

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

Children Looked After and Safeguarding

The role of health services in Barnsley

Date of review:	17 th November – 21 st November 2014
Date of publication:	19 th June 2015
Name(s) of CQC inspector:	Daniel Carrick Lea Pickerill
Provider services included:	South West Yorkshire Partnership NHS Foundation Trust (SWYPFT). Barnsley Hospital NHS Foundation Trust (BHNFT).
CCGs included:	NHS Barnsley CCG
NHS England area:	North of England Region
CQC region:	North
CQC Deputy Chief Inspector, Primary Medical Services and Integrated Care:	Sue McMillan

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Summary of the review

This report records the findings of the review of health services in safeguarding and looked after children services in Barnsley. 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 Barnsley, 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 57 children and young people.

Context of the review

Child and Maternal Health Observatory (ChiMat) data from March 2014 states that; children and young people under the age of 20 years make up 23.4% of the population of Barnsley. 6.1% of school children are from a minority ethnic group.

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

The rate of looked after children under age 18 per 10,000 children as at March 2013, was significantly lower than the England average. However, despite having a smaller proportion of looked after children in the area, the percentage of looked after children having up to date immunisations was not significantly different to the England average.

9.7% of children aged 4-5 years and 21.7% of children aged 10-11 years are classified as obese.

The teenage pregnancy rate is higher than the England average. In 2012/13, 67 teenage girls gave birth. This represents 2.4% of women giving birth which is higher than the England average.

Commissioning and planning of most health services for children are carried out by executive commissioning group of the children and young people's trust and NHS Barnsley CCG.

In comparison with the 2007/08-2009/10 period, the rate of young people aged 10 to 24 years who are admitted to hospital as a result of self-harm is similar in the 2010/11-2012/13 period. The admission rate in the 2010/11-2012/13 period is similar to the England average. Nationally, levels of self-harm are higher among young women than young men.

Acute hospital services are provided by Barnsley Hospital NHS Foundation Trust

Community based services are provided by South West Yorkshire Partnership NHS Foundation Trust.

Child and Adolescent Mental Health Services (CAMHS) are South West Yorkshire Partnership NHS Foundation Trust.

The last inspection of health services for Barnsley's children took place in June and July 2012 as a joint inspection, with Ofsted, of safeguarding and looked after children's services. Recommendations from that inspection are covered in this review.

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

At the time of inspection we spoke with one young person who had experienced several multi-disciplinary health services in Barnsley during and after her pregnancy. On discovering she was pregnant she told us:

"My GP was excellent and very helpful. He referred me very early on and I was seen at the EPAU (early pregnancy assessment unit) very quickly. They really put my mind at rest."

She told us that during her pregnancy:

"Community midwives were all very helpful. Before I gave birth I had a joint visit from my midwife and a health visitor to introduce them to me so I knew what to expect once I had given birth. Since then I have been seen by health visitors every week."

In relation to service provision she went on to tell us:

"Community midwives and health visitors have been very helpful. Before I gave birth a health visitor came to visit me along with my midwife so I could meet her. I am seen by health visitors every week and because they have signposted me to local support I haven't felt isolated at all."

Another person spoke of their experiences of midwifery services:

"I can't praise them enough. I was always seen without having to wait when I had an appointment at the hospital and since I have had my second child the nurses have been very supportive. I really appreciated their being around."

One young person we spoke with told us:

"I have met my school nurse once. I had a problem and thought I might as well speak to her about it though it took a while to pluck up the courage. I'm glad I did because she really listened and afterwards I felt a lot better. She didn't tell me what to do but just backed up what I was already thinking. It was re-assuring."

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 We saw that young people are able to access dedicated paediatric emergency care at Barnsley hospital up until their 18th birthday. All children and young people register their attendance with the receptionist and are then directed to the dedicated paediatric waiting area. There is also a small space used by adolescents who are waiting for assessment and treatment. Children and young people are clearly visible to staff who are able to monitor their health and wellbeing whilst awaiting further care and support.

1.2 There is clear signage within in the emergency department (ED) to advise parents and young people that information of their attendance at the unit will be shared with their GP and health visitor or school nurse. This is good practice in keeping families and young people informed at the outset of their attendance to the unit.

1.3 At the time of inspection, Barnsley ED had a registered paediatric nurse on duty from 8.00am until midnight (Monday to Sunday); and during the remainder of the time children and young people are usually treated by an adult nurse with specialist further training on the care of sick children. However, the current 'e-staff rostering' package does not have the requirement for this training inbuilt into the software which may mean that a nurse could be allocated to the paediatric department without having completed this specialist update training.
(Recommendation 2.1)

1.4 Barnsley hospital ED do not use locum staff at night time and this means that only those medical staff who are familiar with the hospital and the ED department are treating children and young people who attend the unit.

1.5 Babies under one year of age who attend Barnsley ED with an injury are always reviewed by a senior clinician prior to discharge home. A simple system of a 'flash card' is attached to the casualty record to remind staff on this protocol. In records examined for attendances by infants one year of age and under all were seen or discussed with a senior member of the medical team prior to being discharged from the unit.

1.6 Children and young people who leave the ED prior to being seen or receiving treatment are usually followed up either by telephone call or by sharing the information on the attendance with the appropriate health visitor and GP. The trust recognises that staff should be supported in their risk assessment on what action to take following early self-discharge by more formal guidance and work is planned to address this.

1.7 Young people aged between 16 and 18 years of age who attend Barnsley ED following an incident of self-harm are reviewed by child and adolescent mental health services, (CAMHS) and if they are shown to be clinically fit they are provided with an appointment to see a CAMHS specialist at a later date. Usually, only those young people who need further medical observation or treatment are admitted to the medical assessment unit, although we heard that there is some flexibility available by exception.

1.8 South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) provide a specialist CAMHS learning disability service although we saw that there are often long waiting times to access the service, with new referrals taking approximately one year before their first appointment is allocated. We were advised however that efforts to reduce waiting times are underway and in the interim the team psychologist offers telephone support to some parents who require assistance whilst they are waiting for their initial appointment. The assessments for autistic spectrum disorder are NICE compliant and include a multi-agency assessment.

