

# **Review of health services for Children Looked After and Safeguarding in Norfolk**

# Children Looked After and Safeguarding

## The role of health services in Norfolk

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<b>Provider services included:</b>	Norfolk and Norwich University Hospitals Foundation Trust James Paget University Hospitals Trust Norfolk and Suffolk NHS Foundation Trust East Coast Community Healthcare (CIC) Norfolk Community Health and Care NHS Trust
<b>CCGs included:</b>	NHS Norwich CCG NHS North Norfolk NHS Great Yarmouth and Waveney CCG
<b>NHS England area:</b>	Midlands and East Region
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## Summary of the review

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

Where the findings relate to children and families in local authority areas other than Norfolk 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.

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## About the review

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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.

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## How we carried out the review

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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 86 children and young people.

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## Context of the review

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In March 2013 the child and maternal health observatory (ChiMat) working with East of England public health observatory (ERPHO) observed that children and young people under the age of 20 years make up 21.5% of the population of Norfolk. 9.9% of school children are from an ethnic minority group.

The health and wellbeing of children in Norfolk is mixed compared with the England average. Infant and child mortality rates are similar to the England average.

The level of child poverty is better than the England average with 18.1% of children aged under 16 years living in poverty. The rate of family homelessness is better than the England average.

In 2011/12, there were 13,773 A&E attendances by children aged 4 years and under, which gives a significantly better rate than the England average. In 2012/13, the hospital admission rate for injury in children was comparable to the England average and the admission rate for injury in young people was significantly better than the England average.

In 2013, the department for education (DfE) reported that Norfolk had 755 looked after children that had been continuously looked after for at least 12 months as at 31st March (excluding those children in respite care). The DfE reported that 575 (76.2%) of the children had their immunisations up to date. Four hundred and sixty-five received their annual health assessment (61.6%) and 590 had their teeth checked by a dentist (78.1%). As at 31 March 2013, there were 110 children aged five or younger who had been looked after for at least 12 months, with each of the children having up to date development assessments (100.0%).

Commissioning and planning of most health services for children are carried out by Great Yarmouth & Waveney CCG, Norwich CCG and North Norfolk CCG

Acute hospital services reviewed as part of this report are provided by Norfolk and Norwich University Hospitals NHS Foundation Trust and James Paget University Hospitals NHS Foundation Trust.

Community based services are provided by Norfolk Community Health and Care NHS Trust and East Coast Community Health Care CIC.

Child and Adolescent Mental Health Services (CAMHS) at tier three are provided by Norfolk and Suffolk NHS Foundation Trust.

The last inspection of health services for Norfolk's children took place in June 2011 as a joint inspection, with Ofsted, of safeguarding and looked after children's services. Recommendations from that inspection are covered in this review.

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## The report

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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.

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## What people told us

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We heard from one young person looked after who told us:

*“My nurse is really nice and helpful, I always see the same person. I like that.”*

A carer of a young person told us:

*“My health visitor has been excellent, easy to get hold of and a good support, very reliable.”*

We spoke with other foster carers about their experiences. One of them told us:

*“Every time I take a child to Adelaide Street for their initial assessment it’s a different Doctor. Only once out of the four times I’ve been there have I been given a copy of the paperwork. Sometimes it feels like we’re not part of the process, I like to be treated as a parent would, not just have to answer their questions then go. The most recent one doctor was the best, it didn’t just feel like a process that they had to go through on a form, it felt real and inclusive. She actually wanted to listen to us and gave feedback, then she chased loads of stuff up and got us information that no one would tell us. I was taken aback when she gave us her number and said we could contact her, I didn’t realise we could do that with the LAC team, I thought we’d just have to go to GP. We don’t have a key point of contact usually.”*

Another told us:

*“I’d like to get a booklet that tells us what services are available, and who we can ring as nobody tells us. I think it’s different if you have children on long term placements but mine don’t usually get to one year review stage so I don’t know what’s out there and who to ring up in health.”*

We heard about the experiences of another foster carer who told us:

*“Health has been great, especially as children’s social care has changed our social worker five times in three months. The initial health assessment was brilliant and they were very accommodating, we have three very young children and they did the assessments for them together and had someone come out to help me with buggies etc from the car. We got copies of all the plans.”*

One foster carer told us about their looked after child nurse and their GP:

*"The Lac nurse has been really helpful, she arranges to see all three of my children on the same day and makes things easy for us. She goes the extra mile and backs up what I'm saying; particularly to the teenager we have so it's not just like me nagging them."*

They went on to tell us:

*"My GP is really good, there's some issues as the children have relatives in the area that the GP is in, so they let us come in through the back door at the surgery."*

Another said:

*"It's good to have a key point of contact in health, the LAC team always get back to me and don't leave me hanging on for answers."*

One carer told us of their experiences with CAMHS:

*"It's been really difficult to speak to the CAMHS team. The paediatrician referred us for a carer consultation six weeks ago and we've been playing phone tag ever since. The person doesn't work full time in that team and never rings my mobile so I get messages at home then when I reply she isn't in, it's very frustrating."*

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## The child's journey

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

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### 1. Early help

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1.1 Across both Norfolk and Norwich University Hospital (NNUH) and James Paget University Hospital (JPUH) emergency departments (ED) we saw that the environment provided to children and young people was appropriate and conducive to keeping them safe, with skilled staff in place to provide appropriate care and support throughout their time on the units.

1.2 NNUH has a small paediatric ED open from 09:00hrs to midnight seven nights per week. We were made aware the closing time is due to extend imminently and we were made further aware of plans for a new build department with minor works scheduled to create extra capacity in the interim period. At JPUH facilities for children aged 10 years and under are well developed, with a dedicated ED area co-located in the ED, staffed by a paediatric nurse on duty 24 hours.

1.3 Analysis of peak pressure times for children's attendances at JPUH (3-10pm) has led to the introduction of a nursery nurse to work with ED nurses to ensure children are triaged quickly and to allow a point of contact for parents and observations to be carried out in the waiting area at the busiest times. This is good practice which was soon to be repeated at NNUH.

1.4 At NNUH, all children and young people attending the ED have their demographic details taken by reception staff. Electronic IT 'flags' are in place on patient records to inform staff members if a child protection plan is in place. We also saw clear signs in the ED advising parents that information on attendances will be shared with health visitors and school nurses. Children looked after however, are not currently flagged on the NNUH's ED system. This means that practitioners treating a child or young person may not be aware of the child's status and the need to share information and about who has capacity to consent to emergency care. We were made aware that discussions are ongoing to resolve this issue in the near future.

