

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

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

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Contents

Summary of the review	3
About the review	3
How we carried out the review	4
Context of the review	4
The report	6
What people told us	6
The child's journey	8
Early help	8
Children in need	18
Child protection	23
Looked after children	30
Management	33
Leadership & management	33
Governance	38
Training and supervision	41
Recommendations	45
Next steps	51

Summary of the review

This report records the findings of the review of health services in safeguarding and looked after children services in Cambridgeshire. 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 NHS England Local Area Teams (LATs).

Where the findings relate to children and families in local authority areas other than Cambridgeshire, 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 a corroborated set of evidence.

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. It also included some cases where children and families were not referred, but where they were assessed as needing early help that they received from health services. We also sampled a number 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 88 children and young people.

Context of the review

Published information from the Child and Mental Health Observatory (ChiMat) shows that children and young people under the age of 20 make up 23.2% of the population of Cambridgeshire. There are 18.4% of school age children from a minority ethnic group. The proportion of children under 16 in poverty is 12.5%, significantly lower than the England average.

The data from ChiMat shows that, on the whole, the health and wellbeing of children in Cambridgeshire is generally better than the England average. For example, the proportion of children categorised as obese is significantly lower than the England average as is the proportion of children with poor dental health. Infant and child mortality rates are similar to the England average.

The data also shows that Cambridgeshire is significantly better than the England average for a number of other indicators of children's health. These include the rate of emergency department attendances, the rate of hospital admissions caused by injuries to children under 14 and the rate of hospital admissions for asthma in children under 19. Similarly, the rate of hospital admissions for mental health conditions, for alcohol specific conditions and for substance misuse in young people aged 15 to 24 are significantly lower than the England average.

The data reflecting the proportion of teenaged mothers and of under 18 conceptions is also significantly better than the England average.

The data for Cambridgeshire is significantly worse than the England average, however, for some childhood immunisations. Notably these include the MMR vaccinations at two years, the five-in-one vaccine and immunisations of children in care. Cambridgeshire is also significantly worse than the England average for hospital admissions as a result of self-harm.

The Department for Education (DfE) provide annual statistics derived from outcomes for children continuously looked after. As at March 2014, Cambridgeshire had 335 children who had been continuously looked after for more than 12 months (excluding those children in respite care), 45 of whom were aged five or younger.

The DfE data indicated that a greater proportion of Cambridgeshire's looked after children had received an annual health assessment and a dental check-up than the average for England. All (100%) of the children aged five and under who had been looked after for more than 12 months had an up-to-date development assessment. However, only 76% of looked after children were up-to-date with their immunisations, fewer than the England average.

Commissioning and planning of most health services for children are carried out by NHS Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) and the Joint Commissioning Board.

Acute hospital services, including emergency care and maternity, are provided by Cambridge University Hospitals NHS Foundation Trust (CUHFT) and by Hinchingsbrooke Health Care NHS Trust (HHCT).

Community based services and services for looked after children are provided by Cambridgeshire Community Services NHS Trust (CCST). The trust also provides paediatric services at Hinchingsbrooke Hospital.

Child and Adolescent Mental Health services (CAMHS) and adult mental health services are provided by Cambridgeshire and Peterborough NHS Foundation Trust (CPFT).

The last inspection of safeguarding and looked after children's services for Cambridgeshire took place in 2009. This was a joint inspection with Ofsted. At that time, the effectiveness of both the arrangements for safeguarding children and the services for looked after children were judged to be 'adequate'. Recommendations from that inspection are mentioned in this review.

Each of the NHS trusts identified above have been subject to a recent regulatory inspection under the CQC's new inspection approach, examining whether they are safe, effective, caring, responsive to people's needs and well-led. These inspections are not covered in this review except for where they affect safeguarding arrangements or services for looked after children.