1.9 The ethnicity of children and young people, although recorded by the ED reception staff at the time of registration, is not being printed on the casualty ED record. This means that practitioners treating the child or young person may not be aware of any cultural sensitivity in relation to the young person or their family.
(Recommendation 2.2)

1.10 On attending the ED and where a child or young person is noted not to be registered with a GP, we were advised that the receptionist will generate a 'request for allocation for children form' which will be given to the nursing staff who will then speak with the young person and/or family to gather more information. The form will be completed and is then faxed to the nominated lead at the GP registration unit. A GP will automatically be assigned to the child on receipt of the form but they will be free to change this GP in the future should they wish to do so. In addition to this, a cause for concern form will be completed informing the liaison health visitor that the child does not have a GP. This information will then be shared with the health visitor or school nurse for that child. This is seen as good practice.

1.11 Midwives as provided by BHNFT have been actively collating data from the pregnant mothers booking information to better inform themselves as to the scale of female genital mutilation (FGM) in Barnsley. The data collected has advised them of the number of cases identified over a set period of time and this information is now being used to inform staff awareness training about how to recognise and report FGM. It is planned to adapt IT systems to include FGM as an alert to identify victims to health practitioners at an early stage.

1.12 Barnsley specialist midwives have been working in close partnership with South Yorkshire fire and rescue services and have, over the course of four years, developed a 'safe sleeping' campaign. During home visits, and with the permission of service users, they undertake a review of safety at the home including an assessment as to the presence of smoke detector alarms. Where these are not fitted expectant mothers are offered the services of fire and rescue services to fit, at no cost, smoke detectors and also other advice about how to protect their home and families from the risk of fire. Also discussed is the risk of 'second hand, passive smoke inhalation by babies and the risks of smoking whilst pregnant.' This is an innovative partnership.

1.13 In cases examined we saw that the documentation used by midwives for planning the care of expectant mothers does not aid the process to be person centred or specific, measurable, achievable, realistic and timely (SMART). The use of the antenatal clinic care plan document does not aid the recording of planned outcomes with clearly defined timescales for actions to be completed and this is seen as a missed opportunity. (**Recommendation 2.3**)

1.14 Specialist midwifery services in Barnsley include substance misuse midwives and teenage pregnancy midwives. Service provision also includes the 'having a baby programme' with the first class being provided at 16 weeks gestation with various classes offering advice such as foetal development and at 20 weeks being in relation to giving birth and weaning the child. At a later stage health visitors and other family support workers are introduced. The service also provides important information to expectant mothers in relation to the type of services they can expect to access before and after giving birth. We were advised that there has been positive engagement with this service.

1.15 Families in Barnsley are supported well by an effective health visiting team. All expectant mothers and new families benefit from regular contact a health visitor. Antenatal home visits are part of the impressive services on offer and provide the opportunity for an early assessment in the home, to forge a positive relationship with the expectant mother. This is especially useful since the decision of midwifery to no longer routinely carry out bookings in the home unless it is specifically requested.

1.16 Health visitors have benefitted from additional training around the Solihull approach to 'understanding your child's behaviour' courses and other targeted training. They are able to offer and support parenting programmes and support groups across Barnsley. The 'Having a Baby' programme is for both expectant mothers and fathers and the majority of parents complete all modules, including those when the baby is one year old called 'now I am one'.

1.17 Some health visitors have attended additional training in offering more specialist support around perinatal mental health for those new mothers who have mild to moderate emerging mental health needs post-delivery. There is also a 'comfort club' that new mothers can access which focussed on supporting mothers with mental health needs.

1.18 The perinatal mental health pathway for women in Barnsley to access specialist support is not compliant with the national institute for health and care excellence (NICE) guidance. We are aware that providers are working closely with commissioners to develop more robust care pathways. We heard how some pregnant women and those that have recently given birth are waiting for long periods of time to access psychology support despite pregnant women being considered a priority. (**Recommendation 4.1**)

1.19 Most health professionals we spoke with told us that timeliness of responses by local authority safeguarding teams to referrals made is generally good and they are usually given at least 10 days notification for requests to inform child protection conferences. However, school nurses told us that this was variable according to area and as they have only just moved across to electronic records, relevant information used to inform child protection conferences is not always currently held in the same place. This can cause problems if the notification period is less than 10 days. We are advised that work is underway to scan paper records onto the SystmOne IT system and that this is being treated as a priority.

1.20 Formal communication arrangements between GPs and health visitors is variable. We heard of outstanding practice with one GP Surgery in in Athersley who hold monthly meetings to discuss patients of concern with routine health visitor's attendance. This provides an integrated team approach to supporting vulnerable families and information is appropriately shared across the team. However, there are many GP surgeries that are not engaging with this constructive and valuable opportunity and resource. (**Recommendation 5.1**)

1.21 Young people in Barnsley have influenced both the location and times that contraception and sexual health (CASH) practitioners offer care and support. For example, CASH practitioners undertake clinics within the health and wellbeing centre at Barnsley college and several other locations across Barnsley, including health centres, youth hubs and local authority youth services, into which young people can either 'drop in' or attend by prior appointment. The opening times at all clinics have been influenced by young people's wishes and experiences.

2. Children in need

2.1 We heard how the 'stronger families' approach to supporting families in Barnsley is having an increasingly positive impact. The 'stronger families' team provides a multi-agency approach to domestic violence where children are involved, strengthen links with universal services and provide additional support at an early stage where children and young people are 'at the edge' of care proceedings being implemented. Dedicated health visitors are involved in the stronger families' teams and this is effectively strengthening partnership working through increasing reciprocal understanding of professional responsibilities and risk.