1.5 NNUH use ED notes that are specific to age groups (children and adults) and they have space for practitioners to record who is accompanying the child and additional parental details. For example; if parents are separated and, where this information is available, the name of their social worker. This is important detail and facilitates the practitioner in completing a holistic assessment of the child's clinical presentation. However, in records seen some practitioners were not routinely completing this information despite being prompted to do so. (**Recommendation 2.1**)

1.6 At NNUH it is of concern that some young people who attend the ED following self-harm or overdose are not always being assessed as vulnerable. An ED safeguarding children checklist prompts clinicians when to refer to either the safeguarding children team or the paediatric liaison nurse. However, in some records seen, opportunities were being missed to intervene early. Paediatric liaison has recently reduced to respond only to those cases referred to the liaison nurse. The ED safeguarding lead is mid-way through a pilot where a second look at all attendances by children and young people is taking place and this is also identifying missed opportunities for early intervention. (**Recommendation 2.9**)

1.7 At the time of inspection we were advised that all young people under 16 who attend JPUH with self-harm are admitted to the paediatric ward in line with NICE guidance. Support to young people who attend the NNUH ED following an incident of self-harm or overdose is variable, however. Young people can be admitted into hospital if they need further medical treatment or review or they can be discharged home with an appointment to see a CAMHS practitioner the next working day. This means that some young people will be discharged from the ED and will need to wait up to four days for the appointment. We saw no evidence of a risk based assessment in the notes of young people who attended both EDs to explain the decision making rationale around these vulnerable young people. We heard how often it was difficult to obtain a timely response from the child and adolescent mental health service (CAMHS) crises team who work county wide. (**Recommendation 3.1**)

*One case examined demonstrated how paramedics attending the home of a mother and child who required further assessment at the ED at James Paget Hospital recognised at an early stage that the mother might be in need of support and assistance at home. Documentation examined demonstrated their concerns which included the poor conditions seen at home and how the mother seemed to be coping poorly with her other children's needs.*

*On arrival at the ED the paramedics concerns were noted and the child's electronic notes 'flagged' so that staff within the department were aware to continually assess parent/child interactions and record any concerns. Further liaison was also undertaken with the family's health visitor to ensure appropriate follow up and support on discharge from the department.*

1.8 At NNUH, when a decision has been made to admit a young person to either the paediatric ward or assessment unit, and their mental health remains in crisis, it is often left to the existing staff to support these vulnerable young people. In one case we saw how security staff were used to support nursing staff in restraining a young person in crisis. This is not good practice. (**Recommendation 2.6**)

1.9 At both NNUH and JPUH we saw some good detail being included in discharge letters sent to GPs, although this was variable. Detail seen included action taken in response to any safeguarding or child protection concerns.

1.10 At NNUH there are insufficient numbers of paediatric trained nurses to ensure a registered sick children's nurse is rostered in ED at all times. However, adult trained nurses do rotate into paediatric ED and we were advised that they have all attended additional training on the assessment of the sick child and paediatric life support.

1.11 At NNUH babies under one year who are brought to the ED are reviewed either via discussion or physically seen if under 3 months old by a senior clinician prior to discharge. This is good practice and is recommended by the national institute for health and care excellence (NICE). At JPUH children under one year are reviewed by the band seven qualified nurses on duty at the time.

1.12 There is no paediatric liaison in ED at JPUH. The safeguarding named nurse reviews of all under 18 presentations seen in paediatric ED and is an effective backstop to ensure any safeguarding issues are picked up and managed or reported accordingly. However, in all cases seen, ED staff members were taking ownership of both early help support and safeguarding issues, with comprehensive follow up and liaison. Staff are clear on how to articulate and action their concerns around safeguarding to the appropriate people when required to do so.

1.13 The minor injuries (MIU) unit at Cromer hospital is a nurse led service that is open between 08.00hrs and 20.00hrs seven days a week. The emergency nurse practitioners work closely with NNUH ED practitioners. Band six qualified nurses from NNUH ED work at the MIU as part of a rotation which helps to facilitate a joint approach and sharing of information between the two sites. The MIU has no paediatric trained emergency nurse practitioner on site and is currently unable to roster staff with additional paediatric training on all shifts, although all staff have completed advanced paediatric life support. Therefore, children and young people will not always be seen by a suitably qualified or trained paediatric nurse at Cromer MIU.

1.14 At Cromer MIU, in all cases reviewed we saw appropriate documentation in relation to the exploration of risk to children and young people. However, the emergency nurse practitioners were not always completing the safeguarding assessments as provided for older children or using the safeguarding checklist as provided. There is risk therefore, that children and young people are not appropriately assessed in relation to risk. (**Recommendation 2.2**)

1.15 Paediatric liaison is carried out at Cromer MIU by the local health visiting team and was described by the emergency nurse practitioners as robust. All attendances are reviewed by health visitors and we were advised that there is appropriate staff cover for sickness and holidays.

1.16 Cromer MIU provides emergency contraception to young people if requested. Proforma documentation used does include a basic assessment for those young people under 16 years of age seeking emergency contraception, but we saw that this does not sufficiently explore issues around potential child sexual exploitation (CSE) and is not as detailed as those assessment forms used by contraception and sexual health services. (**Recommendation 2.3**)

1.17 Children and young people in some areas of Norfolk who need the support of the school nursing service are referred into the single point of referral. This is a recent initiative to manage capacity within a very stretched service and ensure equity of provision.

1.18 In the Norwich area, school nurses have recently temporarily stopped drop in services to local schools. However, these are being re-instated to include monthly 'themed' sessions according to local need. School nurses based at JPUH still provide drop in services but we were advised that this can be inconsistent due to pressures on the team to attend child protection conferences which are prioritised.

1.19 School nurses have good access to the majority of schools, including academies, faith schools and free schools. The school nursing service also accepts referrals for children and young people who are home educated. This means that most children and young people can be referred for support by this valuable service. We heard about how a school nurse had worked closely with one young person who was home educated and had needed support around weight management, healthy eating and exercise. The school nurse facilitated referrals to the weight management service and sourced a local gym that offered specific young people's exercise sessions. Early feedback is that the young person is engaging well and making progress.

1.20 Representation from the designated safeguarding team at the child sexual exploitation sub group requested school nurse assistance in delivering 'Chelsea's choice' CSE awareness presentations in schools across Norfolk. With this in mind the school nurse team is planning to assist and offer advice to children and young people according to local need.

1.21 Midwives at JPUH provide a range of early help training groups for all expectant parents in addition to targeted groups, in conjunction with local children's centres. Training workshops include 'talking tummies,' a weekly session for women with mental health issues, 'mellow bumps' and 'expectant dad's' which looks at parenting skills and attachment. They also employ a pragmatic and flexible approach to ensuring women with additional needs are well supported throughout their pregnancy, encouraging them to engage with midwifery services and be better prepared for their child's birth.

*One case examined demonstrated how a midwifery healthcare assistant undertook weekly work with a mother to be living with learning difficulties. Her engagement with the expectant mother included the use of 'changes,' a visual resource to aid the mother's understanding of the importance of attending medical appointments, and providing home visits to give practical demonstration on how to change the baby, sterilise bottles etc.*

*The healthcare assistant also accompanied the mother when shopping to purchase items for her 'hospital bag' to ensure she was ready for admission to the ward with appropriate items readily to hand.*

1.22 Both midwifery and health visiting in the JPUH areas have a specialist enhanced service to engage with expectant mothers and new mums within local travelling communities. We saw and heard about a number of cases where these women return to Norfolk sites when pregnant because of the quality of service they receive at JPUH and the team's positive relationships with this often difficult to engage community. Specialist midwives and health visitors conduct joint visits to traveller sites which enhances engagement with antenatal services.

1.23 New clients obtaining services provided by adult substance misuse workers are asked detailed questions about their family make up, including names and contact details of all children and young people with whom they have responsibility or contact. This includes questions asked of males using substance misuse services regarding pregnant partners or where they even considering starting a family or having more children in the near future. These questions are all asked again at three monthly care plan reviews or sooner if required. Details of children in families include; schools attended, GP details and details of other significant adults with whom the young person might have contact.