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

A parent of a two year old child attending Hinchingsbrooke hospital emergency department told us: *"We have been seen very quickly, it's good, there were lots of toys for (my child) to play with."*

We heard from the parents of a young child who had been signposted to Addenbrooke's hospital emergency department by their GP. They told us that they had been very quickly assessed by one of the triage nurses and then directed to the paediatric waiting area. One of the parents said:

"The staff are very friendly... We've been here for half an hour now but that's OK, there is plenty for our child to do here. It seems to be aimed at younger children. I don't know what older kids would make of it (the paediatric waiting area)."

We spoke with a young girl aged 15 who had attended the emergency department at Addenbrooke's hospital whilst waiting for treatment. She told us she had been in the emergency department for up to 50 minutes but she that she was kept informed by the staff about what would be happening next. She felt the process from the point of triage assessment to the wait for treatment was good but that the waiting area was *"childish"* and not appropriate for older children and young people.

The carer of a child who was being looked after described the comments made by the assessing GP in the record of the child in her care as *"vague"* and that this had caused her to request the assessment be carried out by a paediatrician.

Another carer described how the paediatric doctors went *"above and beyond"* in their treatment of a sick child who was placed in their care. They further described this experience as *"excellent care"*.

Another carer said: “*The only thing is there are not enough appointments for looked after children for health assessments.*” They told us that they had sometimes had to wait six to eight weeks for an appointment with looked after children health professional and that this wait “*delays their future*”.

A carer of a looked after child expressed disappointment with the delays experienced by the child in their care when being referred for specialist treatment. She said she had been “*battling to get it done as the child was so far behind*”.

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 who attend the emergency departments at both the Addenbrooke's and Hinchingsbrooke hospitals are met by caring staff who adopt a child-centred approach to assessing and identifying their needs. Children attending both hospitals are seen quickly for triage so that their needs can be initially assessed in good time and their treatment prioritised. However, at Hinchingsbrooke hospital triage takes place in a public area close to the entrance and this compromises privacy and dignity. We were told that patients and families are offered a choice of a more private space but our observations showed that this option is not routinely offered. ([Recommendation 2.1](#)).

1.2. Practitioners at both hospitals have systems in place that help them to identify children and families who might benefit from early help. This includes establishing and recording the details and relationship of the person who accompanied the child and whether or not they have a named social worker. Staff members we spoke with said they were confident in the use of these systems and our review of patient records showed that such information is consistently recorded on each child's admission documentation. In this way, social and family information is visible to staff that care for, or treat, the child as they progress through their emergency department pathway and beyond and can prompt staff to consider opportunities for early help or to identify any potential risks to the child. Furthermore, at Addenbrooke's hospital, a band six nurse is allocated to check children's admission records on a weekly basis to ensure such information has been routinely recorded and to bring it to the attention of practitioners when it is not.

1.3. Although the system is in place to record information about such children, there is no dedicated paediatric liaison function performed at Addenbrooke's hospital emergency department. This function would ordinarily ensure that children who would benefit from early help are followed up with other health providers. Instead, there is a reliance on individual practitioners to inform, for example, GPs and school nurses of attendances by way of a notification raised on the computerised patient records system, known as 'EPIC'. However, there is no formal auditing mechanism to monitor its effectiveness, whether all such children are highlighted and whether information about children is successfully received by other providers. This means the Cambridge University Hospitals NHS Foundation Trust (CUHFT) cannot be assured they are taking opportunities to enable children to access other services to meet their needs. ([Recommendation 1.1](#)).

1.4. At Addenbrooke's hospital, children and young people have access to a dedicated paediatric waiting area tailored to meet their needs. Whilst the paediatric waiting area is sufficiently equipped, the space is small in size and is orientated more towards very young children as opposed to older children. Practitioners can maintain adequate supervision of the area to ensure that children and young people are kept safe at all times and the area is further secured by way of CCTV monitoring.