2.2 Health visitors advised us that they are not routinely notified about domestic violence incidents by the police. This means that the health visitor, who is often the only professional involved with a family that has not yet reached thresholds for multi-agency support, may not be aware of important household information. (**Recommendation 5.2**)

2.3 We were advised of the development of an electronic form to be used by GPs who are requested to inform child protection conferences. We were told that the form is sent to GPs before the conference takes place and that when entered into the patient record (using either SystemOne or EMIS web electronic patient records) the form is automatically populated by the system and can then be sent directly to inform the conference. We have since been informed that the form is always present on IT systems and has to be completed when the practice receive a child protection conference notification. However, records seen across health and looked after children's services did not demonstrate that the form being routinely used.

Although anecdotal feedback on the system has been positive we were advised that there has been no formal quality assurance exercise to examine how well, if at all, the form is being used. There is therefore a missed opportunity for this innovative practice to be used routinely so that GPs can inform vulnerable young people's health assessments. (**Recommendation 1.1**)

2.4 The availability of CAMHS services to support children and young people's emotional health and wellbeing at tier two is limited. In particular, support for behaviour related presentations means that those families who would benefit from early, targeted interventions often have to wait until thresholds for CAMHS input is met. This was confirmed by the named doctor for safeguarding who advised us that CAMHS do not routinely accept referrals for tier two cases rather referring them back to GPs to provide care and support. (**Recommendation 3.1**)

2.5 High numbers of referrals to CAMHS are signposted to other services, where available, or returned to the GP or referrer. Children, young people and families can wait for an unacceptable length of time to access CAMH services, although once they are in treatment the interventions were seen to be effective. We are aware that this is recognised by Barnsley CCG and providers, and continued work is underway to improve waiting times.

In one case examined we saw that a young person had been waiting out of the Barnsley area for almost 12 months for a CAMHS appointment. On moving to Barnsley the family were told they would have to wait a further 12 months for an appointment for assessment. We were aware the case had been escalated by the looked after children's nurse concerned.

2.6 CAMHS practitioners demonstrated good commitment to their service users and work hard to keep children, young people and their families engaged. We saw evidence of robust and targeted risk assessments that resulted in good care planning and high quality safety plans to help protect vulnerable young people.

2.7 We were told that where a young person was admitted to the paediatric ward for observation and needed close observation, then SWYFT are approached to provide additional nursing support during their time on the ward.

2.8 Young people who require specialist in-patient mental health care are usually admitted to the Beckton hospital in Sheffield and admissions to adult wards were seen not to be commonplace. Good arrangements are in place to support any young person who is admitted to an adult ward for short term care whilst awaiting a more suitable placement to ensure they are safeguarded well.

2.9 Most young people who become mentally unwell benefit from targeted intensive support from the young people's outreach team. This intensive and supportive approach helps avoid admission to in-patient care and also supports those young people who attend ED following an incident of self-harm or who are in mental health crises.

2.10 The local mental health section 136 suite at Kendray hospital is specifically designed for people aged 14 years and over. When a young person is brought to the suite a referral is made to the CAMHS on call team and a worker from the team attends for the duration that that service user is being cared for on the suite and also further supports the assessment process.

2.11 In adult mental health, the early intervention psychosis team have developed a system of identifying and managing clients where safeguarding children concerns are present. Each day starts with a brief discussion on all clients who are entered onto a 'smart board' which has a column used to highlight any safeguarding concerns. This enables practitioners in the team to maintain an overview on safeguarding risks with a client and to manage these effectively.

2.12 An effective partnership approach to supporting young people who attend the ED following substance or alcohol misuse means that young people are quickly identified and referred to the Barnsley drug and alcohol addiction service for further care and support.

2.13 We saw evidence of nurses and doctors demonstrating good professional curiosity in challenging parents for more robust explanations of injury and checking with children's social care to see if families were known to them. However, in some cases seen the routine safeguarding assessment was not completed at initial triage, although the consultation record with the nurse or doctor consistently demonstrated awareness on the potential of safeguarding or child protection concerns.

We examined the case of a 15 year old young person who attended the ED following an overdose of tablet medication. We saw that the nurse sensitively explored the circumstances leading up to the young person taking the tablets and also documented the reasons for previous attendances to the department. The notes clearly articulated details of the young person's demeanour and how the majority of the history was taken from the young person's mother. The young person was discussed with the crisis team and admitted to the ward for a period of 'cooling off' and was seen by CAMHS the next day.

2.14 There are currently no specialist mental health midwives in Barnsley. Adult mental health services are provided by SWYPFT and we were advised that there is an integrated mental health pathway into which midwives can refer cases when considered necessary. We are aware that providers are working with commissioners to address this issue. We were further advised by midwives that it can be difficult to refer expectant mothers who have what is considered a lower level of mental health need, such as depression, as there is generally a twelve month waiting list to be assessed and by this time the expectant mother will have given birth. This is a missed opportunity to engage with potentially vulnerable people whose pregnancy might be affected by their condition. (**Recommendation 1.2**)

2.15 Although there is no specific 'hard to reach' midwifery service we were advised that there is a community midwife who is attached to a GP practice who holds a high number of travelling community patients and asylum seekers. She has therefore built up strong working relationships with these often hard to reach communities and will offer advice to other health professionals as and when required.

2.16 Community midwives are attached to specific Barnsley GP practices and as such have maintained close working links with GPs, including access to GP records.

2.17 Maternity services at BHNFT include access to a 'rainbow room' based on the maternity ward. The room provides a quiet space for families to reflect on the death of a child and it is also used when staff members need to discuss possible safeguarding concerns such as before making a referral to children's social care.

2.18 Adult mental health practitioners recognise well the impact of parental mental health on children and young people in families. Records seen demonstrate vigilance in recording interaction between parent and child where this has been observed, and practitioners use a sensitive approach to encouraging and praising positive parenting.

In all cases seen we saw evidence of adult mental health practitioners working collaboratively across partnerships, including children's social care, midwifery and education colleagues.

J is a 3 year old child who's the family had been supported through the common assessment process (CAF). His mother has a long history of substance misuse. Good progress was made through the CAF and during this time his mother became abstinent of substance misuse.

The health visitor continued to visit the family and during this time became aware of increased not attendance and cancelled visits. With this in mind the health visitor contacted children's social care to discuss her concerns and made an unannounced home visit. The health visitor was concerned at the condition of the home and the mother disclosed that she had started to use illegal substances again.

