Care Quality Commission

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

Children Looked After and Safeguarding
The role of health services in Derby

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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 Derby. 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 Derby 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 2015.
- 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 109 children and young people.

Context of the review

The majority of Derby City residents (99.8%, 264,950 residents) are registered with GP practices that are part of the NHS Southern Derbyshire Clinical Commissioning Group (CCG).

Children and young people under the age of 20 years make up 25.7% of the population of Derby. 36.1% of school children are from a minority ethnic group. The health and wellbeing of children in Derby is generally worse than the England average. Of the 32 indicators, Derby featured significantly worse than the England average for 16.

The infant mortality rate is similar to, and the child mortality rate is worse than, the England average. The level of child poverty is worse than the England average with 23.8% of children aged under 16 years living in poverty. The rate of family homelessness is worse than the England average. Of children aged 4-5 years, 8.5% are classified as obese, as are 20.8% of children aged 10-11 years.

The Department for Education (DfE) provide annual statistics of outcome measures for children continuously looked after for at least 12 months. A strengths and difficulties questionnaire (SDQ) was used to assess the emotional and behavioural health of looked after children within Derby. The average score per child in 2014 was 16.3 which is borderline of concern, with 49% of children of concern.

Derby Teaching Hospitals NHS Foundation Trust was formerly known as Derby Hospitals NHS Foundation Trust. The trust provides both acute hospital and community-based health services and has two locations registered with the CQC within the local authority area of Derby City.

Commissioning and planning of most health services for children are carried out by Southern Derbyshire Clinical Commissioning Group (SDCCG), Public Health Derby City Council, NHS England and Derby City Council.

Acute hospital services are provided by Derby Teaching Hospital Foundation Trust (DTHFT)

Community based services are provided by Derbyshire Healthcare Foundation Trust.

Contraception and Sexual Health Services (CASH) are provided by Derbyshire Community Health Services Foundation Trust in conjunction with Derby Teaching Hospital Foundation Trust.

Child and Adolescent Mental Health Services (CAMHS) are Derbyshire Healthcare Foundation Trust.

Specialist Mental Health in-patient facilities are in Nottinghamshire Healthcare Trust Nottinghamshire Healthcare Trust or Coalville, Leicestershire Partnership Trust – this is depending on where in Derby a patient may live, although Nottingham is the usual route.

The last inspection of health services for Derby's children took place in May 2011 (published June 2011) as a joint inspection, with Ofsted, of safeguarding and looked after children's services. All of the six outcomes that were inspected were assessed as adequate. 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

We heard from a mother of young children who said:

“My midwife was amazing, she knew me and was easy to talk to and would tell me off for not taking my iron tablets”.

“My new health visitor is lovely, she’s tried to get me to groups but I’m not very confident around people so wouldn’t go”.

A young person who is currently in care told us:

“My LAC nurse is great to talk to, she knows what she’s doing”.

A family in Paediatric ED told us that they had attended on other occasions and if needed would choose to use the service again. We spoke with their child who said:

“It was a good experience, I was seen quickly and the staff were nice to me”.

A young person who had used CAMHS services told us:

“I didn’t know what was being shared and I assumed that everyone knew everything”.

“It sometimes feels like services are competing with each other, it needs a day when they all come together and learn what each other does”.

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 Children and young people who attend the emergency department (ED) are triaged quickly and wait for treatment in a dedicated paediatric waiting area. However, there is no information available to inform parents, carers and young people that details of their attendance at the ED will be shared with their GP and other health care professionals. *(**Recommendation 2.1**)*

1.2 All attendances at children's and adults ED are recorded on an electronic patient record. There is no differentiation between a paediatric record and an adult record. This can lead to a lack of focus on the needs of young people if they are cared for in an adult environment. *(**Recommendation 2.1**)*

1.3 Paediatric liaison within the ED is effective and a dedicated health visitor reviews all attendances at the ED by children and young people under 19. Attendances are routinely shared with GPs, health visitors and school nurses. Where there are concerns that do not meet the threshold for child protection but it is considered that a family may need additional support, ED practitioners are expected to complete a health visitor/school nurse referral. The paediatric liaison health visitor will telephone health professionals to notify them of the additional concern and also act as a safety net to identify any concerns that have been missed by the ED practitioners. This review is important as we saw evidence of ED practitioners missing opportunities to identify and respond to early concern. It is concerning that the current post holder is soon due to retire and plans for a replacement have not yet been confirmed. *(**Recommendation 2.2**)*

1.4 A clear policy is in place to guide practitioners in responding to children and young people who leave ED being seen. In files reviewed we saw evidence of how this policy was being used effectively and ensured that appropriate action was taken to safeguard children and young people who have not accessed care.

1.5 The majority of expectant women access maternity services through their GP Practice. Where permissions have been given to share information, community midwives are accessing the patient record and using this information to inform the risk assessment of vulnerability at booking. This is helping to ensure that potential areas of risk are identified early.

