last month. The paediatric liaison nurse reports that the majority of these identified safeguarding issues appropriately. However, the paediatric liaison nurse only reviews those cases which are referred for her attention. Currently there is no routine review of all under 18s or adults with children attending the emergency department to ensure that all safeguarding risks have been identified and the appropriate action taken. There is a risk therefore, that some children's safeguarding issues are not being identified. (**Recommendation 2.2**)

- 1.8 An effective flagging system for children with child protection plans is in place on the patient administration system at Torbay Hospital. This is updated routinely as Torbay children's social care send daily changes to the hospital, including identifying children who have become looked-after. In addition, the ED's electronic flagging system for vulnerable children directs practitioners to a detailed hard copy information folder. The hospital paediatric liaison nurse audits the database annually to ensure flags are still active and relevant. This information folder is not available to the MIUs, operated by Torbay & Southern Devon Health and Care NHS Trust, who instead have to contact the hospital for further details on individual patients.
- 1.9 The referral pathway between the acute trust's emergency department and the child substance misuse service run by Checkpoint is effective. With the consent of the young person, practitioners in the emergency department introduce young people to Checkpoint. Since the inception of the new service contract, 14 young people have been referred by emergency department staff. This represents a significant increase on previous referral rates, demonstrating increased practitioner awareness and an improved pathway. As a result, more young people misusing substances have prompt access to the appropriate support. GPs who make referrals to Checkpoint find this is an effective and valuable resource to secure help for young people who do not meet thresholds for CAMHs services. We heard about the lack of early intervention Tier 2 provision however, which is an area for consideration in the local substance misuse strategy which is currently in draft.
- 1.10 The identification and response to safeguarding risk in the minor injury unit (MIU) at Paignton is not fully robust although we did see some good practice; good links with other services and communication with Torbay Hospital. Six of eight cases reviewed did not record the immunisation status of the child although this was understood by staff to be an expectation. Records of the date and time of the incident precipitating the child's attendance were also not routinely recorded. While staff ascertained the name of the accompanying adult, parental responsibility for the child was not always clearly established and recorded. In one case we reviewed, there had been a lack of probing questions about the circumstances of an incident which had apparently occurred at school and there was no record of liaison with the school to verify the circumstances. CAS cards were not routinely reviewed and it was not clear that there is sufficient, robust oversight of under 18 presentations to ensure all safeguarding issues are fully explored and identified (**Recommendation 3.1**).

- 1.11 The Torbay sexual medicine service (TSMS) undertakes good, effective, risk assessment, taking account of the demeanour of the young person and a range of observations of the assessor. Outreach services are flexible, giving good support to young people in schools and meeting the needs of young people well. We heard positive feedback from young people who have used the service. Indicative of the positive impact of the service is that no young people who have engaged with TSMS are in the current cohort of teenage pregnancies. Where looked-after children have engaged with TSMS outreach then this service continues to support the young person up to 24 years of age recognising the heightened vulnerability of care leavers.
- 1.12 Access to CAMHS services is highly problematic. We heard several young people's concerns about the long waiting times to access CAMHS, in some cases waiting months for CAMHS support. Young people have raised concerns with Healthwatch that they felt that the children's ward was not a suitable place to await a CAMHS assessment. This was not only for the individual concerned, due to their mental wellbeing, but they were also concerned for other young children admitted to the ward. Looked-after children with identified urgent mental health needs are fast-tracked to CAMHS support. One foster carer however, told us of a foster child recently waiting a year to access the service. These access issues are well known locally and remain a priority area for development (**Recommendation 3.8**).
- 1.13 The initial CAMHS assessment we reviewed was not child centred and not sufficiently focused on assessing the child's emotional wellbeing, rather it focused on the mother's parenting capacity in dealing with the child's behaviour (**Recommendation 3.9**). We also saw overly clinical language used in another child's care plan. Although this had been agreed with the parent, it was difficult to link the plan to the very child-led goals guiding the therapeutic intervention with the child. This reflects what young people told us about how important it is to them that practitioners do not use overly clinical language with them (**Recommendation 3.10**). When CAMHS are working with a child, parents and carers are well supported by frontline practitioners, being offered their own therapeutic sessions as well as sessions jointly with the child. There are demonstrable beneficial outcomes for children from the CAMHS therapeutic intervention.
- 1.14 In common with other authority areas, Torbay lacks local Tier 4 provision for young people requiring in-patient treatment for mental ill health. While appropriate provision is sourced by NHS England special commissioning; on occasions young people are admitted as an interim into the paediatric ward at the hospital. Clinicians respond promptly and appropriately on these occasions to minimise risk to the young people requiring in-patient treatment and other children on the ward.