1.24 Norfolk children and young people are safeguarded well by contraception and sexual health (CASH) services. The screening assessment for all young people aged 16 and under provides pro-forma questions to be asked by health practitioners at initial screening. We saw that practitioners are going above and beyond asking those questions and are engaging well with young people using professional curiosity where risks, however inconsequential they might seem, are identified. Consultation with safeguarding leads is common place and will result in a referral to the multi-agency safeguarding hub (MASH) when considered necessary. The same comprehensive assessment however, is not being used for young people who are accessing emergency care.

1.25 Capacity issues within CASH can result in delays in service provision for young people. For example, appointments for the fitting of intrauterine devices or where medical conditions dictate a more thorough medical examination is required by a doctor before contraception can be provided can be affected by staff shortages.

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## 2. Children in need

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2.1 All young people up to 18 years of age who attend JPUH ED are routinely admitted to a paediatric ward if considered necessary. Young people aged between 16 and 18 are seen in the adult ED rather than in paediatric ED unless they or their carers request otherwise, such as when the young person is recognised as living with a learning disability.

2.2 Robust arrangements are in place to liaise with both local and out of area social workers for residents and holiday makers who attend JPUH ED. We examined evidence of strong liaison between health and children's social care for both local and out-of-area children.

2.3 Midwives at JPUH and NNUH are fully engaged in the formal child in need and child protection process and we saw consistent attendance and input at important initial and review meetings in all cases sampled.

2.4 Robust arrangements are in place to support information sharing and joint working between midwifery and health visitor services. Formal maternity liaison meetings between midwifery and health visitors take place on a monthly basis where case loads and vulnerable cases are discussed and then followed up with a joint planning and risk assessment visit. From this, community midwives and health visitors agree future plans of action to support vulnerable people.

2.5 Arrangements for supporting mothers-to-be with mental health needs are well developed. Cases seen highlighted comprehensive risk assessment completed along with close working between specialist midwives, the perinatal mental health team and adult mental health recovery team workers. We saw that a perinatal mental health pathway was in place which is compliant with NICE guidelines.

2.6 Specialist midwives are in post at JPUH to support community teams with complex cases and we saw strong evidence of their role in liaising with outside teams to ensure a co-ordinated approach to case management and further ensuring that vulnerable mothers-to-be were well supported. Case-loads include substance misuse, domestic violence, mental health and hard to reach communities. The specialist midwives carry a small caseload depending on women's individual needs and they support community midwives in their work with vulnerable mothers.

2.7 Effective internal systems are in place within midwifery services to record additional vulnerabilities and cases sampled highlighted ongoing risk assessment and updates completed in light of new information received.

2.8 In midwifery services, plans examined for women with additional needs were seen to be comprehensive, with clear action points and targets and in all cases seen they had been followed up consistently with ongoing collaborative working between disciplines. For example, we examined care plans which were updated at 32 and 36 weeks pregnancy, and that adult mental health workers were invited to attend the update meetings.

2.9 NNUH recognise that the lack of specialist midwives does not meet the requirement of NICE guidance. This is on the trusts risk register and we are aware of ongoing early work to identify funding within existing resources to address this anomaly.

2.10 At NNUH, attendance at child protection conference meetings (including strategy meetings and core groups) are not monitored by the trust's safeguarding team. We found examples of midwives not attending meetings because of annual leave or conflict with existing commitments and this was not always communicated to the trust's safeguarding team. In some cases, there had been local discussion between the health visitor and the midwife with an agreement about who would attend to represent health. There is risk therefore that practitioner knowledge pertaining to risk might not be appropriately communicated to multi-agency practitioners and thus inform child protection meetings. (**Recommendation 2.4**)

2.11 At NNUH minutes from core groups are not generally received by midwives and there is no formal process for midwives to record the discussion and details of any outcome or subsequent planning. There is an overreliance on health visitors to ensure that this information is recorded on the woman's electronic record. Also, the majority of maternity records we reviewed did not contain copies of notes from core groups, minutes from child protection conferences or reports prepared by midwives for child protection conferences. This is because some community midwives have no established base in the community, there is no storage arranged for paper records, they do not have easy access to IT and there is no 'safe' process in place to post confidential notes or records across the district. Maternity records are therefore not a complete record of the woman's care and this is not considered good practice. (**Recommendation 2.5**)

2.12 Across Norfolk we observed good working relationships between health visitors, school nurses and midwifery services to ensure best outcomes for vulnerable children and families.

2.13 Adult mental health practitioners routinely develop indicators of mental health relapse and crisis plans with their clients. When shared with other professionals, these can help other services identify early signs of relapse and ensure early help is put in place. Although we were told that practitioners will share these with other professionals such as health visitors, we did not examine any case examples where this had happened and the trust's named nurse acknowledged that this is an area for development to ensure that this happens routinely. Cases reviewed did not evidence good direct liaison and communication between health visitors and adult mental health overall. (**Recommendation 5.1**)

*We were made aware of a family with several children living on a low income. We examined continuous school nurse involvement with the family over several years with intermittent support provided by a midwife. Despite intensive support mechanisms being in place, both health and education professionals continued to be concerned about the ongoing neglect of the children by parents who were unable to demonstrate their ability to sustain change and prioritise the needs of their children.*

*Over time, an increased abuse of alcohol by the father was noted along with verbal abuse and controlling behaviour by him toward the oldest child. Increasing concerns regarding emotional health and wellbeing of the eldest child was raised by the school nurse and following discussion with education colleagues a referral was made to CAMHS for tier three support.*

*The young person attended CAMHS and disclosed both verbal and emotional abuse and as such the CAMHS professional consulted the school nurse and also spoke to a representative at the MASH who advised that a family support plan was already in place and should continue. However, the school nurse considered the threshold for child protection had been met and as such made a referral to the MASH for consideration of child protection measures being put in place. We saw that the referral in this instance was comprehensive and clearly articulated risk through professional analysis.*

*The request for child protection measures to be put in place was rejected by the MASH with a suggestion that the family escalate to child in need instead. This decision is currently in the process of being challenged through professional escalation.*

2.14 The CAMHS service has recently undergone significant restructuring and this has led to a period of consolidation of new arrangements. The team are now identifying children's needs more rapidly via a more robust assessment triage process. However, there continues to be some delay in being able to meet those needs due to lack of resources and increasing (or more visible) demand for service in the new model of working. We are aware that measures are being considered regarding how to rectify this.

2.15 Some CAMHS therapeutic interventions can start within two weeks of initial assessment, but there is a particular backlog with play therapy and in some parts of the county there is an inequity of service as this is not offered. The trust report they are advertising for an additional play therapist to join the team imminently but at the moment children waiting for play therapy appointments without positive, recommended interventions taking place.

*In one case examined we saw that play therapy had been assessed as a need for one child in September 2013 but it did not commence until March 2014. We saw evidence of the foster carer in this instance becoming increasingly frustrated at the continued delay, and despite there being a consultative process on the part of CAMHS workers to continually meet with the carer and child, her frustration was that the play therapy, “Just needs to start.”*

2.16 CAMHS workers were seen to offer appointments at flexible locations including home and school in order to facilitate access for young people who would not attend appointments at clinics. This pragmatic approach helps to ensure young people fully engage with the CAMHS service and is seen as good practice.