1.6 It is not always possible to establish if a woman has been seen alone when booking her pregnancy or at any other time during the antenatal period. Seeing women alone provides for a safe opportunity to discuss confidential information and for routine enquiry about domestic violence. There is an expectation that domestic violence will be discussed at least three times during the pregnancy, including in the postnatal period. It was hard to find evidence of this because of the record management which is detailed later in this report. Domestic violence often starts or escalates in pregnancy therefore it is important that this is explored and the opportunity for any support identified. *(**Recommendation 2.3**)*

1.7 A service for perinatal mental health is in place and that expectant women with peri natal health needs benefit from an effective interface with community based mental health services. . This means that women in Derby who experience mental health difficulties during pregnancy can have access to specialist provision.

1.8 There is a rolling programme of Think Family training in Derbyshire Healthcare Foundation Trust which has been mandatory for all clinical staff since October 2014. The model is embedded within health visiting, school nursing and substance misuse services but this is not the case in adult mental health services. Records in adult mental health services do not readily show that there are children in the household or if the adult has caring responsibilities or has access to other children. Intervening early with a Think Family approach can help avoid problems escalating to crisis level and reduce the number of families and individuals who need intensive support in the future. *(**Recommendation 3.1**)*

1.9 Derbyshire Healthcare Foundation Trust can refer to the Young Carers Service within Derby City and where identified, young people are referred to the service. However, this is reliant upon involvement of children being identified in the assessments processes.

1.10 Families who need support for emerging need can access support through the early help assessments. We saw increasing numbers of early assessments carried out by health practitioners and this is positive. We were told that health practitioners would often be told to carry out early health assessments as a precursor to formalising any request for child protection or child in need assessment. However, outcomes, copies of discussion and plans from early help assessments are not routinely shared with health professionals and therefore the rationale for the chosen pathway is not always evident and other important information is not being shared. *(**Recommendation 4.2**)*

1.11 New parents are supported well by health visitors who carry out key visits as part of the Healthy Child Programme. The majority of women are seen in the antenatal period and this helps to establish good working relationships and trust in the period leading up to the birth.

1.12 New parents benefit from being able to access parenting and support groups. Health visitors offer a good range of early intervention packages including programmes to promote early attachment and bonding, baby massage, physical literacy and listening visits to new parents who are identified with low mood. We saw good engagement with parents and a focus on the needs of the child.

1.13 Families who immigrate into the UK are supported well by the new and emerging communities' team which is multi-agency and based in the areas recognised as being of highest need.

1.14 School nurses are providing a range of services including a good delivery of the healthy child programme. In all schools in Derby city, school nurses provide a range of drop in sessions including in faith schools and academies. This is ensuring a route of access to identify early help for children and young people in the education systems. However, children who are home educated are not routinely seen but liaison does take place with staff in the education departments and visits will be undertaken if requested.

1.15 Adults living with alcohol or substance misuse problems are supported well by an effective and integrated service. Improvement in assessment continues to identify adults who are involved with children in a parenting role. Cases seen demonstrated increased practitioner awareness in identifying and mitigating risks to keep safe children in families.

1.16 In Derby, Aquarius, the family drug and alcohol service provides support for children, young people and families. The role of the team is to work with the whole family when parental drug or alcohol use leads to concerns about children's wellbeing. Via the Derby Safeguarding Children Board, Aquarius also delivers training to staff teams with regard to working with substance misusing parents. We saw evidence of improvement in practitioners working effectively to support vulnerable families through monitoring and auditing of safeguarding children practice in providers in substance misuse and alcohol misuse.

1.17 Young people in Derby City have open access to a fully integrated service of contraception, sexual health promotion and genitourinary medicine (GUM). There is no generic young person specific clinic at Derby City hospital. However, we were informed that young people are able to drop-in to the service anytime they feel they need to for advice and support without having to make an appointment.

1.18 Contraception and sexual health (CASH) staff are providing outreach services to young people in a number of different venues across Derby, including within schools, care homes, and youth offending services. A designated specialist nurse in the team, who has a specialist interest in vulnerabilities, young people and learning disabilities provides this one-to-one outreach work. This means that young people are able to access sexual health advice and support wherever they feel most comfortable.

Example: In adult mental health services staff have developed a group known as 'Mr Grundy's Group'. The aim of the group is to "connect for well being" and is aimed at those patients who would benefit from a group therapeutic process but who are not confident in group situations. The group runs for 10 weekly sessions from 5-7pm in a private room in a local public house. The group sessions involve a range of activities provided on an informal basis but with a purpose of providing an interface to enable participants to access more structured intervention and support services. The group has included parents who have struggled to leave the family home or lack confidence in speaking to others.

This is an opportunity to provide early help to adults who maybe parents and be limited in their ability to socially interact with, or on behalf of, their children.