- 1.15 Young people with mental health problems felt that GPs could do more to help young people engage with the support services available to them and were looking forward to working with GPs on this imminently. One young person told us, “We hope to make sure that GPs have posters about young people and mental health and how to join the Have Your Say Group. At the moment, there is nothing in my GP surgery.”
- 

## 2. Children in Need

---

- 2.1 While children and families are well supported by individual services' interventions, where children do not reach the Child in Need threshold or are stepped down from child protection, there is not always a well co-ordinated health response or a clear 'team around the child' approach involving all appropriate services. While capacity issues within school nursing services can limit the scope of the school nurse offer, we identified some cases where school nurse engagement as an active member of the team around the child should be prioritised (**Recommendation 3.7**).
- 2.2 Vulnerable young parents receive good support from the family health partnership service, which is based on the family nurse partnership model. Community health practitioners, health visitors, adult substance misuse and school nurses who are working with children and families with identified vulnerabilities or risks, are dogged in their efforts to secure positive engagement with the adult or family. The specialist substance misuse health visitors are working well with other agencies to support vulnerable children and we saw positive partnership working between FHP, health visitors and housing officers to address the housing needs of vulnerable families.
- 2.3 Adult mental health does not routinely consider and identify children present in the household as part of their initial assessment. The service's information system does not facilitate this. The record system does not contain trigger questions to include the range of children with whom the client may have contact and thus prompt practitioners to think sufficiently widely (**Recommendation 1.2**).
- 2.4 GPs are well engaged in seeking to safeguard children. Practices we visited hold regular meetings with health visitors to review children about whom there are concerns and we saw some examples of good information sharing. GPs have very little contact with, or from, school nurses and this is an area where opportunities for them to contribute to the practice's vulnerable families information sharing forums, may be lost.

- 2.5 Health visitors' recording of their observations and discussions with parents during home visits is detailed and comprehensive. Practitioners in the community health visiting service are routinely recording their immediate plan of action resulting from an engagement, which is good practice. The introduction of the family needs assessment tool (FNA) is very positive. Details of the household, including male adults is included and the health visitor or FHP works through the assessment with the adult. This means that the process of risk and needs assessment is both transparent and collaborative, encouraging the parent to engage. The FNA is valued by practitioners and has the potential to become a best practice model. However, we did not see explicit and recorded evaluations of health and safeguarding risks, including parental emotional health and its likely impact on the health and wellbeing of the child. Managers acknowledged that this is an area for development which they expect the current review of the FNA to address.
- 2.6 The current FNA proforma also misses the opportunity to address environmental safeguarding risk factors. Health visitors do observe and assess the impact of the home environment on the health and wellbeing of children routinely as part of their everyday work and case examples related to us demonstrated that these issues are often triggers for practitioners to initiate a safeguarding referral. Not including home environment on the FNA is therefore a gap. The assessment is shared and agreed with the parent, so the opportunity for the parent and other health professionals to be alerted at this early stage to environmental risk factors and their potential impact on the child's health and wellbeing is currently being lost (**Recommendation 3.2**).

**Case example 2:** *The Family Health Partnership is working with a young mother who is a care leaver with a previous history of drugs and alcohol misuse and aggressive behaviour. The partner also has a history of drugs and alcohol use. The new baby was failing to gain weight and there were concerns about parenting capability.*

*The couple have engaged well with the FHP who has been working with them on positive attachment. They have also engaged with the Weaning is Fun group at the children's centre which aims to build parenting skills in young parents.*

*Outcomes from the intervention;  
The child has continued to be breast fed and is doing well. Mum and Dad are working as a team and are both drugs free. They continue to participate in the group at the children's centre and are now volunteering to help others in similar situations.*

- 2.7 The *Weaning is Fun* group is having positive impacts on the parenting skills of young parents, facilitating their access to universal services rather than higher levels of intervention and many young couples are being referred by the FHP. The group is popular with parents and is being extended to operate a group in Paignton. In addition to a focus on the positive impact of play between parents and child, the group also covers the risks of choking on blind cords and establishments of healthy diets and is therefore contributing well to keeping children safe.
- 2.8 The effectiveness of handover of cases between health visitors and school nurses is inconsistent. This is acknowledged by community health managers and we understand that an action plan is in place to ensure that effective handover of case between these services, becomes routine **(Recommendation 3.3)**.
- 2.9 CAMHS work closely with special schools for young people with learning disability. We saw an example of early multi-agency transition planning for a young person with learning disability moving into adult services. This was initiated 12 months prior to transition which was appropriate practice, given the complexity of the young person's long-term needs.

---

### 3. Child Protection

---

- 3.1 Across health services, practitioners prioritise child safeguarding and child protection in their work. An effective escalation policy and protocol agreed with children's social care is in place and health staff across services are aware of how to invoke it. Practitioners are confident that this process generally works well to facilitate resolution of professional differences.

**Case example 3:** *A mother with two children of 5 and 2 years. The elder child has a disability and both children were subject to a child in need plan. A health visitor working with the family became concerned that mother was very difficult to engage and was non-compliant with elements of the CIN plan. The elder child was suffering harm as a result.*

*Following the health visitor's referral to the Hub, a child protection plan was put in place for the elder child. This marked a change in attitude by the mother who has since engaged well with services and complied with the requirements of the plan.*

*As a result of this stronger level of intervention, the elder child has started walking and has become continent during the day. The GP describes the level of progress as "stunning", demonstrating the positive outcomes arising from the effective instigation of child protection procedures instigated by the health visitor.*

- 3.2 While most practitioners across services were very clear on how to raise safeguarding concerns, the picture was less clear in CAMHS. Not all practitioners in CAMHS had a clear understanding of the safeguarding pathway and how to seek advice and guidance when they identify concerns. In one case, although appropriate protective measures had been taken immediately to safeguard the child, the practitioner had not followed the referral pathway or sought advice from the trust's safeguarding team. As a result of this review, the designated nurse and CAMHS service manager are working closely together to address practice issues and ensure safeguarding arrangements are well established (**Recommendation 3.11**).