2.17 There is no emergency CAMHS crisis team to attend EDs out of hours as this is not commissioned, although there is a CAMHS consultant on call out of hours. ED practitioners do not routinely have clear protocols and access to this specialist advice. For example, we heard from one consultant who told us that they had spent a significant amount of time in a stressful situation trying to find the contact details of the on-call CAMHS consultant. (**Recommendation 4.1**)

2.18 We examined evidence of consultation with children and young people by way of the ‘involve group’ in developing CAMHS services. Service user involvement is established in CAMHS and, for example, has led to refurbishment of facilities in the eating disorder clinic room and more art work in waiting areas.

2.19 Historic issues of service users ‘bouncing’ between tier two therapeutic services and tier three CAMHS services has now been resolved via the introduction of a joint triage meeting to ensure referrals are picked up by the most appropriate service and this is agreed collaboratively between the teams.

2.20 We were advised that the family nurse partnership (FNP) is often over-subscribed which means some vulnerable teenage mothers might not receive the valuable support offered by those specialist practitioners. However, when enrolled in this valuable service care provision was considered good.

2.21 Children and young people are generally safeguarded well by practitioners working within adult substance misuse services, the Norfolk Recovery Partnership. Safeguarding children and young people is high on the service agenda, and the team have developed close working relationships with midwifery services and there is a county wide protocol in place with health, social services and acute hospital services to manage the care of clients, families and pregnant mothers. Pro-active work with service users from an early stage promotes fast track help to relevant services as required, such as early engagement with midwifery services, specialist consultants and neonatal units.

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### 3. Child protection

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3.1 NNUH and JPUH practitioners are not always routinely identifying children and young people who live in households where adults have attended ED through self-harm, mental health, substance misuse or domestic violence. There is within the adult ED notes at NNUH a safeguarding section for staff completion, but we saw that this was often left incomplete. At JPUH we saw a lack of professional curiosity in obtaining information from adults about potentially hidden children living at home. The 'think family' approach is not well embedded and electronic documentation across both adult and paediatric ED requires further development to better aid effective risk assessment.

In one case examined at JPUH, we observed that no reference was made to children living at home until three days after admission and on ward staff noting concerns around the mental health of the child's parent. In another case a woman with acute mental health needs was being looked after by a security porter who notified staff of his concerns about the safety of children at home. In both cases there was no reference to 'hidden children' in patient records until after concerns had been raised. (**Recommendation 3.2**)

3.2 At JPUH, the number of ED attendances is flagged on EDIS with all attendances during the last four weeks generated as an automatic pop-up when clinicians log in. Practitioners also have read only access to SystmOne to aid information gathering process. The use of EDIS flags helps support information sharing and risk assessment.

3.3 At JPUH ED, electronic flagging are populated on a weekly and fortnightly basis according to information received from both Suffolk and Norfolk local authorities. Information flagged includes; looked after children and children and young people on child in need and child protection plans. This ensures health practitioners are aware of additional needs or concerns about a child or young person.

3.4 At JPUH ED, follow-up action plans are not being routinely recorded in patient electronic records. Although notes are written in a separate diary and checked on a regular basis by the named nurse, the practice does not aid risk assessment or ensure practitioners have access to full information should the child or young person re-attend ED. (**Recommendation 6.1**)

3.5 Referrals to children's social care via the MASH in both provider ED's lack clarity and do not always articulate risk and the reason for the referral being made. We saw many instances where only limited information was provided, sometimes in 'bullet point' style and not clearly identifying the practitioner's views or a detailed chronology of events leading to concerns being raised in the first instance.

*We reviewed one case where a young person had been involved in an argument with his mother. In frustration he had punched a wall causing injury to his hand and admission to JPUH ED. Questions asked at ED highlighted conflict within the family mainly due to the mother's long term alcohol misuse.*

*A referral was made to children's social care via the MASH but although detail of the incident leading to ED admission was clear, an assessment of risk was not made and the health practitioner's expectation of outcome in the case was not made.*

3.6 There is a robust 'did not appear' (DNA) policy in place within midwifery at JPUH. We were advised that there is a low tolerance of DNA's, with the first DNA triggering a phone call and re-booking of the missed appointment, the second DNA resulting in an unannounced home visit and the third resulting in a referral to children's social care.

3.7 Adult mental health has a robust DNA protocol in place and risk assesses any non-attendance at appointments. The service prioritises any identified risks to children presented by the adult DNA. We saw a case example where, due to concerns about potential risks to the unborn, a home visit was undertaken promptly by the mental health case worker and a psychiatrist from the team. Deploying a psychiatrist as part of the routine joint home visit enabled the service to respond promptly to any mental health needs that they identified at the home visit.

3.8 Health visitor attendance at child protection conferences across both areas reviewed is good. Reports are submitted in a timely manner and had usually been shared with families prior to the conference taking place. The reports for conference we examined were comprehensive and clearly articulated the views of the practitioner and their recommendations.

3.9 Referrals by health visitors to the MASH across areas reviewed were seen to be variable in quality and articulation of risk. Although there is a local safeguarding children board (LSCB) policy on resolving professional disagreement this was seen to be little used. We did hear how the presence of a health visitor within the MASH (although not in a 'front door assessment position) was seen as a positive.

3.10 The Norfolk recovery partnership is represented at the MASH and a care coordinator attends MASH meetings on a weekly basis. This is seen as a positive in actioning referrals made to the MASH by substance misuse workers.

3.11 Case chronologies and genograms are not routinely being used in Norwich based health visitor teams. However, ECCH health visitors were seen to use comprehensive genograms to inform child protection conferences and further aid assessment of vulnerability and need and this is seen as good practice.

3.12 We were informed that each GP practice across Norfolk has a link health visitor available to meet with GP practices to facilitate communication about vulnerable individuals and families. However, we were further informed that there is considerable variation across the county regarding how effectively this resource is used.

3.13 We saw evidence of plans in place for joined up working and information sharing between GPs and health visitors for infants and children up to five years of age. However, we were advised that health visitor liaison practice meetings are variable in the way that they take place but they are considered a good opportunity for information sharing and exchange to help keep children and young people safe. Aside from the shared use of the SystmOne patient record programme, there is a gap in opportunities for information sharing for school age children. There was reported to be limited information sharing with school nurse teams and this was put down to their current capacity issues.

3.14 In all areas reviewed we saw effective communication between health visitors and midwives to share information early and respond promptly where risk was identified. Joint visits between health visitors and midwives are commonplace and allow a consistent and co-ordinated approach in supporting vulnerable expectant women. This is good practice.

3.15 Following the implementation of the joint working approach in Norfolk, joint visits between health visitors and children's social care are now routinely offered to all families where the child is under-five years of age and a referral to children's social care has been made. There has been a good uptake of this initiative which has led to improved assessments taking place.

3.16 At NNUH, the trust's safeguarding team have recently introduced a safeguarding children pre-birth, intrapartum care and post natal record. This is used to supplement the expectant woman's maternity record where a social worker is allocated to the family. It provides a comprehensive record, with well thought out prompts for all practitioners to record specific concerns and actions relating to safeguarding and child protection, including a comprehensive postnatal discharge record.