2. Children in need

2.1 A multi-agency protocol for pre-birth assessments is helping to ensure that all unborn babies with additional needs are identified as early as possible. The protocol has clear timescales for arranging early support and also for formal child protection processes including pre-birth conference and the creation of a delivery protection plan. We heard how this protocol was now improving on the timeliness of delivery protection plans which helps co-ordinate services and better supports the woman and protect the baby at birth.

2.2 Women with additional vulnerability through mental health or drugs and alcohol misuse are supported effectively by specialist midwives. These midwives hold some cases but work predominantly through consultation and providing support and guidance to other professionals.

2.3 Teenagers who are pregnant and meet the criteria for family nurse partnership (FNP) interventions and support are referred to this valuable and effective service. However, there are often issues around FNP capacity to accept all referrals made to the service. For those expectant teenagers that are not successful in enrolling with the FNP there is no separate teenage antenatal care pathway on offer. This means that for some vulnerable expectant teenagers there is no schedule for additional targeted antenatal contact and support.

2.4 Birth plans created to support vulnerable women are kept on the electronic maternity IT system or in the handheld medical notes. There is no consistency in where the plans are stored within the record and this makes them difficult to access. Whilst plans are discussed with the expectant woman they are not always written in a separate formal document that she is copied into. This is missed opportunity to involve the expectant woman in her care. *(**Recommendation 4.2**)*

2.5 Arrangements to support children and young people who attend the ED following an incident of self-harm or overdose are supported well. They are admitted to the paediatric ward and once medically fit are referred to the CAMHS liaison team who will assess and create a care plan. It is the expectation that the safeguarding team are advised of all admissions and they then carry out a comprehensive review of all background information, including information about repeat attendances to the department and any other risk factors, including child sexual exploitation (CSE). This information is available to support the CAMHS liaison team in arranging a safe discharge.

2.6 CAMHS liaison routinely record in the nursing or medical notes of children and young people admitted to the paediatric 'Puffin' ward. This provides a comprehensive record of care needs with clear care plans to guide ward staff whilst vulnerable children and young people are in their care. We saw evidence of Puffin ward staff completing comprehensive missing patient and action plans as well as risk assessments and management plans for patients identified at risk of harming themselves or others. However, caring for these children and young people places considerable demand on the staff. We were told that although they are able to obtain additional staff to provide support, it involves a daily assessment to authorise and the staffing is usually provided by bank healthcare assistants who do not have the specialist training to care for children with mental health problems.
(***Recommendation 4.3***)

2.7 We were advised that children and young people who self-harm or take an overdose and attend the ED will soon benefit from more rapid assessment by the CAMHS liaison service. Funding has recently been increased to provide a 24 hour service and this will allow young people to receive a quicker assessment as soon as they are medically fit. This will have a positive impact on more timely discharge from the ward for those young people where this is safe.

2.8 In the adult ED practitioners are expected to identify and record details of any child or young person who is being cared for by an adult who attends the department having demonstrated risk taking behaviours such as self-harm or alcohol abuse. However, the electronic record does not prompt practitioners to ask the questions or provide space to record detail and there is an over reliance on practitioners remembering to explore and record accurate and important information. We found that there is considerable variability in practice and it was not clear in some cases seen whether the questions about children had actually been asked.
(Recommendation 2.1)

2.9 We saw evidence of good and appropriate referrals to children's social care by adult ED practitioners; however, we also saw many cases where adult ED practitioners had not completed the health visitor and school nurse referral form for cases that did not meet the threshold for child protection services, but where the family would benefit from extra support. Unlike the children's ED, paediatric liaison does not extend into adult ED and therefore there is no review to act as a 'safety net'. This means that the opportunity for early intervention may be missed.
(Recommendation 2.2)

2.10 Effective and flexible arrangements are in place to offer ongoing support when a child moves from the health visitor into the school nursing service. Where a family have an established relationship with a health visitor and there are circumstances where it would be more effective for the health visitor to remain the family nurse this is facilitated. This is good practice as it preserves relationships and means that families continue to work with a trusted practitioner at a time of transition.