- 3.3 As a result of a health co-ordinator presence in the safeguarding Hub, the speed of processing referrals from health has improved. The signposting of cases requiring support but not meeting child protection thresholds has become more effective, facilitated also by the regular presence at the hub of the named doctor for safeguarding children for both trusts, who is a consultant paediatrician. The recently introduced safeguarding hub enquiry form for referrals to the Hub (SHEF) has been adopted by health services to facilitate optimum decision making at the Hub about levels of intervention. However, we only saw one case where this had been used and we identified some confusion among frontline practitioners about how to rate risk on the threshold matrix. The extent to which the matrix is reliably used by staff across services is unclear. The graded care profile (GCP) is being used in community services but is not yet embedded and work is in train to ensure that the GCP interfaces seamlessly with the SHEF (**Recommendations 1.7, 2.3, 3.4**).

**Case example 4:** *A mental health practitioner in the Recovery Team was working with an adult male who was sharing a house with another adult who had young children. The practitioner undertook a thorough risk assessment and identified safeguarding risks posed by the client to the children living in the household.*

*The worker made a prompt referral to the Hub via e-mail setting out the potential risks of significant harm to the children very clearly. As a result, the client was removed from the house and the children consequently safeguarded. Despite a very challenging response to his actions by the client, the practitioner has been able to sustain the professional relationship with the client and continues to work with him.*

- 3.4 However, we saw a common theme across a number of services where risks to children are not being as clearly articulated as they could be when making safeguarding referrals. Operational managers are not routinely quality assuring referrals to support practice development in this key area (**Recommendation 1.3, 3.5**). Plans are in hand for the named nurse for safeguarding and children's social care services to undertake a quality audit of referrals to the Hub.

- 3.5 For children identified as being vulnerable or subject to child protection plans, where health appointments are not kept (DNA), all health services, including GPs and adult services demonstrated robust responses in line with the local shared DNA policy in the cases we reviewed. In the acute Trust the safeguarding children team are copied into DNA letters for children subject to child protection plans, and this information is forwarded to the relevant community health practitioner for follow-up. This minimises risks to the child's health and wellbeing. However the scheduled review of the effectiveness of the policy is significantly overdue, as a result of which managers across services, the CCG and the LSCB cannot be fully assured that the policy is embedded across the health economy as a whole (**Recommendation 5.1**).
- 3.6 Children at risk of absconding or going missing from Torbay Hospital are subject to appropriate measures at the hospital to prevent this happening under an established protocol. Where this is identified as being a risk, the child's clothing and appearance is noted and effective use is made of hospital security as necessary. Windows are restricted in opening and there is a single point of entry and egress from the emergency department.
- 3.7 As a result of the Child Sexual Exploitation Best Practice Forum, practitioners have a raised awareness of CSE issues. This has resulted in increased numbers of referrals to the Hub of young people for whom there are concerns potentially indicative of vulnerability to CSE. The multi-agency CSE pathway work is progressing well and key health agencies including TSMS are well engaged.
- 3.8 Attendance at and participation in child protection processes, core groups and conferences is given priority in all services across the health community although some services, most notably CAMHS and adult mental health, report not always being aware of when key child protection meetings are taking place (**Recommendation 1.4** and **3.12**). All relevant health services are not reliably included in strategy meetings (which are also sometimes taking the form of telephone discussions), even where frontline practitioners have the best intelligence about the child or family to inform effective decision making. These arrangements are not compliant with national guidance as set out in *Working Together 2013* (**Recommendation 5.2**).

- 3.9 Managers in the adult mental health service set a clear expectation that practitioners, if involved with a family, are members of the core group and attend child protection meetings. Practice is not consistent however and we saw and heard some examples where adult mental health has not attended. A *Think Family* model is not yet embedded in adult mental health services although was established in the adult substance misuse service. In most services, practitioners submit reports in advance of conference as well as attending in line with best practice. Practitioners are generally well supported to participate effectively, although public health staff nurses' contribution to child protection forums is under developed. The preceptorship scheme for newly qualified staff has not included this cohort to date although their imminent inclusion is planned (**Recommendation 3.6**).
- 3.10 Health agencies are well engaged with multi-agency risk assessment conferences (MARAC) which address families with identified issues of domestic violence. The acute trust's public health midwife, named nurse and emergency department sister routinely attend. The quality of information submitted to the conference by health visitors and school nurses is good and is likely to help the MARAC to make good decisions and safeguard children. The addition of practitioner guidance to the MARAC information proforma has contributed to this improved and consistent practice by community health services.
- 3.11 We saw good child protection practice in the adult substance misuse service, Shrublands, where a *Think Family* model is well established. Practitioners routinely identify children within a household. Effective risk assessment of children subject to child protection is well supported by strong information sharing and close working with the specialist health visitor. This is particularly important when the service is working with parents who may have different perspectives or understanding about risks and compliance with expectations. The service also adopts effective strategies to be sensitive to risks where parents of a child on a child protection plan are engaged with the service and have different needs. This has been a lesson learnt from a previous SCR. An example we saw was for the mother and father of a child at risk to receive support and appointments at separate service bases.