1.5. The CUHFT had carried out an analysis of peak attendance times at Addenbrooke's emergency department. As a result of this work, a nursery nurse who is a play specialist is employed at these times to further enhance the waiting experience for children who attend the department. This staff member acts as an additional point of contact for parents during busy periods. As an added benefit, the staff member also provides a further means by which opportunities for early help or potential risk can be identified through protracted interaction with the child whilst waiting. This is an example of good practice according to the 'Standards for Children and Young People in Emergency Care Settings' issued by the Royal College of Paediatrics and Child Health (RCPCH) and indicates a child-centred approach to emergency care at the hospital.

1.6. At Hinchingsbrooke hospital, children and young people wait for treatment in the emergency department in the main waiting area. A small space has been created for young people to play in whilst waiting to be called through for treatment but this does not adequately meet their needs or the aforementioned standards issued by the RCPCH. The Hinchingsbrooke Health Care NHS Trust (HHCT) recognises the limitations of this area and there are plans to reconfigure the emergency department to include more appropriate paediatric space, including a dedicated waiting area.

1.7. Further, there are limited dedicated clinical areas to see and treat children accessing emergency care at Hinchingsbrooke hospital emergency department. There is only one specially designed cubicle in both the minor and major treatment areas. On the day of our review one of these cubicles was occupied by an adult, even though the department was not busy. We were told that should a child be admitted then the adult would be moved. ([Recommendation 2.1](#)).

1.8. Nonetheless, we found that the HHCT had introduced an innovative way of supporting local children to alleviate any anxiety they might experience if visiting the emergency department in an emergency. Children at local schools are regularly invited to visit the emergency department as part of an initiative known as the '999 club'. They are encouraged to comment on the environment and facilities as well as being given the opportunity to familiarise themselves with the emergency department and some of the equipment that they may experience if they were to attend the department for care and treatment.

1.9. During a regulatory inspection of Hinchingsbrooke hospital in September 2014, CQC inspectors had significant concerns about the care of paediatric patients in the emergency department. At a follow up inspection in January 2015, inspectors found the level of paediatric nursing had improved and that the trust had employed two further specialist children's nurses. This means that, currently, children can receive specialist nursing between 7am and midnight, seven days-a-week.

1.10. We acknowledge that, at the time of this review, continued and considerable progress has been made by the trust in this regard. For example, paediatric care pathways in use help to ensure that children and young people receiving treatment at Hinchingsbrooke hospital emergency department are seen by sufficiently experienced medical practitioners. Further, young children attending with head injuries or pre-mobile babies with bruising are seen by senior doctors, and are also referred to paediatricians. However, the trust recognises that they are still on an improvement route-map and that action is still required to ensure its resourcing is compliant with the RCPCH standards as outlined above. For example, there is currently no consultant with paediatric qualifications working in the emergency department. ([Recommendation 2.2](#)).

1.11. We were advised by staff that staffing across the county's minor injuries units (MIU) has been reduced to the minimum on many shifts. Despite this, the MIU at the Princess of Wales Hospital in Ely normally has an excellent record of timeliness in relation to arrival, assessment, treatment and discharge. As a result, people often travel distances to attend this unit by choice and this was borne out by the patient feedback we looked at.

1.12. The ELY MIU is a busy and valuable seven-day service for an area of the county that has no easy access to a general hospital. There was no information available to us to assess what proportion of patients attending the unit were children and we understand such data is not routinely gathered. However, the staff we spoke with estimated the proportion is high accounting for around half of the 1300 to 1500 attendances each month. Moreover, even though the MIUs use an established patient management system designed to be integrated with other health care providers, there is no management oversight of children's attendances and no paediatric liaison function. This means that Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) cannot be assured they are taking such opportunities to enable children who might benefit from early help to access other services to meet their needs. Furthermore, as people choose to travel some distance to get to the MIU, this creates a potential weak link in the identification of children at risk. ([Recommendation 3.1](#)).

1.13. The MIU staff are trained in paediatric resuscitation. We have been advised that nurse practitioners have received additional paediatric training as part of their qualification. One member of the nursing team at the Ely MIU is also a registered sick children's nurse. However, there are no other paediatric qualified staff in any of the MIUs. An effect of this is that there is no minor injuries service provided for children under two years of age. Families with very young children are re-directed to the emergency departments at Hinchingsbrooke or Addenbrooke's hospitals. ([Recommendation 3.2](#)).