3.17 We examined one case where a baby was formally looked after whilst it's mother was in a residential assessment unit as well as being the subject of the child protection planning process. The conference report prepared by the substance misuse worker clearly expressed the voice of the child and articulated well the risk to the child of the mother's continued illegal substance misuse and non-engagement with professionals.

3.18 The following case demonstrated the impact of supervision in enabling the practitioner to reflect on their role as part of the core group and how best to utilise their professional skills in promoting and maintaining the health of the child. The health visitor had provided support around sleep, carried out development reviews, supported the nursery application and facilitated the hepatitis and HIV screening.

*Child S lives with her mother and spends a lot of time with their grandmother. Child S currently attends the local nursery funded by the local authority. There has been sporadic contact with their father though this now appears to have ceased altogether. S's mother has a long history of class A substance misuse and has remained engaged with Norfolk recovery partnership throughout her pregnancy and she currently remains in treatment.*

*Child S was first protected by a child protection plan at birth and following progress they came off plan in the spring of 2013. However, soon after the plan was discontinued there was a police report of substance misuse at the family home and following a professionals meeting in the autumn of 2013 it was agreed that due to S's mother's poor compliance with the requirements of her methadone prescription, the family needed additional support and Child S became a child in need.*

*There was no improvement in circumstances since becoming a child in need and in January of this year child S was placed on a child protection plan. At a recent review child protection conference the substance misuse agency indicated that they planned to discontinue the methadone treatment programme as S's mother had continually failed to provide negative drug tests and she had a high DNA rate for her appointments. Child S remains the subject of a child protection plan with multi-disciplinary and multi-agency support plans in place.*

3.19 On cases reviewed, we examined evidence of adult mental health practitioners making efforts to engage with multi-disciplinary and multi-agency practitioners where safeguarding concerns about a child had been identified by making repeated telephone calls, e-mails and leaving messages requesting call back. This included children's social care and health visitors. However, in many cases reviewed, this significant effort and use of resource did not always result in effective liaison.

3.20 Operational managers in the adult mental health service have a clear expectation that mental health practitioners will be members of core groups and attend child protection conferences; submitting written reports if they are unable to attend. We examined case examples of practitioners attending child protection conferences and contributing to the decision making process in a coherent and effective manner.

3.21 Where a child protection plan is in place, adult mental health managers told us that there is an expectation that the adult mental health practitioner will develop a more detailed care plan with the client to underpin the child protection plan. We examined a good example of this during our review. However, we did review a case where no care plan was in place to steer the intervention and this was recognised as a gap by both manager and practitioner. (**Recommendation 5.2**)

3.22 Adult mental health is working towards the operation of a 'think family' model of service, but acknowledges this is not yet established and that it is at different stages of development within teams across Norfolk. We saw some variation in approaches to identifying what children and young people the client may have contact with as part of both initial and routine risk assessments. We saw that the crisis team risk assessment process prompts practitioners to identify if client has children under 18. The assessment asks about any children aged under one year living in the household, but does not prompt workers to identify any other non-related children in the household. We were made aware that the assessment proforma is overdue a review. (**Recommendation 5.3**)

3.23 The introduction of the new IT system (Lorenzo) gives the opportunity to make risk assessment more robust and consistent and the safeguarding team lead/named nurse is ensuring that mandatory fields are introduced to ensure robust assessment of risks to children.

3.24 Adult mental health practitioners are not routinely invited to pre-birth planning and discharge planning meetings where there are identified risks to an unborn/new born, although they may be the key professional working with the mother and therefore an essential component of effective multi-agency work to safeguard a child. It is not clear if there is any monitoring within adult mental health of attendance at strategy meetings, child protection core groups and child protection conferences to ensure engagement and participation in these processes is robust. (**Recommendation 7.1**)

3.25 In adult mental health one referral to the MASH we examined had merit and set out some key issues, but it did not fully set out the risks of significant harm to the children resulting from the incidents and issues previously identified. Omitted from the referral was the significant risk to the two children's mental wellbeing from long-term exposure to enduring parental mental ill-health. This was acknowledged as an area for development to link referrals more clearly to threshold guidance to ensure best quality referrals to inform optimum decision making. (**Recommendation 4.2**)

3.26 GPs do not usually attend child protection conferences, although they will submit a letter of information if they receive the request in a timely manner. One GP told us how he had recently received a request for information with less than 24 hours' notice before the conference took place. As a result of this he phoned the social worker to give a verbal report. However, although some child protection report letters examined were detailed, most mainly consisted of a chronology of events and attendances at surgery. We saw significant variability in the information contained in these reports. Specific training or implementation of a standard template across the area for reports may be beneficial. (**Recommendation 1.1**)

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## 4. Looked after children

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4.1 There are significant capacity pressures on both provider looked after children's health teams visited which is inhibiting effective performance on ensuring the timeliness of initial health assessments (IHA's) and review health assessments (RHAs) and reducing the ability of the team to ensure that known areas for development are addressed. Poor performance on the timeliness of IHAs has been identified on the Norfolk Community Health and Care Trust (NCH&C) risk register.

4.2 Ensuring the effective identification and provision of health support to looked-after children placed out of area is an area for development. There are a number of young people placed out of area who have not had their health needs reviewed within 12 months. As these are likely to be children with the highest level of complex needs and vulnerability, and are likely not to be seen directly by Norfolk health practitioners for a lengthy period of time, this is of concern. We were advised of difficulties in obtaining the services of suitably qualified and experienced practitioners to undertake out-of-area reviews. (**Recommendation 1.2**)

4.3 In Norfolk, IHAs are undertaken by appropriately qualified medical practitioners in line with statutory guidance. Policy and practice on this in both trusts is clear and consistent with best practice. Where older teens coming into care are reluctant to engage with an IHA, the looked-after child nurses are creative in trying to engage them in managing their health. Since the looked-after child nurses in East Coast Community Healthcare (ECCH) began to make telephone contact with older young people newly taken into care over the past two months, there have been no DNAs at IHA clinics whereas previously each clinic would have used slots where a young person did not attend.

*One case examined demonstrated how both the natural mother and foster carer of the child were present at the IHA. The assessment was well managed by the specialist doctor undertaking the assessment and discussions were had about the child's changing behaviour, eating and sleeping habits and other health issues which appeared different from time spent with the natural mother and the foster carer. These were well recorded and as a result gave a clear picture of the child's behaviour according to both adults that had cared for them.*

*Since becoming a looked after child, positive health outcomes included a reduction in attention seeking behaviour and bed wetting.*

4.4 Health visitors undertake RHAs for under-fives in both provider trusts. There is a champion health visitor link worker who supports newly qualified health visitors in undertaking RHAs. Looked-after children's nurses in NCH&C and ECCH undertake all RHAs for over-fives up to age eighteen.