**Case example 5:** *A mother with a 10 month old baby. The mother was difficult to engage with services and due to substance misuse issues. The midwife and health visitor referred to the Hub and the unborn was made subject of a child protection plan. The mother engaged with the substance misuse service at 31 weeks of pregnancy. The plan specified that she remain engaged with the substance misuse service and the social worker was to be notified of any DNAs. The mother did present at the SCBU intoxicated, disengaged with services and the baby was taken into care.*

*Progress made by the mother resulted in herself and the baby being accommodated in a mother and baby foster placement.*

*As a result of the effective multi-agency working in this case, mother and baby now live in an independent flat. Mum has completed a baby massage course and has a strong attachment with her baby. Although still on a child protection plan, the baby is thriving and Mum is parenting effectively.*

---

## 4. Looked after Children

---

- 4.1 When children become looked after, overall they experience significant and unacceptable delay in having their health needs assessed. This includes children who become looked after by virtue of prolonged in-patient hospital treatment. Two such cases we reviewed were not identified as looked-after children on the looked-after child health information system. Performance on the timeliness of initial health assessments is very poor, and is a priority area for improvement. Late notifications from children's social care contribute to this low level of performance however, there is more to do across all of the agencies within the partnership for looked after children's services. This area for development has been identified for some time by both health and social care managers with some joint exploration of the issues and provision of additional training, but remains unresolved. This review identified a particular problem in ensuring formal arrangements are in place to meet the statutory expectations for the healthcare of children and young people who are looked after by virtue of an extended hospital stay. As a result, the designated nurse and a children's social care representative are meeting to establish a pathway which will ensure statutory health assessments and plans are reliably undertaken within expected timescales. Systems to support both acute and the community trust's administrators to access the same information systems and align their approaches to performance monitoring and data collection are due for imminent implementation. This should provide a solid foundation from which to drive improved performance on the timeliness of health assessments for the whole cohort of looked-after children (**Recommendation 4.1**).

- 4.2 The quality of initial health assessments (IHAs) undertaken by the designated doctor is good, however the quality of IHAs which had been undertaken by clinicians other than the designated doctor, was very poor. The young people's ethnicity is not routinely recorded on health documentation that we reviewed. This is important as cultural needs may inform how health support can best be delivered to the young person (**Recommendation 4.3**). Whilst an audit of content of IHAs has been undertaken and was due to be reported on, our sampling evidenced that the regular assurance arrangements currently in place have not been fully effective in ensuring that all young people benefit from IHAs of sufficient quality. Good use is made of the CRAFFT drugs' use screening tool, developed in Boston, and introduced in partnership between Checkpoint and the looked-after children's health team. Health plans resulting from IHAs, including those of children placed out of area, are task focused rather than SMART. Timescales are vague for actions to be taken and the current approach makes it difficult to ensure that the risk of drift is minimised. (**Recommendation 4.6**).
- 4.3 Most children who are looked after by Torbay can expect to have their health needs reviewed within expected timescales. Performance in this area is well monitored and co-ordinated by the community trust administrator who is a significant asset to the service. At the time of the review, only three health reviews were overdue. Health reviews undertaken by health visitors and school nurses are generally good quality; linking with the previous health review and the positive impact of the recent training programme to these practitioners, is clearly demonstrated. The approach is child centred; prioritising the voice of the child and in most review health assessments (RHAs) we evaluated, there was a good sense of the individuality of the child. School nurses are not routinely aware of other specialist health professionals such as SALT and CAMHS involvement with a child on their caseload. For looked-after children receiving specialist interventions, there is therefore a risk that the health review will not be fully informed. We also did not see evidence of the health reviewer liaising routinely with the child's school although we saw case examples where it seemed this would have been beneficial (**Recommendation 4.4**).
- 4.4 The provision and use of strengths and difficulties questionnaires is underdeveloped. This is recognised by the service and the designated nurse has worked on the introduction of a new joint approach with children's social care. From July, the application and review of SDQs will fall under the remit of the new CAMHS practitioner for looked-after children. They will be completed by the foster carer, the young person and the school in order to give a more comprehensive and inclusive picture, potentially much more useful and participative for the young person.

- 4.5 Health plans generated from the RHAs are less well developed than the health reviews and are also not sufficiently SMART (**Recommendation 4.6**). In the RHAs reviewed, there was an absence of parental health history. This is essential information. It can be gathered only at the point the child becomes looked after and partner agencies need to ensure it is transferred to the looked-after child health team to inform IHAs and all subsequent health reviews. Equally, the looked-after child health team have a responsibility to ensure that they receive the information and that it follows the child. Care leavers across the country tell us that the failure of agencies to ensure this information stays with them on their journey through health and social care can have a significant and detrimental impact on them as young adults. This issue has not been included in the local quality assurance framework being developed (**Recommendation 4.2**).
- 4.6 None of the looked-after children we met had been offered a choice of venue or time for their health review and they did not know they had any option to choose. All had their review health assessments take place in school. Feedback from foster carers about the support from health visitors to themselves and children was positive. However, the understanding among foster carers of the potential to have the child's health review in places other than school or clinic was also limited. While some foster carers told us that health reviews had been done at home if the child chose or this better met their needs and wishes, some did not know that the young person could exercise some choice (**Recommendation 4.5**). Foster carers are also well supported by CAMHS when their foster child is engaged with the service. We saw evidence of tailored work with one foster carer in individual sessions as well as joint sessions with the child.
- 4.7 Young people told us how important having a consistent health reviewer is to them, and how difficult and unhelpful they find the review when they have to engage with a new professional each time (**Recommendation 4.7**).
- 4.8 The previous looked-after children's lead nurse encouraged the young people to write songs about being in care, one of which has been put forward for a national award and the young people are very proud of this achievement.