2.11 Children and young people have access to a range of specialist CAMHS services. Derbyshire CAMHS continue to develop their core services to deliver evidence based treatment modality. A new eating disorder service is in development with practitioners undergoing specialist training to offer local support to this group of vulnerable children and young people. There is however, the need for a locally agreed care pathway to ensure that where these children are admitted as an in-patient to the paediatric ward following ED attendance then they are cared for in an appropriate environment by staff that are appropriately trained.
(***Recommendation 4.3****)*

2.12 We saw increasing evidence of outcomes being measured and in cases seen children and young people were benefitting from intervention and support from CAMHS. However, children under 16 can face delay in accessing CAMHS support: The under 16 team usually receive referrals through the single point of access (SPOA) where each referral is discussed by a multi-agency team. Whilst the SPOA has led to a reduction in children being passed from service to service by enabling them to access the most appropriate support at the earliest opportunity and a choice appointment being offered within six to eight weeks, there is often a further delay before a child is allocated to a CAMHS practitioner for treatment to start. The longest wait for a partnership appointment is approximately seven months. There is some contingency to support a child or young person who is waiting, including referral to the health hub. *(**Recommendation 3.2**)*

2.13 The health hub is a multi-agency referral point and includes a CAMHS practitioner who offers support to children who are only under CAMHS consultants due to current prescribing or where children and young people who need additional support around healthy lifestyles. Where a child or young person is at risk and needs an emergency or urgent appointment, the request for involvement is screened by the duty worker and emergency appointments are available to be provided where considered appropriate.

2.14 For young people aged 16 and over who are newly referred into CAMHS or who self-refer are seen by the young people specialist service (YPSS). Waiting times to access this service is usually between four to six weeks.

2.15 Where children and young people are being supported through a team around the family (TAF) multi-agency care plan, CAMHS practitioners are not routinely creating an individual care plan to specify how they are going to help the child or young person achieve their overall goals. The lack of direction in goal planning means that some young people do not benefit from a care plan that they could comment upon. This is a missed opportunity to involve children and young people in their own care. The outcomes from CAMHS cases discussed at internal team meetings are not routinely recorded onto the patient's record.
*(**Recommendation 4.6**)*

Case Example: A young person was referred to CAMHS/YPSS by a GP in December 2014. A case discussion revealed a conflicting practitioner view regarding the young person's needs and the appropriateness of the referral to CAMHS. The service had not recorded their rationale for opening the case and there was no evidence of any professional challenge to this decision.

An initial CAMHS assessment was undertaken in February 2015. This identified complex factors which were impacting on the young person. Safeguarding risks were evident in the notes but this was not fully explored. A review in June 2015 identified safeguarding issues around family violence as an immediate concern. A verbal safety plan had reportedly been agreed as an outcome between the young person and CAMHS practitioner. However, there was no evidence of this recorded in file. This case highlighted variable practice around identification and analysis of safeguarding risk to young people.

2.16 Children, young people and families are at risk of experiencing delays in accessing appropriate services based on their needs. The decision making process for opening referrals to YPSS or signposting to other essential services requires strengthening. This would reduce the risk of unnecessary delays for accessing support and enable concerns to the safeguarding arena to be escalated.
*(**Recommendation 3.2**)*

2.17 We were advised that child in need network meetings and team around the family (TAF) meetings are often cancelled without informing members of the core group, including parents. In records we saw examples of parents and health practitioners having attended meetings and there was no social worker present to chair the meeting. In some cases we saw considerable drift in escalating cases where little or no progress had been made by parents in safeguarding or protecting their child. In one case seen there had been a delay of five months and there had been no progress made in meeting the requirements of the plan.
*(**Recommendation 4.1**)*

2.18 We heard about good relationships and information sharing with the local police custody suite and substance misuse workers; practitioners are made aware of any service user who has been detained and the reason. This is often a good indicator of domestic violence. Risk assessments are updated with new information however it is not always clear what actions have been taken. In one case we could not see if important information disclosed by a parent had been shared with a family support worker and in another case continued failure to attend appointments had not led to an updated risk assessment. Failure to share information is a common feature in serious case reviews. *(**Recommendation 4.2**)*

3. Child protection

3.1 The trust has an electronic flagging system to alert practitioners in ED of any concerns that are, or have been, present about a child or young person. It is easy for a practitioner to explore further the reasons behind the electronic flag and use this information as part of their assessment. However, the electronic record does not prompt practitioners to carry out any triage for child protection concerns and there is no dedicated space on the template to record any findings relating to child protection. There is an over reliance on practitioners exploring and recording their findings. This means that practitioners may miss opportunities to identify any potential safeguarding or child protection concerns. *(**Recommendation 2.1**)*

3.2 There is confusion about the process for ED practitioners in both children and adult EDs making formal referrals to children's social care and whether these are copied to the safeguarding team. All practitioners are confident in telephoning through their concerns to children's social care, however, it has been established that children's ED are not routinely completing a multi-agency referral form to confirm the details or follow up in writing. In comparison, we did see copies of referrals made from the adult ED to children's social care where practitioners had identified concerns about the safety of their adult patient and these contained appropriate level of information and detail.

3.3 In records seen across Derby we found that ethnicity, language and religion are not always recorded in service user records. Recording these important details assist practitioners to ensure that they have the correct resources in place to respond to the family in a culturally sensitive way and ensure access to interpreters where needed.

3.4 The Derbyshire Teaching Hospitals Foundation trust's safeguarding team do not routinely audit referrals or outcomes. This is a missed opportunity to share learning across all staff on outcomes and producing good quality referrals that support children's social care in their decision making.