1.14. The accommodation at the Ely MIU is older and has limited facilities for children. For example, although staff can observe the waiting area from the reception desk, there is no dedicated area for children to wait in and no child-specific treatment rooms. We were told by staff that the paediatric facilities in the two other MIUs at Doddington and Wisbech were better, although we did not visit these locations. However, the paediatric facilities at Ely do not meet the RCPCH standards as outlined above. ([Recommendation 3.3](#)).

1.15. Across the county generally, the needs of children who require emergency care are met satisfactorily. There are some disparities outlined above, however, between the processes used at both of the emergency departments and the minor injuries units in terms of access, facilities, staffing and the opportunities for referring children onwards for early help arising from effective oversight of records. This means that children experience a differential level of service depending on where they live and differences in the effectiveness of process that identify children at risk as alluded to above. ([Recommendation 6.1](#)).

1.16. We saw that expectant mothers across Cambridgeshire experience generally good maternity care from both of the principal maternity units at Addenbrooke's hospital (the Rosie) and Hinchingsbrooke hospital. However, as outlined below, there are some inconsistencies in the service in relation to the way the midwifery teams can explore opportunities for early help arising from multi-disciplinary working and the provision of specialist care.

1.17. At both the Rosie and Hinchingsbrooke hospital midwifery services we saw that women are encouraged to book their antenatal and maternity care at between eight and 10 weeks pregnancy. This is in line with guidance issued by the National Institute for Health and Care Excellence (NICE). The midwifery teams demonstrate a flexible and individualised approach to ensure that women are well supported and engaged with midwifery services. Antenatal assessments are undertaken in a variety of locations including GP surgeries, children's centres, hospital and the family home. This enables the midwifery team to make full use of the pregnancy pathway to ensure that the best outcomes for expectant mothers and their babies are achieved. This is particularly the case for those women whose care during pregnancy requires additional planning.

1.18. At Hinchingsbrooke hospital we were told that approximately half of all the maternity care pathways are booked at the mother's home. This enables the midwife to observe and consider any familial, social or environmental factors that might have an impact on the safety of the expectant mother and the postnatal care of the child.

1.19. At Hinchingsbrooke hospital we noted that joint visits by midwives and health visitors are undertaken as part of the antenatal assessment whenever a need for this is identified. This allows the professionals, there and then, to jointly consider factors that might have an impact on both the pregnancy and the care of the new-born child and to develop a joint plan of care to fully support the mother-to-be throughout her pregnancy and after delivery.

1.20. At the Rosie hospital, however, we were told that it is not standard practice for midwives and health visitors to undertake joint visits to meet with expectant mothers unless it is deemed to be necessary by an individual midwife for particular women. Although we were further advised that health visitors will visit expectant mothers at 28 weeks, this is generally undertaken as a sole agency visit, and so the opportunity for joint, dynamic assessment is lost. ([Recommendation 1.3](#)).

1.21. At the Rosie hospital specialist midwives are employed in dedicated roles, including a teenage pregnancy midwife, a mental health midwife and a substance misuse midwife. Their function is to offer dedicated, specialist care and support to expectant women who fall into these categories. The specialist midwives carry case-loads according to their own expertise so they can better engage with and support vulnerable expectant mothers on a one-to-one basis and other health services. This is good practice. We have reported on an example of effective collaborative working between the adult mental health service and the specialist mental health midwife under 'Child protection' below.

1.22. Since our visit, we have been advised that three specialist midwives are also employed at Hinchingsbrooke hospital who have additional expertise areas such as domestic violence, mental health and young parents. These midwives work together with the trust's named midwife in managing safeguarding cases and provide support and advice to the community and hospital midwives to enable them to support and care for that Midwife's own caseload women. The specialist midwives also carry case-loads of women who require specialist support. The trust might wish to note that the availability of these specialist midwives was not widely known by staff we spoke with on the day of our visit. At that time we were advised that such specialist care is provided by midwives who have an interest in certain specialist subject areas but who are not employed specifically for that purpose.