- 4.9 Not all GPs have a good level of understanding about the looked-after child system and framework, including the processes and aims involving health; the roles of the designated looked-after children's nurse in the CCG and the providers' looked-after children's health team. Whilst the potential value of GPs' contributions to looked-after child health assessments and reviews is recognised by GPs, they do not currently contribute to these, this creates risk that these important processes may not be fully informed and comprehensive and not all the health needs of the child be fully identified and met (**Recommendation 4.4**).

**Case example 6:** *A male looked-after young person who is an older teen. The young person has a significant medical condition which needs addressing but he is reluctant to engage with health support services, despite the efforts of the looked-after children's nurse.*

*The GP and paediatrician were informed by the Designated Doctor about the young person not engaging for his health assessment. His health needs were clearly outlined for the GP so these could be prioritised if/when he presented at the surgery. However, to date, the potential for the GP to undertake the review health assessment and help the young person understand the potential impact of not managing his condition on his future has not been fully explored.*

- 4.10 All health assessments for children in out of area placements have been audited by the new looked-after children's designated nurse, with no quality issues being identified.
- 4.11 Care leavers do not have adequate health support as they leave the care system and enter young adulthood. There is no care leavers' age appropriate health information pack, and care leavers don't usually receive their health history. This priority area for development is acknowledged by the CCG and the providers (**Recommendation 4.8**). The In Care Council has recently completed a Pledge document which includes the commitment for easy access to the full range of health opportunities and providing a personal health plan. The regular presence of the designated nurse at CIC council meetings, instigated the week of this review, will provide children in care and care leavers a good opportunity to hold health to account in delivering against the Pledge commitment (**Recommendation 5.3**).



---

# 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 The establishment of a discrete CCG focused on South Devon & Torbay is viewed across the partner agencies and providers as a positive development for Torbay. Partners identify that this localised commissioning focus is facilitating improved safeguarding practice and has been instrumental in forging closer, co-operative relationships between providers. An example where this has worked well, being a recent local concern about a potential suicide pact among a cohort of young people. Partners worked promptly and cohesively to address the concern; a strategy meeting was quickly convened and all young people about whom there was concern were seen with their parents and the risk alleviated. There is strong relationship between the local authority, health services and education and regular dialogue with new Devon CCG which covers the rest of the county. CAMHS low level (Tier 2) services are commissioned by the CCG and young people often access these services within their schools.
- 5.1.2 Partnership working at a strategic level between agencies is good. The CCGs, local authority and providers are working co-operatively and the CCG and NHS England's area team relationship is developing well. Both the CCG and children's social care identify the designated nurse's presence in children's social care one day a week, initiated recently, as a highly beneficial development raising mutual understanding of roles and responsibilities. The partners are also exploring development of some joint commissioning posts. The children's re-design board, chaired by children's social care but hosted by the CCG is the key multi-agency forum driving children's service development across the partnership of commissioning and providing agencies. Children's social care cites their new ability to engage directly with GPs as a key outcome from the positive partnership with the CCG.

- 5.1.3 Health is well represented on the LSCB and sub-groups contributing well to the stronger strategic oversight and outcome focused performance approach being brought to the LSCB by the recently appointed independent chair. Safeguarding development includes the newly established joint Devon and Torbay LSCB health advisory group chaired by the Executive Leads for safeguarding children in both CCGs. The group will explore shared safeguarding issues for a population who may access services from across the CCGs and council areas.
- 5.1.4 The multi-agency safeguarding Hub, under the management of the local authority with a social care manager as decision maker, operates well as the single safeguarding and support referral pathway. The provision of an administrative health referral co-ordinator, regular input from the named doctor who is a paediatric consultant and development of a specialist health visitor post contributes positively to the continuing development of the Hub model. The rate of processing health referrals has improved and there is more effective step-down of cases not requiring safeguarding intervention to lower levels of early help and CIN support.
- 5.1.5 The CCG has set a clear agenda and is making progress towards establishing an effective commissioning and governance infrastructure and reporting framework. Child safeguarding and child protection has appropriate high priority and profile within commissioning arrangements. Contracts and service level agreements include these elements and set clear expectations for providers. The designated nurse for safeguarding children provides oversight and support on the contract monitoring process in relation to safeguarding issues.
- 5.1.6 CCG investment in a discrete designated looked-after child nurse role to provide support, guidance and strategic oversight to the providers delivering the looked-after children's health service, is commendable; demonstrating a high level of commitment to this cohort of children and to providers. The designated nurse is a member of the corporate parenting board and sits on the fostering and permanence panels. This ensures effective strategic and operational health representation at these key partnership forums.