3.5 Child Protection Medicals of children over one year are completed by the Community Paediatrician. Children under one year or emergency Child Protection medicals would usually be undertaken on a paediatric ward. However, we were told that on occasion a child protection medical would take place in the Emergency Department (ED). ED is not an appropriate environment for this confidential and anxious time for parents or the children. *(**Recommendation 2.4**)*

3.6 We were assured that midwifery attendance at child protection conference was good and that arrangements were in place to ensure that reports were completed in time for conference. However, we were not able to see any reports or minutes from conference because these are kept by community midwives and the safeguarding team do not have copies on their records. This is not good practice and means that important information pertaining to children is not readily accessible. *(**Recommendation 4.1**)*

3.7 Police are sharing notifications of domestic violence with health visitors and school nurses. In all cases seen these had been followed up with families. This helps to ensure vulnerable families are supported and that family nurses are able to assess risk more effectively. Where either the perpetrator or victim is known to be pregnant, police also share notifications with the Trust Named Midwife for safeguarding. This information is then shared with the named community midwife.

3.8 Health visitors share case conference reports with families prior to conference and this is good practice. We saw evidence of health visitors working sensitively with complex families to keep them engaged with services and improve outcomes for their children. However, sometimes this work was not guided by SMART planning with clear outcomes. *(**Recommendation 5.1**)*

3.9 School age children who will be discussed at an initial child protection conference have their health needs assessed. School nurses are part of the core group only where there is an ongoing identified health need. We were told that school nurses continue to receive minutes from review conference to monitor if there are any emerging health needs; however, the minutes were not seen on electronic records.

3.10 In school nursing we heard about use of the CSE toolkit and how it assists with a base assessment to a specialist CSE worker and escalation within the child protection procedures. However, GP practices visited were unaware of the details of the CSE toolkit, the risk indicator tools or how in their roles they could be operationalising the toolkit and risk assessment. This means that vital information relating to children at risk of sexual exploitation is being missed in primary care. (***Recommendation 1.3***)

Case Example: A young person then aged 14 had seen the GP for a pregnancy test. The test was negative and the GP offered and prescribed a contraceptive pill. The CSE toolkit had not been used and no details about the young person's partner were taken or further discussions that would inform an assessment of risk.

The GP had noted Fraser competence but there were no details recorded of how the decision had been reached.

Records did not indicate that any other agency had been made aware of the attendance.

3.11 Vulnerable families are discussed at most GP and health visitor liaison meetings. This is good practice and provides an opportunity to ensure a co-ordinated approach to care.

3.12 Health practitioners are not routinely following up verbal referrals to children's social care and there is an over reliance on informal discussions and processes. We saw few completed multi-agency referral forms or written emails or letters confirming the content of the referral, including any analysis or articulation of risk or what action they wish children's social care to take. This means that health practitioners are not formally providing children's social care with all the necessary information they need to make an informed decision. Also, the lack of formal, written response by children's social care on decisions taken, means that there is often ambiguity on how vulnerable children will be supported.

3.13 In other examples seen, (outside of the vulnerable children's team), health practitioners are not being proactive in escalating cases formally and health records demonstrate what appears to be a lack of communication between partners and apparent involvement in decision making. This lack of formal communication and over reliance on informal conversations means that there is often confusion around cases and gaps in health records. *(**Recommendation 4.6**)*

3.14 We were told that the Local Safeguarding Children's Board (LSCB) monitor attendance at child protection conference and submission of reports. However, CAMHS receive very few requests for involvement in the safeguarding vulnerable process. Safeguarding teams in health providers are not proactively collating data about key safeguarding activity and there is an over reliance on the LSCB reporting. This means that there is an over reliance on historic reporting by the LSCB rather than health providers identifying and responding proactively to any emerging trends in poor compliance around safeguarding activity within their own organisations. However the Named Nurse within Derbyshire Healthcare Foundation Trust reviews all case conference minutes received and will address poor compliance with the individual practitioner within supervision. Emerging issues and trends are captured via the advice systems and referrals to Children Social Care.

3.15 There are good links between adult mental health services and MAPPA and MARAC with representation on each panel. Alerts are placed and updated on the PARIS IT systems. PARIS IT system has recently been introduced and is the process of implementation. PARIS offers an alert system. The alert system is used to highlight that the patient has been subject to a MARAC plan. However the copy of the outcome plan is not uploaded onto the electronic record but held by the adult mental health representative in a separate paper file for all MARAC minutes. The MARAC plan provides details of children and risks. IT systems cannot be fully effective unless individuals from organisations co-operate around meeting the needs of the individual child. However, because the detailed information from the plan cannot be stored on the electronic record vital safeguarding information in respect of children is not readily accessible. *(**Recommendation 4.6**)*

Case Example: X was 17 when she was referred to the youth offending service as part of a Referral Order. X has past experience of physical abuse, domestic violence in her current relationship with an older male and was using illegal substances. She was not in education, employment or training.