4.5 Strength and difficulty questionnaires (SDQs) where indicated are not being used to inform RHAs. This is a lost opportunity for the SDQ to inform the health assessment. Also, the opportunity for older looked-after children to use their own SDQ in tracking their own emotional growth is being lost. (**Recommendation 1.3**)

4.6 There is a mixed picture in relation to obtaining and recording parental and carer consent to the health assessment. No examples of young people providing their own consent were seen during our review. Potentially, this is a lost opportunity for the young person to begin to take ownership of their health. (**Recommendation 1.4**)

4.7 Cases reviewed were inconsistent in setting out the legal status of the child, reasons for the child becoming looked-after and the inclusion of birth and parental health histories which was often missing or very scant. The latter can have long-term detrimental impact on the young person as they move into adulthood. (**Recommendation 1.5**)

4.8 In most cases, although not all, the ethnicity, language and religion of a looked-after child was recorded. This is important information to capture at the outset, enabling the looked-after child nurses to arrange interpreting service as needed. The identification of a child's ethnicity and religion can also inform how best health support can be delivered.

4.9 Both NCH&C and ECCH have recently introduced health training to foster carers. The joint nature of this training with children's social care is positive however none of the foster carers we spoke with had yet taken up the offer. The CAMHS looked after and adopted children (LAAC) team also offer a range of training options to foster carers, which we were told is having positive outcomes on carers supporting difficult placements and developing carers understanding of attachment disorders and challenging behaviour. Training includes an 18 week didactic therapy 'nurturing attachment' programme and workshops about how to handle emotional issues related to contact visits.

4.10 Health plans reviewed across LAC were generally not specific, measurable, achievable, realistic and timely (SMART). Plans seen were mainly task focused or basic lists of appointments rather than setting out measurable objectives. Timescales were vague and accountabilities were not always appropriate and realistic to enable effective follow-up to ensure tasks are completed. In Lowestoft for example, we saw a thoughtful and comprehensive RHA completed by a looked-after child nurse let down by a weak health plan. (**Recommendation 8.1**)

*One case sampled demonstrated how a child of five years of age was identified with severe tooth decay. In this instance the birth mother was made responsible for ensuring the child received appropriate dental treatment but as she had been responsible for the child's tooth decay in the first instance it was seen that she might not be the person most likely to play a part in meeting the child's needs and ensure the best outcome.*

*We did not examine any evidence of explanation for the decision being made or that other choices had been explored in this instance.*

4.11 GPs are not routinely contributing to IHAs or RHAs although the looked-after child nurse team in ECCHCIC have recently begun to write to the child's GP to invite contribution. To date, no GP has contributed as a result of this contact. One GP we spoke with showed us how alerts were placed on the health file of children looked after and confirmed that health plans were routinely received. By not asking GPs to contribute to IHAs and RHAs for looked after children there is a missed opportunity to ensure that all relevant health information is used to inform the health review. (**Recommendation 1.6**)

4.12 Where young people who are looked-after are also engaged with CAMHS, we saw that there is currently no report on progress or outcomes from this intervention into the RHA. This is seen as a gap. (**Recommendation 4.3**)

4.13 In a number of cases reviewed, health visitor observations of the demeanour, behaviour and communication of children five years of age or under was well reflected in the running record in the child's health record but not always reflected in the looked-after child IHA and RHA documentation. Overall, across providers, the voice and sense of individuality of the child did not come through sufficiently clearly. This was particularly evident in IHAs undertaken by paediatricians. These tended to be very basic in nature, lacking detail, voice or sense of the child as an individual. (**Recommendation 1.7**)

4.14 Health support to care leavers is being developed but is still not a strong offer across both provider areas. NCH&C introduced the health passport commissioned from Cornwall and the Isles of Scilly in April 2014 and now send a letter to young people following their last RHA to reiterate the use of the passport. Young people have not yet had the opportunity to feedback their response to the letter and the experience of having the passport and completing this at their final RHA. We are aware that this is 'work in progress.'

4.15 Young people in the area covered by ECCH do not currently get a health passport when leaving care; they are simply sent a copy of their last health review and immunisation history. The assessment is sent to the GP but not to foster carers. We did see that care leavers are given a range of health and wellbeing public information, based on the discussion they have with the looked-after child nurse and tailored to their individual needs and interests. Overall, health support to care leavers is being developed but it is inconsistent across Norfolk. We are aware that this is an area that is undergoing further development.

4.16 There are gaps in looked after and adopted children (LAAC) CAMHS service for children out of area placed into Norfolk. Increased demand on the need for more direct rather than consultative work for Norfolk origin children is also being monitored and discussed with commissioners as LAC do not currently receive rapid access to interventions

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## Management

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

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### 5.1 Leadership and management

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5.1.1 The designated safeguarding children's team are developing a quality assurance framework to provide a body of evidence to assure themselves that both they and commissioned providers are compliant with the safeguarding children and young people requirements placed on them. Minimum standards for compliance are developed and those providers are then required to provide evidence of safeguarding compliance, and where non-compliance issues are identified the providers will be required to evidence how and when they will become compliant.

5.1.2 The current vacancy for a designated doctor for Norfolk remains open since July 2014. We were advised that it is hoped a suitably qualified practitioner will be in place soon but the lack of a designated doctor does not meet with the latest intercollegiate guidance. Designated health professionals currently seek advice from the Suffolk designated doctor for safeguarding. (**Recommendation 1.12**)

5.1.3 Both Looked-after children's health teams visited during our review told us they receive good leadership and support to develop their service provision for looked-after children from the their designated and named nurses.

5.1.4 The recent assignment of each of the three NCH&C looked-after children's nurses to specific geographical areas within their patch is a positive development, facilitating the development of closer working relationships between health and social care professionals which means looked after children increased health oversight.

5.1.5 The NCH&C named nurse reports increased scrutiny and accountability by the LSCB since the appointment of a new chair. A more robust and challenging section 11 audit has just been undertaken and this is seen as a positive.

5.1.6 At NNUH we heard how the trust was strengthening support to adults and young people attending the ED in mental health crises. Additional specialist staff are being recruited with the aim of extending mental health liaison to 24 hour, seven day a week cover. Additional training is also planned for ED staff in relation self-harm and how best to plan support and care.

5.1.7 We were advised that domestic violence notifications from the police are routinely forwarded directly to the MASH. Where it is recognised that there are or may be children in households where domestic violence has taken place health visitors and school nurses are automatically notified.

5.1.8 In Norwich, progress is being made to recruit to vacancies within health visiting teams and the trust is set to meet 'call to action' requirements. The healthy child programme has been re-commissioned with an enhanced visit schedule. HV's are now expected to carry out an antenatal visit prior to 28 weeks gestation and good performance in compliance with this performance indicator is reported. Most new birth visits are taking place before the baby is 14 days old.

5.1.9 Although there is an improvement in the delivery of the remaining key visits there is still some concern about the overall delivery of the health child programme. Health visitors are key professionals in identifying the need for early help and if visits are not taking place or are delayed this could impact on the timeliness of subsequent interventions being offered. We are aware that this is being closely monitored and reported through the Trusts risk register.

5.1.10 At JPUH information sharing arrangements within the hospital are considered robust with the named nurse for safeguarding attending all paediatric ward handover meetings. The purpose of this is to discuss current cases and to further update staff members about any safeguarding concerns that occurred during the working week.

5.1.11 CASH practitioners are under resourced and unable to provide any pro-active sexual health promotion work or outreach clinics. This is a missed opportunity to engage well with potentially vulnerable children and young people. We are aware that the service is currently 'out to tender' and a decision as to future service provision is expected soon. This will be brought to the attention of public health following publication of this report.

5.1.12 The consultant sexual health practitioner covers a population of some 800,000 people in Norfolk. The faculty of sexual and reproductive health recommends a service standard of 200,000 head population per consultant.