- 5.1.7 There is further work for the CCG and providers to do to ensure the provision of health for looked-after children is fully and effectively co-ordinated and quality assured. The work plan as set out in the 2012/13 annual report for safeguarding and looked-after children does not set SMART objectives. It is unclear that sufficient attention is being given to local looked-after children performance in the report, making it difficult for the partners to measure and assure themselves of continuous improvement (**Recommendation 5.4**). Partners are taking steps to bring the three strands of the looked-after children infrastructure together; children's social care, the acute provider and the community health provider; rationalising the information systems. Provision of IT infrastructure is expected to be in place imminently. This will facilitate the provision of shared and consistent health information leading to a more robust joint monitoring and information management approach.
- 5.1.8 Significant lack of capacity in the existing arrangements to deliver the operational aspects of looked-after child lead nurse made this a priority area for development to ensure effective operational management. The lack of this role put additional capacity pressures on the designated nurse for looked after children at a time of building her designated role with providers and developing an improvement plan (**Recommendation 4.9**). A business plan for joint funding to address the capacity issues within the service has now been agreed between the CCG, SDHCFT & TSDHCT. This will enable the appointment of a full time lead nurse for looked after children, representing a very positive development for the service.
- 5.1.9 The integration of the acute and community health trusts planned for April 2015 presents an ideal opportunity to identify good safeguarding practice in each agency and roll it out across the new trust. The safeguarding teams from the two organisations are in regular discussion to explore issues and develop this agenda.
- 5.1.10 Torbay has experienced a high number of Serious Case Reviews and all partner agencies give high priority and are working co-operatively to ensure that lessons are learnt; interagency and inter-professional communication is effective and practice improvement becomes embedded. All actions from previous SCRs published have been addressed. There is evidence of learning and service improvement as a result of SCRs, however strategic oversight and monitoring of complex cases and day-to-day operational monitoring in provider services, is not yet fully robust. The CCG is aware of this and is working to strengthen governance arrangements with providers.

- 5.1.11 Best practice forums are well regarded across the health and social community as effective multi-agency forums in which frontline staff explore issues from SCRs and learn lessons. Most recently, these have explored the involvement of fathers in maternity services and services for looked-after children.
- 5.1.12 The designated nurse for safeguarding is providing effective leadership on developing safeguarding practice across the health community, working closely with her counterpart in new Devon CCG. She is available when providers seek advice and provides named nurses and the named midwife with regular individual supervision. GPs are also well engaged with the designated nurse, actively seeking her out for advice and guidance. The absence of a named GP or other support to primary care creates additional capacity issues for the safeguarding children team within the CCG, particularly when specific complex cases arise that require work around chronologies and information gathering for multi-agency meetings. Designated doctors in safeguarding and looked-after children are in place and show leadership in modelling good practice. Named midwife, named nurses and named doctors are well known in their services and are effective in their roles.
- 5.1.13 GPs are well represented in the CCG with a GP as the clinical lead for patient safety. GPs report good support from the named nurse and doctor and the safeguarding hub when they have concerns about a child they see. The development of an Early Help model for primary care through the GP and Head Teachers' network is a positive development. The weekly GP newsletter is well read as evidenced through GP feedback on issues raised in it. We were told that GPs also value the *Yellow Sub-marine*, which provides an update on quality matters for primary care.
- 5.1.14 GP appraisals are being used effectively as part of the developing governance arrangements for GPs and include review of the GP's participation in safeguarding children's training. GP safeguarding training at the appropriate level of competency, in line with statutory and intercollegiate guidance is an acknowledged area for development (**Recommendation 5.5**). The current lack of a named GP creates a leadership and support gap for GPs. This important role in facilitating and supporting the achievement of effective GP engagement with safeguarding arrangements is currently being recruited. To date, the potential impact of establishing a named GP role has not been fully explored although there is now good opportunity for the NHS England area team (AT) and CCG to do this. The provision of a team of nurses and GPs to support primary care, funded by the AT and embedded in the CCG should, however, further strengthen GP safeguarding practice.

- 5.1.15 Local Healthwatch is well engaged with the CCG, contributing to the governing body integrated quality & performance report. Healthwatch is working with young people, capturing their experiences of health services and using this to inform the commissioners' health service development and governance agenda. Connection with young people in the *Have Your Say* mental health support and participation group has been made although this is at an early stage. The *Have Your Say* group are confident that the CAMHS service has listened to their concerns and experiences and feel they are making a difference to how the service is delivered.
- 5.1.16 Adult mental health are making progress towards ensuring the service operates a *Think Family* model, although this is not embedded and effective information sharing remains a challenge. Progress on establishing the model is facilitated through the recent recruitment of a safeguarding lead from a social care background, regular audits of practice, training and supervision. We saw some good and prompt child safeguarding practice in one case resulting in children being very quickly and effectively protected from possible harm. This level of risk assessment was not evident in all adult mental health cases reviewed and this is consistent with the service manager and named nurses' assessment of the service's overall performance (**Recommendation 1.2**).
- 

## 5.2 Governance

---

- 5.2.1 The South Devon Healthcare Foundation NHS Trust's safeguarding team undertake regular audits of safeguarding practice and managers are confident that practice has improved as a result of these. Clinicians at the Trust at Torbay Hospital do not routinely identify their role and sign patient records. It is difficult therefore for managers and safeguarding leads to feedback to practitioners if sub-optimal practice is identified (**Recommendation 2.4**).