The health visitor's record of the visit was seen to be detailed and demonstrated good professional curiosity around the challenges being faced by the family. The record noted that the mother had a new partner and the health visitor had recorded his full name, previous address and date of birth. This is good practice as the absence of partner details is a common feature in serious case reviews.

The CAF was resurrected and clear outcome focussed SMART goals were set to improve home conditions, provide support to J around his toileting and to address his delayed speech. J's mother was expected to re-engage with substance misuse services and become abstinent once more.

We saw that referrals were made to agencies as considered necessary and professionals provided necessary support. Life has now significantly improved for J and his mother. His speech and language is now sufficiently developed and he has been discharged from services. He is sleeping in his own room, is attending nursery and his mother remains drug free. Arrangements are in place for J to receive ongoing support when he transfers into infant school through school action plus to ensure that the improvements made are maintained.

2.19 School nurses routinely provide 'drop in' services in schools within Barnsley. An 'open door' policy exists but each session has an agenda with suggested items for discussion which can include bullying, sexual health, drug and alcohol advice or relationship advice. This methodology promotes children and young people to think about what they want to discuss and provides opportunity for those who might not otherwise think they can discuss such subjects with the school nurse. School nurses told us that they also make themselves available to young people to discuss other issues as and when required to do so. We spoke with young people who told us that this was a system that, 'worked for them'.

2.20 School nurse practitioners we spoke with told us of problems obtaining relevant dental information pertaining to children and young people in Barnsley, from both private and national health providers. Often important dental information which might be used to corroborate evidence presented at child protection conferences can be difficult to obtain even when school nurses tell the dentist that it is required for safeguarding vulnerable children purposes. They also disclosed some difficulty in obtaining information, even to inform safeguarding concerns, from GPs although this was more variable than in obtaining information from dentists.

2.21 School nurse practitioners have, in some instances, made good inroads into faith schools within Barnsley and although might not be able to promote sexual health advice on site, they can, when asked by individual young people, offer that advice in confidence and direct those young people to where they can receive appropriate care and support.

2.22 Families who move areas within Barnsley, and who have children five years of age or under, benefit from a smooth and co-ordinated transfer of health visitor. We saw one case where the old and new health visitors made joint visits to a vulnerable family so as to better transfer care. This helped the family to adjust to the introduction of new health professionals at a particularly stressful time.

2.23 All families new into the Barnsley area with a child under five years of age are visited by the allocated health visitor as soon as possible after notification is received of the move. This helps the family to link into local health support groups and networks if they wish to do so. The transfer arrangements worked well in those cases examined; however, there has been no recent audit to demonstrate overall compliance.

2.24 Where a family is being supported through universal plus or above (an enhanced health visiting programme) and the health visitor is aware that they plan to move out of the Barnsley area or have moved, the health visitor has a telephone conversation with their counterpart in the new area. This helps to ensure continuity of support.

3. Child protection

3.1 In almost all cases that we have reviewed in Barnsley we saw a consistent, shared approach to supporting vulnerable families through joint visiting and the sharing of information. This collaborative approach has supported families well and we have seen positive outcomes for children and young people with demonstrable improvement in the quality of their life and health across multi-disciplinary health sectors.

3.2 At Barnsley ED, where there are known concerns about a patient, an entry on the casualty card alerts practitioners to the need for further interrogation of a separate IT database. This newly introduced system is unwieldy and time consuming. The alerts are generic and can range from a person being identified with MRSA to a child having a child protection plan in place and in practice means that practitioners can spend several minutes searching the database to discover the nature and significance of the alert. (**Recommendation 2.4**)

3.3 Effective paediatric liaison means that all attendances by children, young people and adults with risk taking behaviours (where there are children in the family) are reviewed and information shared where considered appropriate. We observed ED staff completing paediatric liaison forms where they had identified that additional support was needed within a family to either support or safeguard the health and wellbeing of a child, although the detail on the form was often limited in detail and relied on the health visitor reading through the full patient record to obtain full detail of the attendance.

3.4 The identification of children under the care of parents who attend the ED with risk taking behaviours, including drug and alcohol abuse, self-harm or who have significant mental health concerns is underdeveloped. The ED paperwork has prompts to remind practitioners to explore any potential safeguarding risks but we saw that this is not always being completed, and even when it was the practitioner had not always identified the names and ages of the potentially hidden children making their identification more problematic. (**Recommendation 2.5**)

3.5 Referrals to children's social care by ED staff were often seen to be brief and did not clearly articulate or analyse risk to the young person as perceived by the health practitioner making the referral. There is therefore a risk that referrals made will not be accepted for further examination due to the lack of information provided. (**Recommendation 4.2**)

3.6 CAMHS practitioners use a datix incident recording process to record when a referral to children's social care has been made. Referrals are not routinely copied to the trust's safeguarding team. There is no complete client record, documents are not scanned into the RIO IT system, some documents are kept in a hard copy file and some are scanned in or saved onto the trust's shared drive. This is not safe practice. (**Recommendation 5.3**)

3.7 Chronologies are not routinely used by CAMHS practitioners working with complex families and this means that there is sometimes no easy way for practitioners to identify and locate documentation resulting from significant events. This is a key finding in serious case reviews and is especially relevant when a child or young person's case notes are spread across three systems. (**Recommendation 3.2**)

3.8 Appropriate arrangements are in place for suitably qualified paediatricians to undertake child protection medicals in Barnsley.

3.9 In cases examined we saw that midwives are routinely making detailed and risk based referrals to children's social care. Referrals examined were seen to clearly articulate risk to children, including unborn, and clearly detailed the reason for the referral being made and what action was considered necessary following the referral.