The CAMHS practitioner carried out the initial assessments and using the CSE risk assessment tool identified that X was high risk. A risk strategy meeting was called within the youth offending service and one of the outcomes was that X would be referred to children's social care. A referral was made to children's social care.

A joint visit took place with the CAMHS practitioner with the YOS care manager but they were unable to see X. They asked police to place an alert on their IT systems around domestic violence. X saw the consultant psychiatrists for a review of her mental health and she continued to see the CAMHS practitioner on a regular basis.

The CAMHS practitioner wrote regularly to the GP to update them on her care and progress.

X is now living independently in a housing association property supported by a housing officer. She has stopped using illicit substances and is considering attending the Freedom programme.

4. Looked after children

4.1 Derby's Looked-after children who are placed within the city can expect to have their health needs assessed and reviewed in a more timely way and to a higher standard since than in 2011, but for children placed outside of the city they are not always timely.

4.2 In most records seen recording of family details, ethnicity, religion and dates of birth and family medical history had not been recorded. This is a missed opportunity the absence of this information can have a lifelong impact upon the child's journey through placement into adulthood. *(**Recommendation 4.5**)*

4.3 With regard to consent we saw little evidence of voice of the child. Plans are not always SMART with clear timeframes and areas of responsibility. Not obtaining and recording the voice of children and young people in the health assessment process is a missed opportunity to engage them in the process and 'set the scene' for future interventions. *(**Recommendation 4.6**)*

4.4 Whilst recognising the limitations of the strengths difficulties questionnaire (SDQs), the assessments are not being used appropriately to inform review health assessments of children and young people in accordance with the guidance. This is because they often arrive in bulk or are not timely. This is a missed opportunity to consider emotional and mental health needs of looked after children.
*(**Recommendation 3.3**)*

4.5 We were told that there is no dedicated Looked After Children (LAC) CAMHS; instead most children receive support from a dedicated clinical psychology team who work out of the Royal Derby hospital. Where it is indicated that a child or young person requires specialist CAMHS then the two services aim to work together. We were told that LAC are prioritised within the CAMHS, however, there is no separate reporting on children involved with CAMHS to the corporate parenting board so we could not be assured. *(**Recommendation 3.3**)*

4.6 Communications and efficiency in systems between the local authority and the LAC health team to support the health needs of children in care have been improved, but lack of access to compatible IT systems continues to present barriers and inefficiencies. The LAC health team does not have access to children's social care's liquid logic IT system or data base that would facilitate an effective and timely information sharing process. We were told that notification of placements are generally faxed from the children's social care: In fax records seen the information was not always accurate. *(**Recommendation 4.6**)*

4.7 Although there is a leaving care team in Derby, the LAC health care services are only resourced for young people up to the age of 18 years. The LAC nurses aim to offer a last health assessment within three to six months of leaving care but not all young people are able or willing to take up the offer and health care support from the team discontinues. This is a gap in service for young care leavers who often require additional support with their health needs during the crucial transition from care to independent living.

4.8 We saw good examples in development work and consultation with young people in care including consultation around the health passports.

> One young person who had left services told us:
>
> *"It was hard reaching 18 and having no service because I didn't fit with adult mental health services. I had had support for so long and it was difficult adjusting to no support – a loose contact would have helped".*

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 South Derbyshire CCG and the Derby City council are ambitious about commissioning an integrated service to support children and families; their agenda is to transform services and change philosophy of care to respond to need in a co-ordinated and responsive way. The partnership have started on a journey of transformation in how services to support emotional health and wellbeing are delivered in Derby City. Strategic multi-agency meetings, including the local authority and NHS England, are already planned for the near future to explore how those children and young people who need high cost services as a result of complex needs are supported.

5.1.2 The CCG continue to experience difficulty in appointing to the role of named GP. The designated doctor is caretaking some of the responsibilities of the role and is offering training to GPs and chairing the GP safeguarding leads meetings. Safeguarding children practice in primary care remains an area for significant development, too many child protection conferences take place without a report from the family GP and there is a lack of understanding and engagement around CSE, FGM and other vulnerability. *(**Recommendation 1.2**)*

5.1.3 Safeguarding children is promoted throughout Derbyshire Teaching Hospitals NHS Trust through a network of safeguarding link professionals. Link professionals have a role description in place and they are expected to attend a minimum number of meetings throughout the year. However, there is no additional resource allocated to the role of safeguarding link professional and their performance in the role does not form part of their appraisal/performance development review. *(**Recommendation 4.7**)*

5.1.4 Working groups are in place to develop services to support early help in meeting the emotional health needs of children and young people and securing a more effective LAC CAMHS provision. However, there remain some operational issues that need addressing, including reducing the number of CAMHS patients cared for on paediatric wards and clarity around the CAMHS liaison team and whether this should be operating as a Tier three plus service.