- 5.2.2 While we did not see any case examples where safeguarding issues had been missed at the point of the child's attendance at the hospital emergency department, there is no operational review of all under 18s coming through the department to ensure that all safeguarding issues have been considered. Currently, safeguarding leads and managers at the SDHFT cannot be fully assured that all safeguarding concerns are being identified. This is also a particular issue for the MIUs provided by TSDHCT where recording on patient notes had key omissions and did not reflect best safeguarding practice. Safeguarding arrangements for the MIUs lack a system for robust operational review of all MIU under 18 attendances to ensure that all concerns and vulnerabilities have been identified and acted upon. A paediatric liaison role is employed by the hospital trust but not the by Care Trust for the MIUs (**Recommendation 3.1**). Where the paediatric liaison nurse has received referrals on adults with children and children from clinical staff, the liaison nurse keeps a clear and robust tracking system to ensure necessary actions and follow-up takes place.
- 5.2.3 We identified a small number of cases where we were not assured that the information held by the services involved had been fully shared and jointly evaluated to ensure all safeguarding and health needs of the child and family are addressed and we referred those cases back to managers in health and social care for further review. As a result of these multi-agency reviews, we were given assurances that appropriate actions had been taken and lessons learnt from these were being taken forward across the health community with the oversight of the designated nurse. We have reflected these actions in this report.
- 5.2.4 Flagging of known vulnerabilities to children and families across GP practices' patient information systems is not robust and does not follow a consistent system. Whilst the information systems in GP surgeries we visited do flag children on child protection plans, there is inconsistency in the use of flags for other cohorts of vulnerable children and members of their families. Information about a child's status is not up to date in some practices. We saw several examples where looked after children were not known to be looked after and were not flagged. We referred some cases back to managers in health and social care to ensure that the position is clarified and relevant professionals and services are aware of the current status of vulnerable children (**Recommendation 5.6**).

- 5.2.5 A number of practitioners told us that there is a risk that if any health professional does not attend a child protection meeting, they may not be included in minutes or future meetings. Managerial oversight and governance of this issue is not fully robust to ensure that all key practitioners are fully engaged with formal child protection processes. While we have seen examples of individual health practitioners across services making determined efforts to ensure they remain well engaged, it is not clear that this is routine for all health practitioners or managed effectively in all health services (**Recommendation 1.4** and **3.12**).
- 5.2.6 Shrublands, the adult substance misuse service, routinely tests its clients for substance misuse and parents providing clean tests is a key protective element within child protection plans. We reviewed two cases where it had recently been identified that duplicate drugs testing by another provider had taken place. In one of these cases, results from the two providers were reported to a child protection conference and showed the parent to be drugs free in one test but not in the other. As information about parental drugs use is a key factor under consideration at a child protection conference informing decisions about whether or not a child is at risk of harm, this is an important issue to be resolved. Children's social care commissioners are working with social workers, Shrublands and the other provider to resolve the issue and clarify arrangements quickly.

---

## 5.3 Training and Supervision

---

- 5.3.1 Multi-agency level 3 training is becoming increasing practice based, using case studies and scenarios. Practitioners who have attended told us that they find this more relevant to their day-to-day practice.
- 5.3.2 Robust supervision arrangements are not in place in all agencies and services in the health community although there is good practice in some services. The LSCB has a working group developing standards for supervision to be shared across the partnership. Safeguarding supervision arrangements are well established in community health services and when case discussions take place in supervision; these are recorded in the child's record. While the perinatal service records all discussions held in supervision on the mother's case record, this is not routine practice in the adult mental health recovery team. (**Recommendation 1.5**)

5.3.3 Adult mental health, maternity and other acute trust services do not have supervision arrangements compliant with statutory guidance in *Working Together 2013* and CQC's expectations of good practice. Formal supervision is essential to ensure staff are fully equipped to discharge their safeguarding responsibilities for children. Though practitioners currently make good use of opportunities for ad hoc advice and guidance from safeguarding leads. The acute trust recognises the gap and is taking positive steps towards establishing formal arrangements. Thirty clinicians including staff from maternity, paediatrics, sexual health and speech and language therapist supervisors have received safeguarding supervision training. This should release capacity for the trust's safeguarding leads to provide leadership and oversight and a more focused quality assurance role rather than providing direct supervision. An element of group supervision inclusive of non-clinical staff has also been built into team meetings and there are plans to provide role play scenarios on the trust intranet to facilitate group learning (**Recommendations 1.6, 2.5**).



---

## Recommendations

---

### **1 South Devon and Torbay CCG and Devon Partnership NHS Trust should;**

- 1.1 Ensure that relapse indicator documentation includes clear guidance to other services in how to respond should they observe the signs and symptoms indicating possible mental health relapse.
- 1.2 Ensure that the adult mental health service routinely considers and identifies children present in the household as part of their initial assessment and that the information system supports practitioners effectively in discharging their responsibilities to safeguard children as part of a robust Think Family model of service.
- 1.3 Ensure that written referrals to the Hub articulate the risks of significant harm to the child clearly, to best inform decision making about the level of intervention most likely to result in a beneficial outcome for the child. Ensure that these referrals are subject to regular quality assurance to drive continuous improvement.
- 1.4 Work with children's social care to establish a robust system which ensures that invitations to child in need and child protection meetings and conferences are transmitted effectively and that attendance by mental health practitioners is established as routine practice.
- 1.5 Ensure that where cases are discussed in supervision or team meetings, this is recorded with any decisions made, on the patient record.
- 1.6 Ensure that arrangements for safeguarding supervision are robust and in line with *Working Together 2013*.
- 1.7 Ensure that practitioners in adult mental health are equipped to use the Thresholds Matrix and Safeguarding Hub Evaluation Form (SHEF) effectively.

### **2 South Devon and Torbay CCG and South Devon Healthcare NHS Foundation Trust should;**

- 2.1 Ensure that emergency department clinicians are routinely completing risk assessment documentation to support effective safeguarding practice.
- 2.2 Ensure that all emergency department attendances of under 18s or adults with children are reviewed by a suitably skilled practitioner to confirm that all safeguarding risks have been identified and referred appropriately.