3.10 Midwifery services have a strict did not appear (DNA) policy of which all staff are aware. However, we were advised that midwives will generally go above and beyond policy recommendations and even after one missed appointment they will 'chase' the expectant mother to ascertain the reason for non-attendance and to make a further appointment in person. Failure to attend for three appointments will result in an immediate referral to social services and information sharing with the expectant mothers GP. This is seen as good practice

3.11 Midwives are exploring all available means to ensure the safety of unborn children and their mothers. Decision making rationale was seen to be clearly recorded in client notes and although the recording of safeguarding supervision in client notes was varied, in some cases examined it clearly demonstrated what advice had been sought and how that advice affected consequent care planning.

In one case examined we saw how the expectant mother was herself considered medically at risk as a result of her pregnancy, as was the unborn child. The mother had a history of poor engagement with midwifery services and was considered to be in a controlling relationship instigated by her husband. The husband was known to be both verbally and physically aggressive to health professionals.

We examined evidence of midwifery staff considering all available options to protect the mother and unborn child, with the final decision being that she would be at her safest if kept on the maternity ward until she gave birth. This was backed up by continued safeguarding and other professional advice, clearly recorded in the patient notes. The expectant mother's husband however, did not want his wife to remain on the ward and as a result of this the mother likewise refused stating she would rather stay at home which was considered by health professionals to be a high risk decision made without due consideration for the safety of the unborn child.

A decision was made to apply for a 'deprivation of liberty' order in line with the mental capacity act 2005, and assessments of the mother's capacity to make informed decisions were arranged. These assessments took place on the ward and authorisation was given for the deprivation of liberty to protect the unborn child. Arrangements were made for health assistant supervision on the ward and diversionary tactics were employed to try to better engage with the expectant mother to ensure she complied with the order. Midwifery staff also had to manage the woman's husband who could present as aggressive to staff, although with persistence on their part his aggression soon waned.

Multi-agency meetings were planned to further discuss safeguarding but the child was born early. Since birth the baby had to be transferred to a specialist unit at another hospital and we saw that she was offered the opportunity to transfer there too so as to be with the child during its care there. We again examined good evidence of decision making processes and rationale with the emphasis on safeguarding the safety of both the child and mother.

3.12 SWYPFT are developing a single-agency organisational approach in identifying and responding to child sexual exploitation. The trust provide master classes on child sexual exploitation (CSE) and there is good representation by CAMHS and the trust's safeguarding team on the Barnsley local forum where individual young people of concern are discussed.

3.13 School nurses have a 100% attendance rate at initial child protection conferences and prioritise attendance at review child protection meetings. We were advised that school nurses prefer to attend review conferences even if they have little health input to share as they maintain a consistent person representing the young person at these important meetings. Even if a child moves to a different school within the Barnsley area school nurses will routinely 'hold onto cases' where child protection measures are in place so as to remain a consistent presence for the young person which is seen as a positive approach in supporting vulnerable young people.

3.14 School nurses spoke positively in relation to CSE awareness training that they had received from both SWYPFT and the LSCB. All those we spoke with told us they felt confident in both recognising where CSE might be an issue and how to report it.

3.15 We heard how health visitors have benefitted from the recent introduction of the new threshold guidance and the continuum of assessment. Training has been provided on the revised approach to safeguarding and child protection in Barnsley and some referrals we examined demonstrated an increased awareness on the need to analyse and articulate the risk by health professionals when seeking support from children's social care. This new approach has resulted in stronger and more robust referrals that support the children's social workers in their decision making process. However, this was not repeated routinely in CAMHS and adult mental health.

3.16 Young people accessing CASH services in Barnsley are safeguarded well. Initial assessments are comprehensive and provide good and relevant safeguarding information to practitioners from which they can make judgements in relation to risks to young people.

3.17 CASH practitioners are recording well their interactions with young people and, when personal circumstances change, they are reviewing risk by undertaking a new under 16 and vulnerable person's checklist. This is good practice. However, in one case examined we saw that although the practitioner had clearly recorded their assessment of risk, their interactions with the client and plans of action, and even though the client was considered to be at high risk of CSE, they 'held onto' that risk for over three days when the person they wanted to speak with for safeguarding advice was not available, this despite their being offered to speak with a safeguarding advisor from the Wakefield area. This presented a risk to the young person who had been considered highly vulnerable and was not good practice.

3.18 CASH practitioners in Barnsley are not routinely informed of the outcomes of referrals made to children's social care. Further, they are not routinely invited to attend child protection conferences nor are they advised if a child or young person is made subject of protection measures. CASH practitioners 'chase' referrals made to inform their work with young people and will routinely attend case conferences and meetings when invited to do so.

3.19 Children in families where adult substance misuse is present are safeguarded well. Although formal updates on risk plans are not always completed, entries following consultations record good practitioner awareness on the need to protect the child. Notes examined document conversations around safeguarding children, including safety plans, and where children are seen with the adult client, then observations are made about interactions and general appearance of the child.

4. Looked after children

4.1 Children and young people benefit from timely initial health assessments when they first become looked after. Initial health assessments were generally seen to be comprehensive and informed well by carer's assessments and parental histories; this is good practice. However, in some cases examined we saw how the information provided in carers' assessments, young people's own personal assessments and parental histories was not used to inform the initial health plan. This could mean that the opportunity to record and monitor the impact of parental health is lost. (**Recommendation 1.3**)

4.2 Review health assessments were also seen to be conducted in a timely fashion, but similarly to observations made in relation to initial health assessments, strength and difficulties questionnaires (SDQ's), although present within files seen, were not always used to inform the assessment process. We examined little written evidence in electronic records of SDQ scores being used to influence the planning process. (**Recommendation 1.4**)

4.3 We were advised of plans to take forward an offer from another area out of Barnsley to share in the peer review of each-others initial health assessments. If this offer is taken up it is hoped that the quality of information obtained in the assessment process will improve consistently in Barnsley.