5.1.5 CASH services are not currently represented at, or are partners of, the CSE operational or strategic management meetings. This has been identified as a risk by the management team and we were informed that they are taking active steps to ensure CASH services are represented at the CSE meetings. Currently the named link nurse provides the team with any relevant information following CSE meetings; however we saw no evidence of how this information was used in practice. This is a missed opportunity as representation at the meeting should mean that CASH can contribute to and gather meaningful information and intelligence and decision making about potentially vulnerable young people in Derby City, in particular in relation to CSE.

5.2 Governance

5.2.1 Governance around record keeping and care planning in CAMHS is weak. The trust has invested in PARIS IT system as the preferred option for patient records; however, there has been no firm directive for practitioners to move to being paper free. Most new clients into the service are still supported by a paper patient record alongside the electronic record and it is down to practitioner preference as to how and where documents are stored and where entries are made. This means that there is no single complete record of patient care and this is not good practice and is impacting on the ability of managers to audit files work for consistency and quality of work. *(**Recommendation 4.6**)*

5.2.2 There is no single set of patient notes that hold a complete record of care during the antenatal period. Midwives keep a set of notes in their community bases. There is a safeguarding file kept by the named and specialist midwives where concerns have been identified and there is an electronic patient record that contains some information. Chronologies are not routinely used and therefore there is no opportunity to identify significant events. Copies of child protection reports and conference minutes are not routinely held by the safeguarding team and because there is no opportunity for one to one supervision on child protection cases held by community midwives, the team have no oversight of the cases. We were told that when requests are made to meet with the Trust named midwife / safeguarding liaison midwife to discuss cases on a 1:1 basis, this opportunity is facilitated. *(**Recommendation 4.6**)*

5.2.3 In numerous records seen in adult mental health the basic demographics were not completed including language, ethnicity and religion. This is vital personal information that will inform assessments and service provision. In some records seen letters were filed and password protected but not accessible as no password was available. This means that vital information is not readily available. *(**Recommendation 4.6**)*

5.2.4 In adult mental health services when inpatients are due for discharge there is a notification and a planned discharge meeting. The aim is to allocate a care co-ordinator to meet the patient and attend the discharge meeting. However, we were told that there are long waiting lists for care co-ordinators and therefore they are not always allocated prior to the discharge also that on some occasions, notifications of discharge are not received. Capacity and resource shortfall is resulting in wait times of up to eight weeks for allocation of a care coordinator. This means that children may be left in vulnerable situations without any evidence of planning to consider inclusion of their needs in the context of the wider family and therefore involvement of other childcare professionals. *(**Recommendation 3.2**)*

5.2.5 Substance misuse services have recently transferred to an electronic patient record kept on SystmOne. Practitioners are increasingly using the groups and relationships function to update the system to track any dependencies. This is good practice and will facilitate the identification of any hidden children in the family. We saw good use of alerts on SystmOne. On one case there was an alert on one client record to remind practitioners not to schedule appointments at the same time as another of their clients to avoid potential for violence. Pop-up alerts are used to identify additional vulnerabilities and the IT system currently has recall functionalities, which is often used to remind practitioners to proactively check on case progress.

5.2.6 In CASH services we were informed that the new IT system will mean that practitioners working in any of the sexual health/contraception services will have access to all sexual health records of young people living in both Derby City and County. The current Lillie IT system used by the rest of CASH service demonstrates comprehensive recording in place for all records that were reviewed

5.3 Training and supervision

5.3.1 Supervision arrangements across Derby Teaching Hospital Foundation Trust and Derbyshire healthcare Foundation Trust are not supporting strong and effective safeguarding children practice. It is important that staff working with children and families are effectively supervised to support them and to promote good standards of practice in safeguarding children.

5.3.2 Named midwives and safeguarding midwives and midwives working in the acute hospital setting offer safeguarding supervision on a one to one basis for the specialist midwives and group supervision for the community midwives. However, community midwives hold many cases where there is significant concern and child protection procedures are in place. We found evidence of drift in some cases, including a lack of clarity in child protection process. Had these cases been discussed in supervision then there may have been the opportunity for challenge and reflection, strengthening casework and support for expectant mothers and protection for the unborn child. *(**Recommendation 4.8**)*

5.3.3 In maternity notes of one to one supervision are entered onto the patient notes, however, this does not happen for any cases that are discussed at group supervision. This is a gap. *(**Recommendation 4.8**)*

5.3.4 The arrangements for supervision in safeguarding children in CAMHS is weak, there has been a recent move to cascade a model of supervision and group supervision. Whilst we saw evidence of informal guidance and support from the trust's safeguarding team to CAMHS practitioners working with complex families, we saw no evidence of formal supervision with clear action planning recorded on patient records. *(**Recommendation 4.8**)*