1.23. Expectant mothers across Cambridge who do not meet the threshold for specialist intervention are cared for well by the network of community midwives and children's centres. There are good working relationships between the community services and GPs who can signpost families for further support from other community based services.

1.24. At the Rosie hospital the use of the EPIC computerised patient record system enables all health professionals at the hospital to have access to the latest patient information. This is provided it is recorded appropriately and all staff know how to find it. However, community midwives based at eight locations in the county do not yet have access to the EPIC system. As such, practitioners in the community are dependent on their colleagues to provide updated or discharge information by way of email. The over reliance on staff to share information in this way means that there is the potential for elements to be missed in a busy ward environment. For example, in complex cases, with a range of professionals involved, it is essential that all parties are reliably informed of discharge arrangements to ensure ongoing care at the discharge destination. This is particularly important if mother and baby are discharged to different addresses or the discharge destination is out-of-area. Since this information sharing arrangement is informal and not monitored we could not be assured of its effectiveness in getting key information to professionals who might use it to help them to plan postnatal care. ([Recommendation 1.3](#)).

1.25. At Hinchingsbrooke hospital staff do not use the EPIC system but use hand-held, paper-based records instead. Record keeping in maternal hand held notes is not always complete. Social information such as ethnicity and religion are often missing. This information is necessary to help staff to meaningfully consider the woman's religious, ethnic or cultural needs and to plan how these will be addressed during pregnancy, birth and postnatal care. ([Recommendation 2.3](#)).

1.26. The 'Service Planning and Care Pathway' form for Vulnerable Women (V3 form) appropriately highlights concerns at an early stage. These forms are completed comprehensively and are regularly updated throughout pregnancy. However, there are no consistent flags in the maternity hand-held notes to signpost staff to concerns or vulnerabilities recorded elsewhere such as the V3 forms. In the records we looked at the brief social assessment sections within the hand-held records were not always updated three times during pregnancy as required by the procedures. Furthermore, the hand-held notes did not sufficiently identify those instances where staff needed to look for V3 forms and a check box on the inside cover of the notes intended for this purpose was not always ticked. Whilst we acknowledge that there are risks of unwanted discovery of sensitive information if it is kept in patient-held records, the inconsistent means of alerting staff to information recorded elsewhere means that such information could be overlooked.. We saw that the V3 forms are used as an effective intra- and multi-agency information sharing tool and include action plans where appropriate. Action plans we looked at, though, did not always contain timescales. There is a risk that this might lead to drift in ensuring services are engaged in a timely way. ([Recommendation 2.3](#)).

1.27. A good range of additional support is available to parents through the health visiting service and families of children under five years of age benefit from good delivery of the 'Healthy Child' programme. All families are offered an antenatal contact and receive a new birth visit, a six week visit and three to four month contact. Development reviews are provided at between 10 – 12 months and again at two-and-a-half years although the new, integrated two-and-a-half year development check is not yet available to children in Cambridgeshire.

1.28. All families with children under five years of age who move into Cambridgeshire are sent a letter by the health visiting service. The letter welcomes them into the area and advises them of local health services and support through the children's centres. A senior health visitor screens the records of all children moving into the area; those families with children under two-and-a-half years, or those where there is any identified vulnerability, are offered a home visit. This helps to ensure engagement with the Healthy Child programme and the opportunity to respond to any identified or emerging need.

1.29. A good range of additional support is available to parents through the health visiting service. Assessment of maternal mood has become more sophisticated through new screening tools. Health visitors can offer a series of 'listening visits' and can facilitate referrals to GPs or to specialist perinatal mental health services. New parents can also access baby massage and baby essentials where they can learn about how to recognise and treat minor illnesses in infants. Health visitors work closely with the local children's centres and use nursery nurses effectively to provide packages of support around toilet training, sleeping and other needs.