4.4 We heard how access to the child or maternal hospital notes was often difficult and that these were generally not made available for the initial health assessment. In addition, although many of the initial health assessments we saw identified existing concerns around a child's emotional health and wellbeing and that CAMHS were already involved, the input of the practitioner was not sought or recorded. (**Recommendation 1.5**)

4.5 Paediatricians are not routinely using the substance misuse screening tool as part of the initial health assessment process, even when the young person has disclosed alcohol or substance misuse. (**Recommendation 3.8**)

4.6 Children looked after do not benefit from a dedicated CAMH service. The corporate parenting board and NHS commissioners were unaware of how many children and young people looked after are waiting to access CAMHS. This is not acceptable. There is a children looked after CAMHS pathway which starts with the referral being discussed at a monthly consultation clinic to establish how best to address concerns. However, there is no ongoing monitoring of cases as they progress through treatment. We were also advised that CAMHS professionals working with children and young people looked after are not routinely asked to contribute to the initial or review health assessments. (**Recommendation 5.4**)

4.7 The CAMH service does provide some group support to kinship carers, foster carers and adoptees through an 18 week course. However, places on the course are oversubscribed and we were advised that there are long waiting times for carers to be offered a place on the course. (**Recommendation 3.3**)

4.8 In all records examined we saw that GPs are not routinely invited to contribute to the initial health or review health assessments for children looked after, and if they were this was not clearly recorded. We saw no evidence of GP information being provided and used to inform the decision making process. Also, in some GP records, we saw that associated GP health plans were not held on patient electronic records. (**Recommendation 1.6**)

4.9 There is currently no formal, routine quality assurance of initial health assessments. This means that the opportunity to refine and improve on performance to demonstrate continuous quality improvement is missed. We saw variability in the overall quality of assessments and health plans in all cases examined.

At the time of inspection we saw that the quality of health plans following the initial health assessments was variable. In some cases examined we saw excellent follow up by a paediatrician to ensure that referrals were made to obtain specialist assessment and support from a number of clinicians to address the health needs of a child new into care. However, we saw that resultant care plans were not specific, measurable, achievable, realistic and time-targeted (SMART), and in some cases it was not possible to confirm that recommendations made had actually been actioned or completed. (**Recommendation 3.9**)

4.10 Pregnant looked after children and care leavers are prioritised within the family nurse partnership to ensure they are provided with intensive targeted support to help improve the life chances for both themselves and their children. The family nurse partnership is a voluntary home visiting programme for first time young mums and dads, aged 19 or under. A specially trained family nurse visits the young parents regularly, from early in pregnancy until the child is two years of age.

4.11 The newly appointed named nurse for looked after children regularly attends the local forum for child sexual exploitation and missing children. She is able to provide the link across agencies for these vulnerable children in care.

4.12 The looked after children health team acknowledge that the current support to care leavers is poor. We are aware of plans to implement better quality leaving care health summaries and to better prepare young people for taking responsibility for their own health care when moving into adulthood and that this is currently under review.

4.13 The voice of the child is not always present in initial health assessments, with some assessments referring to 'the child.' However, in review health assessments we saw that the voice of the child was better articulated with clear representations often made as to the young person's future goals and current likes and dislikes. This gives practitioners reading the assessment a clearer picture as to the overall personality of the young person and is seen as good practice.

4.14 Training on the health needs of children looked after and the health review process was seen to be provided to all health visitors and school nurses prior to their beginning to carry out health reviews. However, we were advised that no recent training has taken place either to refresh practitioners' knowledge or to further upskill those practitioners who are new to the organisation. However, we were unable to test this further during our review.

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 Barnsley CCG have developed strong multi-agency relationships with partners throughout Barnsley further promoted by strong leadership and an open and transparent view to further developing the safeguarding of vulnerable young people linked to continuous service improvement.

5.1.2 Children looked after have their health care provided through a partnership agreement between South West Yorkshire foundation trust, Barnsley NHS foundation trust and the Barnsley local authority. Initial health assessments are carried out by paediatricians employed by Barnsley hospital NHS foundation trust and review health assessments are carried out by health visitors and school nurses employed by SWYPFT. The local authority provides administrative support to the teams.

5.1.3 SWYPFT have an active young person's user group that meet on a weekly basis. More recently the group have influenced the décor of the new, temporary premises and the group are often used in the recruitment process for new CAMHS practitioners.

5.1.4 SWYPFT are part way through a substantial transformation programme, with CAMHS and learning disability services now being provided through a specialist business unit. Adult mental health services are now provided through local business units. The gaps in the clinical and management interface is recognised, and some teams are now starting to make links to improve the overall care experienced by clients moving between services.

5.1.5 Since the last joint inspection in June/July 2012 NHS Barnsley CCG has been working closely with Barnsley local authority to identify areas for ongoing improvement resulting from the action plan drawn up following the inspection. This has resulted in a strong strategic partnership with much improved multi-agency joint working to protect vulnerable children and young people. Oversight of challenges and progress is maintained by regular meetings and this promotes a clear understanding of each agencies roles and responsibilities.

5.1.6 Work is ongoing with a view to implementing a multi-agency safeguarding hub (MASH). The document 'working together to safeguard children' states that multi-agency working is key to early and effective identification of risk, improved information sharing, joint decision making and coordinated action. Having a well-constructed and effective MASH in place helps to mitigate the risk of children and young people slipping through the safeguarding net and is considered good practice.

5.2 Governance

5.2.1 In the Barnsley ED the paediatric liaison health visitor brings to the attention of ED staff any patient record where they think that the opportunity to safeguard or protect a child has been missed. There are formal opportunities within the department to review such incidents either at the team's governance meetings, email correspondence or in one-to-one discussions.

5.2.2 Following the last multi-agency inspection in 2012, the health team developed a database to track the progress of initial health assessments. This helps to identify trends and provides the opportunity for internal challenge which has strengthened a partnership approach to providing timely initial health and review health assessments.