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## 5.2 Governance

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5.2.1 Looked after children services provided in Great Yarmouth and Waveney regularly obtain feedback from young people at every health review. The findings are then used to inform actions to improve outcomes and responsibilities once young people leave care. For example, we heard how that the majority of young people requested health assessments to take place at home. This has led to a flexible approach as to where health assessments now take place according to individual need.

5.2.2 Those CCGs examined as part of this review are strengthening the governance arrangements in relation to the health provision for looked-after children. New service contracts are in the process of being introduced which set more rigorous performance expectations. For example, the current target for the completion of IHAs within four weeks of the health trust receiving notification from children's social care is moving to an expectation of completion within 15 days which would bring IHAs within the recommended target of 28 days from children and young people becoming looked after. However, as there is currently a backlog of IHAs it is difficult to see how tighter targets can be met within current resources.

5.2.3 Across Norfolk we observed very little in the way of quality assurance or oversight of referrals made to children's social care. Most health practitioners we spoke with advised us that they had received little in the way of critical examination of referrals made during the previous 12 months of our review taking place. At JPUH ED for example, referrals made to the MASH are not routinely copied to the named nurse for safeguarding. Referrals made did not routinely articulate risk or expectation of outcome. A lack of governance oversight and clear guidance of practitioners making referrals is resulting in some cases which might be considered appropriate for further intervention not reaching the threshold. (**Recommendation 1.8**)

5.2.4 At NNUH the ED consultant with lead responsibility for safeguarding has recently introduced a formal ED management review and feedback form to record those cases that have been referred back for closer scrutiny. We saw completed reviews where action taken on specific cases had strengthened the response to individual children and safeguarded them well.

5.2.5 At NNUH the use of audit throughout the trust to ensure compliance with safeguarding children practice at a local and national level is underdeveloped. The trust also recognise that supervision is also not embedded throughout the organisation. (**Recommendation 2.7**)

5.2.6 The NCH&C specialist looked-after child doctor who undertook the bulk of the IHAs for the trust retired in September and despite a round of recruitment attempts the post remains vacant. We were advised of that the intention is to recruit a consultant paediatrician to the role and work is underway to do this. Currently IHAs are being undertaken by a number of community paediatricians which was seen to be adequately addressing substantive post holder vacancy.

5.2.7 In LAC, the re-instigation of an operational health and social care group that meets regularly and is currently focused on the establishment of shared and accurate performance data is positive, but it is not part of any formal governance infrastructure; it does not report to the corporate parenting board nor does it act as an LSCB sub-group. Action logs are generated at the meeting but progress on actions are not followed up and monitored at subsequent meetings.

**(Recommendation 1.9)**

5.2.8 Progress has been made in some areas of performance of the health provision for looked-after children, such as in improved notifications by social care to health of children becoming looked after since the introduction of the Norfolk county council administrative hub in July 2013. However, there is not yet a robust health and social care whole system approach to the provision and effective governance of high quality health support to looked-after children. Information sharing between health and social care has been improved by establishing read-only access to the NCH&C client record systems. Both trusts cite significant improvement in receiving timely notifications to attend child protection and child in need conferences.

5.2.9 Information sharing arrangements within JPUH are robust with the trust named nurse attending paediatric ward handover meetings to discuss and update staff on any safeguarding cases that have occurred that week.

5.2.10 Quality assurance of IHAs and RHAs is underdeveloped in both provider trusts. This is an acknowledged area for development and as a response; both providers have recently introduced the use of a set of standards based on the intercollegiate guidance. At the time of the review it was too early to evaluate the impact of this.

5.2.11 We were advised that there were good arrangements in place to affect the safe transfer of vulnerable children, young people and their families between health visiting teams across Norfolk and out of county. However, we were made further aware that there has been no audit to provide robust assurance of this.

**(Recommendation 1.10)**

5.2.12 There is a significant backlog of paperwork and documentation in the Great Yarmouth adult mental health team which is not recorded on case records due to administrative capacity pressures. This includes some child protection plans and potentially other key documents. While mental health practitioners are currently managing their case records, there is no strategy in place to address the backlog awaiting appropriate filing. This creates a risk that practitioners will not always have key documents within the case record. **(Recommendation 5.4)**

5.2.13 NSFT operates a mix of electronic and hard copy recording systems. Adult mental health practitioners told us of their frustrations and the difficulties in ensuring effective communication and information sharing both within the service across different teams and with other agencies. This difficulty can be exacerbated when working with some clients who may move around the area. We are aware the trust has plans in place to introduced electronic recording across the trust in 2015.

5.2.14 We saw variation in the use of flagging alerts between GP practices visited in the same area of Norwich. In some records examined we saw comprehensive use of 'blue dot' alerts on SystmOne, including child protection information linked to parental records (including unborn babies in domestic violence cases) and adult mental health and substance misuse issues linked to child's notes as alerts. However, this was in one practice visited and not another. Looked after child alerts were seen in some cases, but these were inconsistent. Practices visited lacked clarity in when they were 'allowed' to use the blue dot alerts (they thought these could only go on when a child had been placed under a child in need or child protection plan by children's services.) Information and training on this might be considered beneficial.

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## 5.3 Training and supervision

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5.3.1 Training for health visitors in how to undertake high quality RHAs is underdeveloped, limited by lack of capacity in looked-after child health teams. However, where possible, looked after child nurses do provide training for health visitors in how to complete the British association for fostering and adoption (BAAF) documentation and have recently run roadshows to remind health visitors of how to undertake RHAs.

5.3.2 There are robust safeguarding supervision arrangements in place for staff working in NCH&C. The named nurse safeguarding team in the trust provide safeguarding supervision to operational managers/team leaders who are themselves trained to provide safeguarding supervision to their teams. These team leaders have group supervision on a regular basis with the named nurse.

5.3.3 At JPUH there is no formal peer group safeguarding supervision in place for all ED nursing staff. Practitioners currently access ad-hoc supervision from the hospital safeguarding team.

5.3.4 JPUH ED staff are not compliant with intercollegiate guidance for level three multi-agency training. Level three training is provided in-house as a single agency. Although staff members are advised to attend LSCB training attendance is not centrally monitored. (**Recommendation 6.2**)

5.3.5 At NNUH good progress is being made in the numbers of staff who have attended level three safeguarding training within the ED. However, the core single agency level 3 training is provided in house and is currently capped at three hours. It consists of the trainer presenting the training to teams of ED staff only and as such is not multi-disciplinary or multi-agency as per recommendations. The training has also not been accredited by the LSCB. We were told that the LSCB accreditation process has not been pursued, due to procedural difficulties with the accreditation process. (**Recommendation 2.8**)

5.3.6 At JPUH the bi-monthly 'lessons learned' meeting includes a safeguarding slot and the twice yearly 'peer review safeguarding meeting' (consisting of a full day) for paediatric ward and ED staff provides a platform for peer support, case discussion and training issues.

5.3.7 Norwich health visitors are expected to attend level three safeguarding training consisting of a core programme supplemented by attendance at workshops or private study including reflection. Progress in meeting the requirements of level three training is closely monitored through the staff performance, development and review process. Great Yarmouth health visitors report good progress in improving the content of level three training by the Trust. There is ongoing liaison with JPUH and social care to strengthen the current training package to make it multi-agency. This is good practice and when in place will meet with the latest intercollegiate guidance.