1.30. We saw evidence of good collaborative working between health visitors and children's centres and the Common Assessment Framework (CAF) was well understood and used by those health visitors we spoke with. One CAF plan we looked at clearly identified the goals that a family needed to achieve, although there were no timescales included.

1.31. A number of specialist health visitors are available to offer consultation and advice to practitioners working with families with additional needs. These include parents of children with complex health needs, travelling families, families who require support with the care of the next infant and where there may be issues of attachment between the mother and the infant.

1.32. The Integrated Contraception and Sexual Health services (iCASH) provided by the Cambridgeshire Community Services NHS Trust (CCST) has good links with GP surgeries. GPs have a good pathway into the iCASH services for additional advice and support, and an outcome of the referral is shared with the referring GP as long as consent has been gained from the young person.

1.33. Arrangements for assessing risk to children under 16 in iCASH are generally good and the service's computerised client records system known as 'Lillie' is used to record these assessments. Consent is appropriately gained from all children under 16. A mandatory field on the system prompts staff to use the relevant guidelines (Fraser guidelines) to assess their competence to provide consent about contraception and we saw that this is consistently applied.

1.34. An under 16 risk assessment is completed and reviewed at every new episode of care for such young people in the iCASH service. Young people are also routinely asked whether they are known to other services, including children's social care, and we saw that details of social workers were clearly documented within the records we looked at. This is good practice and shows that practitioners fully assess potential vulnerabilities of young people at every contact.

1.35. However, vulnerabilities of young people aged between 17 and 18 are not routinely checked. An under 18's checklist is currently being developed which will be added to the Lillie system once it has been agreed. The current checklist does not include any questioning about domestic violence, and we found that practitioners do not routinely record details of the young person's sexual history. There is currently no formal management oversight of young people's attendances to ensure that appropriate questions are being asked. As a consequence, the risk of exploitation might not be thoroughly assessed or opportunities to refer onwards for early help might be missed. ([Recommendation 4.1](#)).

1.36. Young people have access to iCASH services in both generic and young people specific clinics across Cambridgeshire, Monday to Friday. This service is provided from three main 'hubs' and a number of satellite, or 'spoke', locations. This includes a joint initiative with the Terrence Higgins Trust to provide outreach services in a number of different venues including schools, youth services and local communities.

1.37. Drop-in services for young people are provided by the iCASH service to coincide with school finishing times. In order to further meet the needs of children in outlying areas, a band six nurse employed by iCASH delivers a weekly lunch time service in some schools that are geographically further from the hub or spoke centres. This is good practice, as young people are able to access sexual health and contraception advice at a time and in a location that suits them best. Whilst access to iCASH services is generally good, we found that there was no specific service targeted at children who are looked after. This has the potential to overlook a particularly vulnerable group of young people, particularly since we learned that pregnancy rates in children looked after and those leaving care are higher as reported below in 'Looked after children'.

1.38. During our visit to the Child and Adolescent Mental Health service (CAMHS) provided by CPFT we learned of a single point of access to the service. The function of the single point of access is to screen all referrals and ensure that a CAMHS clinician has the opportunity to consider risks and assess the urgency of the referral after contacting the family of the child concerned. Thereafter the clinician identifies which team is best placed to see the child.

1.39. Referrals are received into the service from, for example, GPs or the school nursing service but excludes referrals through the emergency departments. The single point of access is located in the same premises as the multi-agency safeguarding hub (MASH). The staff we spoke with felt this was a strength of the system as it enabled them to discuss individual cases with the MASH team, consider risk and make appropriate referrals there and then. This was demonstrated in the case files we sampled where we saw good examples of interagency communication and information sharing.