5.2.3 Barnsley has been without a designated doctor for looked after children for several months although we have been informed that a replacement is due to commence practice imminently. There have been two registered paediatricians undertaking initial health assessments during the absence and we are aware of no adverse effects on the timeliness of initial health assessments taking place. However, it is apparent that there is inherent risk where contingency planning does not account for the loss of such an important link in safeguarding looked after children at short notice. (**Recommendation 3.10**)

5.2.4 The named doctor for safeguarding, in close collaboration with the designated nurse for safeguarding, provides important oversight of the role of primary healthcare in safeguarding vulnerable children. However, the limited number of hours offered to the named doctor role does not do justice to the role requirements. For example, we were advised that the seven and a half hours designated to the post includes oversight of adult safeguarding as well as that for children, and we are further aware that the post holder currently routinely works in excess of their contracted hours to ensure appropriate cover is provided. (**Recommendation 1.7**)

5.2.5 FGM, although not considered prevalent in Barnsley, is being considered by the CCG and provider partners due to the ever changing demographic in the area. Work includes raising the profile of FGM amongst frontline staff members. This includes ensuring staff are aware, for example, of the importance of using independent interpreters as opposed to family members when meeting with non-English speaking service users. This is seen as positive and forward thinking action to ensure potentially vulnerable children and young people are further protected from harm.

5.2.6 Midwifery community team leaders employ a 'self-audit' process of case files to ascertain, for example, if questions are being asked of expectant mothers about domestic violence at every contact, the quality of referrals made to children's social care and are father and significant other family details being recorded.

Attendance at child protection conference and submission of reports to inform conference is not monitored by the SWYPFT safeguarding team. Instead, there is an over-reliance on notification from the local authority or LSCB. (**Recommendation 3.4**)

5.2.7 SWYPFT's RIO IT system does not have an electronic flag to indicate if a child is the subject of a child protection plan or if there are any other safeguarding concerns. We are aware that this issue has already been recognised and is being discussed by the trust to try and find a solution. (**Recommendation 3.7**)

5.2.8 Most adults being referred to adult mental health service are first assessed by the assessment and brief intervention service who carry out an initial assessment. In most files seen there was poor recording of names and dates of birth of children in the household. This is a significant gap that has already been recognised by the trust's safeguarding team who are working with the IT developers to include a separate section of the client record to ensure these important details are captured at the earliest opportunity.

5.2.9 Midwives do not have the facility to receive answerphone messages and we were advised that this can make them difficult to access. We saw evidence from adult mental health practitioners who had made repeated attempts to contact midwives to discuss clients. This is a potential barrier to partnership working and timely information sharing. (**Recommendation 2.6**)

5.2.10 Attendance by practitioners at child protection conference is monitored by the LSCB and reported on to all partners. We saw no evidence of any health provider proactively reporting on attendance within their own organisation. This means that there could be a delay in health providers becoming aware of a problem in their services and families might not be appropriately represented and supported by key child protection meetings. (**Recommendation 6.1**)

5.2.11 The introduction of new 'electronic care plans' has resulted in health visitors demonstrating an increased understanding of outcome focussed, SMART planning when working with families. This is facilitating improved recording on visits and interventions and avoiding drift.

5.2.12 Chronologies of significant events are not being used effectively to support practitioners, supervisors and managers across Barnsley to keep an oversight of any particular case. Many health services in Barnsley are in the process of transferring records to electronic systems and crucial information is often stored in a number of places. This is high risk. The absence of chronologies is a frequent feature in serious case reviews. (**Recommendation 6.2**)

5.2.13 Outcomes from the adult substance misuse risk assessments should inform the subsequent risk management plan. However, we saw limited evidence of effective consideration on the impact of substance misuse behaviour on children forming part of SMART planning. We also found that practitioners were not updating risk plans on a regular basis but that this issue is improving and senior members of staff are implementing improved supervision structures to rectify this.

5.2.14 GPs told us of how they valued the CCG led audit visits to their practices and of the positive impact of these visits. One practice had changed their system of holding separate hard copy files of child protection notes and now scanned all documents on to the patient's notes when they arrived. This is safe practice and ensures that the GP treating the patient has immediate and full access to all information.

5.3 Training and supervision

5.3.1 ED practitioners are not routinely accessing formal supervision in safeguarding children practice. However, we were advised that ad-hoc advice, guidance and support to staff following serious incidents is readily available. (**Recommendation 2.7**)

5.3.2 Good progress is being made in relation to ED practitioners attending mandatory training for safeguarding children; with staff being released to attend the Barnsley safeguarding children board multi-agency level three training.

5.3.3 CSE is included in level three safeguarding children training as provided to all practitioners in primary care. The training includes how to recognise the signs and symptoms of CSE and further ensures practitioners are aware how to make appropriate referrals as a result. CASH practitioners in particular are aware of risk and CSE risk assessment is considered a priority at the early assessment stage.

5.3.4 We were told that attendance at Level 3 safeguarding training by CAMHS practitioners is good with 88.4% of staff members currently having attended either the multi-agency LSCB training or in-house training. We were advised that the trust's in house training has been endorsed by the LSCB

5.3.5 CAMHS practitioners access group safeguarding children supervision with peer support. The sessions are minuted and there is an expectation that the practitioner should record the session and the plan in the RIO notes. However, this does not always happen and means that the RIO is not a complete record of all discussions held. (**Recommendation 3.5**)

5.3.6 Responsibility for attending supervision within CAMHS is at the individual practitioner's discretion and currently there is no monitoring of attendance. This means that some practitioners may not have attended supervision for a considerable length of time and this is not good practice. (**Recommendation 3.6**)

5.3.7 Adult mental health practitioners access group supervision similar to that of CAMHS practitioners. In all cases examined we saw that practitioners were recording the outcomes of supervision in client records and this is seen as good practice.

5.3.8 Midwives are all trained to level three in safeguarding children and that training is provided in a multi-agency setting in line with the latest intercollegiate guidance. Safeguarding supervision is provided on a one-to-one basis at least every four months or sooner if required by the practitioner. Other peer group support is offered with debriefing meetings following difficult cases. However, we saw little evidence of the details of safeguarding supervision or outcomes and goals following supervision being recorded in patient notes. This is not in line with the latest guidance. (**Recommendation 2.8**)

5.3.9 Safeguarding supervision rates in school nursing currently stands at 61.5%. We were advised of concerted efforts to better engage practitioners in the supervision process and it is hoped that these figures will soon rise with one-to-one supervision taking place every four months with ad-hoc supervision and group supervision/discussion in between.