5.3.8 A comprehensive preceptorship programme supports well newly qualified health visitors across both areas reviewed. Safeguarding competencies are integral to the preceptorship with good support being provided to those newly qualified staff members.

5.3.9 The NHS Norfolk and Waveney designated safeguarding children team provide a looked after children resource pack providing independent practitioners with advice of their roles and responsibilities in safeguarding vulnerable children and young people. This includes a laminate child protection guide advising practitioners what to do should they be concerned that a child is being abused. The guide is suggested to be placed in consulting rooms and includes designated professional contact details so that advice can easily be sought. However, where intercollegiate guidance is suggested as reading material we saw that this does not refer to the latest March 2014 edition.

5.3.10 Supervision arrangements are in place in adult mental health. However, discussions about cases and the decisions made in supervision are not recorded on the client record in line with best practice. (**Recommendation 5.5**)

5.3.11 Norfolk recovery partnership practitioners are mostly trained to level three safeguarding children. Nurse qualified practitioners are all trained to level three. Where newly employed non-registered nurse practitioners are not currently at level three training they are supported to attend multi-disciplinary and occasionally multi-agency safeguarding training to ensure they are at level three at the earliest opportunity. This is good practice.

5.3.12 No additional training or peer support forums are in place for GP safeguarding leads. GP practices visited report feeling disconnected from the CCG and aside from point of contact support when needed from designated nurse. We were advised that there are no ongoing safeguarding network events for GPs. (**Recommendation 1.11**)

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## Recommendations

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1. **NHS Norwich CCG, NHS North Norfolk CCG and NHS Great Yarmouth and Waveney CCG should:**
  - 1.1 Ensure GPs across Norfolk are aware of their obligations to inform child protection meetings and that the quality of the information provided is consistent and of suitable quality to inform decision making processes.
  - 1.2 Develop more robust practice in identifying and providing health support to looked-after children placed out of area, including the undertaking of health reviews by experienced and suitably qualified practitioners.
  - 1.3 Consider the use of SDQ scores (where available) to better inform RHAs and involve young people in tracking their own emotional health and wellbeing.
  - 1.4 Ensure consent is sought, explained and appropriately recorded prior to health reviews being undertaken.
  - 1.5 Consider improved multi-agency working together to ensure both child legal status and parental health histories are better shared and recorded where available.
  - 1.6 Consider methods to ensure GPs are made aware of IHA and RHA activity and that they are routinely invited to inform these important reviews.
  - 1.7 Ensure the voice of children and young people is adequately represented in IHA and RHA documentation across providers.
  - 1.8 Ensure quality assurance protocols are put in place to assure consistency in the quality of referrals made to children's social services, that appropriate professionals within health are made routinely aware of referrals made and that practitioners are aware of threshold expectations when making referrals.
  - 1.9 Ensure more formal oversight of the operational health and social care group so that progress actions are appropriately monitored.
  - 1.10 Consider arrangements to assure themselves that children, young people and families are transferred effectively between health visiting teams across Norfolk and out of County.
  - 1.11 Consider methods to better involve and inform GPs in the safeguarding of vulnerable children and young people.

- 1.12 Ensure the designated doctor vacancy is advertised and filled at the earliest opportunity.

**2. Norfolk and Norwich University Hospital (Norwich) should:**

- 2.1 Ensure staff compliance in recording detail of significant adults with whom children and young people have regular contact with including separated partners.
- 2.2 Assure themselves that nurse practitioners are routinely completing safeguarding assessments at Cromer MIU by undertaking routine audit.
- 2.3 Put in place procedures and questioning to explore CSE such as those currently used by CASH services.
- 2.4 Assure themselves that attendance at core group meetings is prioritised in midwifery services and appropriately monitored.
- 2.5 Ensure safe processes are put in place to ensure maternity records are a complete record of an individual's care and that they can be routinely updated by healthcare professionals working within midwifery.
- 2.6 Ensure, where possible, only appropriately trained staff are employed to support young people in mental health crisis whilst resident on paediatric wards.
- 2.7 Review safeguarding compliance with the latest intercollegiate guidance, including that of staff member safeguarding supervision.
- 2.8 Review training arrangements to assure that they are in-line with the latest intercollegiate guidance and to further explore methods to ensure the training is appropriately accredited by the LSCB.
- 2.9 Ensure better assessment of children and young people's vulnerability within ED following self-harm or overdose so that appropriate, early intervention can be further considered.

**3. Norfolk and Norwich University Hospital (Norwich) and James Paget University Hospital (Great Yarmouth and Waveney) should:**

- 3.1 Ensure risk based assessment and decision making processes with clearly defined actions are recorded in patient records prior to discharge from ED.
- 3.2 Strengthen procedures within EDs to ensure the ready identification of potentially vulnerable children and young people living in the homes of adult attenders to the departments.

- 4. South Norfolk CCG and Norfolk and Suffolk Foundation Trust should:**
  - 4.1 Review arrangements for health practitioner ready access to out-of-hours CAMHS support advice.
  - 4.2 Ensure referrals made to children's social care by adult mental health practitioners are more clearly linked to threshold guidance and that risks are better articulated and considered when making a referral.
  - 4.3 Consider improved methods to better inform review health assessments where CAMHS interventions are already taking place.
  
- 5. Norfolk and Suffolk Foundation Trust should:**
  - 5.1 Develop mechanisms for practitioners to routinely share important health relapse and crisis plans with other relevant health professionals.
  - 5.2 Ensure all client care plans reflect where there are children within households of adults living with mental health problems, especially where child protection measures are known to be in place so that child protection meetings can be better informed and planned client/practitioner interventions can be better planned with regard to children and young people.
  - 5.3 Ensure a 'joined up approach' is in place across adult mental health services in Norfolk in identifying children within households and with whom clients might routinely have contact and that the proforma used is reviewed.
  - 5.4 Consider and implement arrangements to ensure the backlog of paperwork and documentation within the Great Yarmouth mental health team is safely filed and that practitioners will always have ready access to complete client notes.
  - 5.5 Review methodology to ensure supervision discussions, actions arising from those discussions and set timescales for review are recorded in client notes.
  
- 6. James Paget University Hospital (Great Yarmouth and Waveney) should:**
  - 6.1 Assure themselves that patient electronic records are routinely updated to ensure health practitioners have access to complete records to aid their decision making processes.
  - 6.2 Review training practice and staff attendance at training as provided to ensure compliance with intercollegiate guidance at level three safeguarding training.

**7. Norfolk and Norwich University Hospital (Norwich), James Paget University Hospital (Great Yarmouth and Waveney) and Norfolk and Suffolk Foundation Trust should:**

- 7.1 Ensure arrangements are in place for attendance at meetings and sharing of information where adult mental health practitioners are working with expectant mothers and those who have recently given birth and that attendance at meetings is routinely audited.

**8. Norfolk Community Health and Care NHS Trust should:**

- 8.1 Ensure health plans for looked after children are 'SMART' and effectively evaluated.

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## Next steps

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An action plan addressing the recommendations above is required from NHS Norwich CCG, NHS North Norfolk CCG and NHS Great Yarmouth and Waveney CCG within **20 working days** of receipt 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.