1.40. We noted that the trust's computerised records system, known as 'RIO', was often not used to its full potential to support practitioners in making decisions about young people's needs. In each of the cases we looked at, the child or young person's key relationship details, such as parents, siblings and carers were not routinely recorded, even though the system is set up to prompt practitioners to capture it. Such information is essential for professionals to understand and assess the impact family life may have on a child and the impact that the child or young person's behaviour or mental health may have on their family members. In turn this helps practitioners to understand what other services the child or family might benefit from. The absence of this information meant that we could not be assured that it had been considered in the assessment of the child's needs or that it would be passed on if the case was transferred to another practitioner. ([Recommendation 3.5](#)).

1.41. All referrals that would ordinarily be managed through an intervention at tier two of the 'CAMHS Strategic Framework' were referred back to community services. All cases of children who would ordinarily be subject of core CAMHS were held on the provider's waiting list to be seen. Such children would be those who required an assessment and more specialist treatment at tier three of the framework for more complex, severe or persistent disorders.

1.42. However, by far the biggest issue we encountered during our review is the impact that the capacity of the CAMHS to manage its waiting lists has had on the experience of children in Cambridgeshire and on other health professionals. Data was made available to us that showed that significant pressures brought about by an increase in demand for core CAMHS services alongside an unprecedented increase in emergency work, has led to a breakdown of the trust's ability to manage its waiting lists for that core and planned work. For example, we noted that the average wait time for core services was 45 weeks.

1.43. The impact of this on other services has been significant. For instance, we learned from the school nursing service that young people requiring emotional support are being signposted, where possible, to online support services and self-help. However, we were advised that some young people continue to self-harm or overdose whilst waiting for further support. We were told that school nurses were finding it increasingly difficult to undertake any proactive health promotion work due to having to emotionally support children and young people who might otherwise be in receipt of other mental health care. Since the school nursing service operates generally during term time, we learned that children and young people's GPs are being advised of the potential requirement for support to this vulnerable group during school holidays. The risk of young people who require emotional support during this time being overlooked is unknown.

1.44. The situation for children awaiting an assessment and support for Autistic Spectrum Disorder (ASD) or Attention Deficit Hyperactivity Disorder (ADHD) is worse. The average waiting time has risen to 52 weeks with the longest wait time being 84 weeks. As a result, the waiting lists for children referred for an assessment for ADHD and ASD were closed in May 2015. Such children would not be seen by the CAMHS unless they were already being treated with medication, had an associated urgent medical health need or were transferring into the service from another trust.

1.45. We are aware there has been considerable dialogue between the CPFT and the commissioners about how this unmet need will be resolved. We have been told that there is an expectation that the trust will re-establish the waiting lists by November 2015. We also know that there is a service redesign taking place that will involve the creation of a multi-agency single point of access for all health services, ensuring that those children who would ordinarily be referred for assessment by CAMHS are subject of early community work at tier two by other teams. However, this is not likely to be in place until sometime during the latter part of 2016. In the meantime, we make it clear that the inability, to here and now, meet the needs of those children affected by this service breakdown is unacceptable. ([Recommendation 5.1](#), [recommendation 5.2](#)).

1.46. We saw evidence that the 'Think Family' approach to considering risk to children and opportunities for early help was well embedded in adult services. For example, the adult mental health service considered children to whom their clients had access by using a 'Keeping Children Safe' assessment tool. This tool is based on the three attributes of the well-established Department for Education (DfE) Assessment Triangle; child's developmental needs, parenting capacity and family and environmental factors. The adult substance misuse service have developed very effective methods to both record the details of children and young people with whom their adult clients have contact but also ensure those details are routinely updated should the person's circumstances change, such as when entering into a new relationship. In each of these services we found evidence through our case sampling to show that these approaches were well understood by practitioners and that opportunities to signpost clients to other services of benefit to families were taken.