5.3.10 Health visitors and nursery nurses access supervision in safeguarding children practice and attendance is monitored by the trust's safeguarding team. Attendance has recently been cause for concern and a recovery action plan is in place. We examined evidence of supervision being recorded on patient records and this is good practice.

5.3.11 There has been an influx of new health visitors recruited to Barnsley as part of the 'call to action' campaign. Newly qualified and newly appointed health visitors are supported well through preceptorship and a robust 'health visitor competence framework' that contains specific competencies around safeguarding children. This approach ensures that practitioners are competent and confident in their support of vulnerable families and in meeting the challenges of working with families where children are protected through a child protection plan.

Recommendations

1. **NHS Barnsley CCG should:**

- 1.1 Review the effectiveness of the electronic form used by GPs to inform child protection conferences by way of audit and GP consultation.
- 1.2 Continue to work with providers to ensure appropriate care and support is provided to expectant mothers who require lower levels of mental health support with reduced waiting times.
- 1.3 Ensure all available information is used to inform initial health assessments including parental histories where known.
- 1.4 Consider methods to include SDQ scores to inform review health assessment processes and planning.
- 1.5 Work with providers across Barnsley to ensure practitioner involvement across disciplines is included in the initial health assessment process.
- 1.6 Consider methods to better involve GP contribution to initial and review health assessment processes.
- 1.7 Consider the role of the named doctor for safeguarding to assure themselves that contracted hours account for the responsibilities of the role and that children's safeguarding responsibilities are sufficiently accounted for.

2. **Barnsley Hospital NHS Foundation Trust should:**

- 2.1 Assure themselves that all health practitioners providing care and support to children and young people within the ED have received appropriate specialist training and that this is recorded electronically for reference.
- 2.2 Ensure children and young people's ethnicity is carried across to all documentation used whilst they are present at Barnsley hospital so that all staff can be alerted to any cultural sensitivities.
- 2.3 Review documentation used by midwifery practitioners so that when planning the care of expectant mothers the process is SMART and person centred.
- 2.4 Improve the IT system to make alerts (codes) more specific rather than generic, such as when in relation to child protection alerts, self-harm or regular attenders.

- 2.5 Ensure staff awareness is improved in relation to the recording of children in the care of parents or adults who attend Barnsley ED and that this is effectively monitored.
- 2.6 Review methods to make it easier for other health practitioners to make contact or make arrangements to make contact with midwifery team members.
- 2.7 Implement more formal, scheduled safeguarding supervision outside of clinical supervision in line with the latest intercollegiate guidance.
- 2.8 Ensure that the outcomes of any safeguarding supervision in relation to patients are recorded in those patient notes in line with the latest intercollegiate guidance.

3. South West Yorkshire Partnership NHS Foundation Trust should:

- 3.1 Consider methods for improving tier two CAMHS support to young people in need of emotional care and support.
- 3.2 Consider better use of chronologies by CAMHS practitioners, especially when working with complex families.
- 3.3 Consider methods to reduce waiting times to access CAMH support to kinship carers, foster carers and adoptees to reduce the risk of placement breakdown.
- 3.4 Ensure attendance at child protection conferences and the submission of reports to inform conference is appropriately monitored to drive continued improvement where necessary. This should include a formal audit process of patient case files.
- 3.5 Ensure oversight of CAMHS safeguarding supervision and decisions arising from those discussions to ensure client electronic records are updated in line with the latest intercollegiate guidance.
- 3.6 Maintain oversight of individual CAMHS practitioner attendance at safeguarding supervision to ensure regular attendance.
- 3.7 Monitor electronic systems, including RIO to ensure appropriate 'flags' are in place to alert all staff as to children and young people's current and previous safeguarding concerns.
- 3.8 Ensure paediatricians undertaking initial health assessments use the substance misuse screening tool (or equivalent) as a part of the process whether disclosure has been made in relation to substance or alcohol misuse or not

- 3.9 Initiate quality assurance processes to oversee the quality of initial health assessments to refine and improve quality. This should include oversight of the quality of health plans following initial health assessments to ensure they are consistently SMART, appropriately reviewed, actioned and completed.
- 3.10 Consider contingency planning to ensure where important lead health professionals are unable to undertake their responsibilities at short notice that alternative arrangements can be made at short notice and replacement suitably qualified staff be found with the minimum of delay.

4. NHS Barnsley CCG and Barnsley Hospital NHS Foundation Trust should:

- 4.1 Consider ways to ensure perinatal mental health pathway for women in Barnsley is compliant with NICE guidance and to reduce waiting times for priority pregnant women.
- 4.2 Improve quality assurance processes to assure themselves that referrals made to children's social care are of sufficient quality and meet current thresholds, sufficiently articulating risk.

5. NHS Barnsley CCG and South West Yorkshire Partnership NHS Foundation Trust should:

- 5.1 Consider methods to improve information sharing between GPs and health visitors to better promote an integrated approach to supporting vulnerable families.
- 5.2 Consider methods to ensure health visitors are routinely notified of incidences of domestic violence by police at the earliest opportunity after the alleged incident.
- 5.3 Review the methods used to record client contact and general record keeping ensuring safe practice is maintained across CAMHS in Barnsley, including methods to routinely update the trust's safeguarding team when referrals are made to children's social care. This should include quality assurance processes being put in place to continually review practice.
- 5.4 Review CAMH service provision to children looked after to include regular, routine audit of the number of looked after children waiting to access services and that CAMHs practitioners are routinely asked to contribute to initial and review health assessments.

6. **NHS Barnsley CCG, Barnsley Hospital NHS Foundation Trust and South West Yorkshire Partnership NHS Foundation Trust should:**
- 6.1 Ensure all partner health providers proactively monitor report on attendance at child protection conference from within their own organisation.
 - 6.2 Consider methods to ensure the use of chronologies of significant events are effectively authored and used to support practitioners in maintaining accurate and effective oversight of cases where children and young people are considered at risk.
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Next steps

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

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