5.3.5 Staff in adult mental health services are provided with monthly supervision which includes a safeguarding component. In addition there is an open door policy for staff to access supervisory support at other times. We were told by supervisors that copies of case discussion and agreed action plan are sent to each health practitioner to be held in the patient record. However, in cases seen the records did not reflect this and therefore the management overview and agreed actions are not evident. *(**Recommendation 4.8**)*

5.3.6 Where skill mixed teams are delivering 5-19 services clear leadership, accountability and access to supervision is essential. Health visitors and school nurses attend supervision at least quarterly and for newly qualified health visitors there is the expectation that they will attend monthly needs led supervision. Supervision is recorded directly onto a template and recorded on the family record. However, not all cases seen in health visiting had been discussed in supervision over the past quarter and there had been considerable drift in resolving areas of concern within some complex families. *(**Recommendation 4.8**)*

5.3.7 ED staff do not access supervision in safeguarding children. There is occasionally feedback to adult ED staff on the quality of referrals made to children's social care but this is ad-hoc. *(**Recommendation 4.8**)*

5.3.8 There is a risk that some staff may not have sufficient relevant knowledge to ensure that children and young people in Derby are safeguarded. The Derby Teaching Hospitals NHS Foundation Trust recognises that training in safeguarding training requires improvement. There has been improvement in raising the quality of level two training to meet the intercollegiate guidance and Level 3 training, especially around "Think Family" is now a priority. Practitioners working in CAMHS, perinatal mental health, learning disability and drug and alcohol teams are expected to attend level three training and compliance is reported, however, this needs to extend to other adult services practitioners working with families. *(**Recommendation 3.1**)*

Recommendations

1. Southern Derbyshire CCG should:

1.1 Support Primary Care in standardising READ codes to identify vulnerability.

1.2 Evaluate and monitor the interim arrangements for the named GP and continue to prioritise recruitment to the post that will support the development of safeguarding practice in primary care.

1.3 Ensure primary care practitioners are aware of and are competent in the use of the CSE toolkit

2. Southern Derbyshire CCG and Derby Teaching Hospital Foundation Trust should:

2.1 Ensure that the paediatric and adult records used in ED are reviewed so that the needs of adults and children are differentiated and support an appropriate assessment of safeguarding, vulnerability and harm and that there are notices to indicate information sharing protocols.

2.2 Ensure that there are plans in place to continue with the ongoing support across ED through an effective paediatric liaison service.

2.3 Ensure that midwives discussions with women about domestic violence are recorded and retained in records.

2.4 Ensure that child protection medical examinations of children are carried out in family friendly appropriate private space.

3. Southern Derbyshire CCG and Derbyshire Healthcare Foundation Trust should:

3.1 Ensure that the safeguarding and Think Family training priorities are implemented and that all staff working in healthcare settings, including those who predominantly treat adults, receive training to ensure they attain the competences appropriate to their role.

3.2 Ensure that adult in-patients in mental health services are supported by thorough discharge plans and an allocated care coordinator prior to discharge. Ensure that children and young people who require help with emotional and mental health needs are able to access appropriate CAMHS services in a timely way.

3.3 Ensure that all looked after children have timely and high quality holistic assessments of their physical, emotional and mental health needs informed by SMART health plans which reflect the child's voice.

4. Southern Derbyshire CCG and Derby Teaching Hospital Foundation Trust and Derbyshire Healthcare Foundation Trust should:

4.1 Ensure that health records are complete and comply with professional standards and organisational policy.

4.2 Ensure that information sharing between agencies is underpinned by national and local protocols and that families are copied into any relevant plans.

4.3 Ensure that a care pathway is developed to ensure that children and young people who have mental health problems, and who are subject to admission to the paediatric ward, have a comprehensive assessment of their needs to ensure that they are supported by an appropriately skilled and experienced practitioner.

4.4 Ensure that health practitioners' record when they have seen children and young people alone and that they have been asked about caring responsibilities as part of the information gathering process when accessing services.

4.5 Ensure that demographics and full family histories are completed and that there is an agreed process of care planning that accurately reflects those and that children and young people are involved with age appropriate informed consent.

4.6 Ensure that a review of all recording systems and record keeping is undertaken with a focus on family inclusive practice.

4.7 Ensure that the capacity of the role of Safeguarding Link is strengthened to reflect areas of responsibility.

4.8 Strengthen supervision practice for all healthcare staff and ensure that discussions and action plans from supervision are clearly documented in the patient records.

5. Derbyshire Healthcare Foundation Trust should:

5.1 Ensure that health professionals are clear about their role, task and expected outcomes when working with families as part of a child protection plan and that the detail of the protection plan is documented in the patient record.

Next steps

An action plan addressing the recommendations above is required from NHS Southern Derbyshire 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.