- 2.3 Ensure that practitioners are well equipped to use the Thresholds Matrix and Safeguarding Hub Evaluation Form (SHEF) effectively.
- 2.4 Ensure that all clinicians sign and identify their role on patient records in order to facilitate effective practice governance.
- 2.5 Ensure that arrangements for safeguarding supervision are robust and in line with *Working Together 2013*.
- 2.6 Ensure that young people in Healthwatch and the Have Your Say group are consulted on how care pathways for children can be improved in the hospital and the waiting area of the emergency department.

**3 South Devon and Torbay CCG and Torbay & Southern Devon Health and Care Trust should;**

- 3.1 Ensure that the identification and response to children's safeguarding risks at the Minor Injury Units is robust and well supported through regular review of under 18 attendances, routine managerial oversight and quality assurance.
- 3.2 Ensure that the Family Needs Assessment includes risk assessment of the home environment and how this may impact on the health and wellbeing of the child and fully demonstrates practitioners' analysis and evaluation of safeguarding risk.
- 3.3 Ensure that handover of cases from health visiting to the school nursing service is effective and consistent.
- 3.4 Ensure that the Graded Care Profile interfaces effectively with the Safeguarding Hub Evaluation Form (SHEF) and that all practitioners are equipped to use the thresholds matrix effectively.
- 3.5 Ensure that written referrals to the Hub articulate the risks of significant harm to the child clearly to best inform decision making about the level of intervention most likely to result in a beneficial outcome for the child. Ensure that these referrals are subject to regular quality assurance to drive continuous improvement.
- 3.6 Ensure that public health nurses are well supported to participate in child protection forums as required.
- 3.7 Ensure that where, children do not reach the Child in Need threshold, a clear Team Around the Child is put in place and that all relevant services are involved in order children are well supported.
- 3.8 Ensure that young people have prompt access to child and adolescent mental health services. .

- 3.9 Ensure that child and adolescent mental health assessments are child centred and that the child's emotional health needs are fully assessed and documented.
- 3.10 Ensure that care plans used in CAMHS link clearly to the goals set by the child as well as the clinician and parent and that terminology is accessible to all parties.
- 3.11 Ensure that all trust practitioners are aware of safeguarding referral pathways and when and how to seek safeguarding advice should they identify any child safeguarding concerns.
- 3.12 Work with children's social care to establish a robust system which ensures that invitations to child in need and child protection meetings and conferences are transmitted effectively and that attendance by CAMHS practitioners is established as routine practice.
- 3.13 Ensure that young people in Healthwatch and the Have Your Say group are consulted on how children's and young people experience of the waiting area for the MIU at Torbay Hospital could be improved.

**4 South Devon and Torbay CCG, Torbay and South Devon Health and Care NHS Trust and South Devon Healthcare NHS Foundation Trust, working in partnership with Torbay Council, should;**

- 4.1 Ensure that all children who are looked after receive an initial health assessment in line with national timescales and subject to robust quality assurance.
- 4.2 Ensure that parental health history information informs initial and review health assessments.
- 4.3 Ensure that the diversity and cultural needs of all looked-after children are identified and addressed effectively.
- 4.4 Ensure that schools, GPs and specialist health services are facilitated in making contributions to a child's health assessment or health review as appropriate to ensure the assessment is comprehensive.
- 4.5 Ensure that young people and foster carers are able to exercise choice about the venues for health reviews whenever possible.
- 4.6 Ensure that health plans developed from initial and review health assessments are SMART, setting out clear timescales for the delivery of actions and clear accountabilities.
- 4.7 Ensure that wherever possible, young people will have their health reviewed by a health practitioner who knows them and with whom they feel comfortable.

- 4.8 Ensure that care leavers enter adulthood with health histories and health passports with age appropriate information using a consistent format which should be developed/ co-produced with young people.
- 4.9 Ensure that the looked-after children's lead nurse role has sufficient capacity to ensure effective operational oversight and management and delivery of service improvement.
- 5 South Devon and Torbay CCG, working with Torbay Council and other partners, should;**
- 5.1 Ensure that the multi-agency non-attendance at health appointments policy is reviewed and that it encompasses all appropriate services.
- 5.2 Ensure that systems and processes are in place that facilitate health practitioners' routine participation in strategy meetings when they are working regularly with the child or family and are likely to hold information key to facilitate effective decision making.
- 5.3 Ensure that young people who are looked after have the opportunity to meet health commissioners regularly to give feedback to the CCG on the delivery of health for looked-after children and the health commitments as set out in the Pledge.
- 5.4 Ensure that the work plan for the improvement of health support for looked-after children is fully SMART, setting measurable objectives against which commissioners can be confident that providers can demonstrate continuous improvement.
- 5.5 Work in partnership with the NHS England Area Team to ensure that GPs undertake children's safeguarding training in line with statutory guidance.
- 5.6 Ensure that appropriate systems are in place to support GP practices in maintaining up-to-date information on the status of vulnerable children.

---

## Next Steps

---

An action plan addressing the recommendations above is required from South Devon and Torbay CCG within **20 working days** of receipt of the final version of this report.

Please submit your action plan to CQC through [childrens-services-inspection@cqc.org.uk](mailto: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.