2. Children in need

2.1 Practitioners dealing with adult patients in Addenbrooke's hospital emergency department are routinely expected to identify and record details of any children or young people who are being cared for by an adult patient with risk taking behaviour or mental health needs. This is done by means of prompts on the EPIC electronic patient record system. However, as we have reported above in 'Early help', there is a reliance on practitioners to complete such records. Apart for the weekly check for completeness by the allocated band six nurse, there is no formal audit mechanism to monitor how effective the system is in highlighting all such children. This means that the CUHFT cannot be assured they are identifying all children in need or at risk in such circumstances.

2.2 Where any safeguarding concerns or children in need are identified, all practitioners in both the adult and paediatric emergency department at Addenbrooke's hospital are routinely prompted to refer to children's social care. Referrals are initially made by telephone to children's social care, and this is followed up in writing within 24 hours using a templated multi-agency referral form (formerly known as a statutory intervention form). This form is then faxed to children's social care and a copy is also sent to the trust's named safeguarding nurse. The named nurse then notifies the health visitor, school nurse or GP to ensure all health professionals have a clear picture of the child's needs and any concerns.

2.3 The quality of referrals seen from both adult and paediatric emergency department practitioners at Addenbrooke's is generally poor with limited information recorded. Practitioners do not routinely and fully articulate the perceived or actual risk to children and young people or their needs. The amount of information and detail recorded on the statutory intervention or multi-agency referral form is inconsistent. For example, in the referrals that we dip sampled, some practitioners had recorded full details of other siblings in the household, whereas other referrals we looked at did not demonstrate any exploration of siblings or significant others. We have since been advised that all referrals are reviewed by the named nurse and in her absence, another safeguarding children professional when further information coming to light is then added although we did not see examples of this on the day of our review.

2.4 The absence of a formal paediatric liaison role at Addenbrooke's hospital has led to this function being carried out by the named safeguarding nurse. We were advised that the named nurse provides *ad-hoc* safeguarding advice and guidance and ensures that all safeguarding concerns are signposted to the appropriate person or team for further assessment. We found, however, that there is an over-reliance on individual staff members to inform the named nurse of any referral made to children's social care or of any safeguarding concerns. In large part this is as a result of the extent of the role and the capacity of the named nurse.

2.5 We have since been advised by the trust that a live daily electronic report of all young people under 18 and any other safeguarding information is generated within the emergency department and other in-patient units. We have been told that this is accessed frequently by the named nurse and is also available to the named doctor and trust safeguarding lead. However, we were not made aware of this report during our review and its use as a monitoring tool was not evident during our visit. We could not be assured, therefore, that all cases of concern are being recognised and directed for appropriate care and support following attendance at the emergency department. Furthermore, the absence of management oversight of referrals to children's social care from the Addenbrooke's hospital emergency department reduces the opportunity to take learning from the process in order to improve quality and consistency. ([Recommendation 1.1](#)).

2.6 Hinchingsbrooke hospital emergency department practitioners demonstrate professional curiosity and frequently identify children, young people and families that would benefit from additional help, advice and guidance from their health visitor or school nurse. In such cases a health visitor or school nurse liaison form is completed which explicitly states what the initial concern is and what action the emergency department practitioners are recommending. These forms are sent in addition to the routine sharing of information on all attendances to the emergency department by children and young people to their GP and health visitor or school nurse and we saw evidence of them being completed consistently. The named nurse for Hinchingsbrooke hospital routinely checks all emergency department attendances of children and young people to ensure that any potential safeguarding or child protection concerns have been identified and appropriately referred.

2.7 At Addenbrooke's hospital emergency department all children and young people up to the age of 16 in mental health distress or following incidents of self-harm or substance misuse are routinely admitted to a paediatric ward to await CAMHS assessment prior to being discharged. Young people between the ages of 16 and 18 are admitted to the clinical dependency unit (CDU) for assessment. CAMHS practitioners call the CDU and paediatric wards every morning to check if there have been any admissions requiring their attendance and we were advised that all children and young people are seen by a CAMHS practitioner within 24 hours if requested. We found that, generally, the relationship between CAMHS and the emergency department at Addenbrooke's hospital is effective and ensures children are assessed in a timely way.

A serious incident report highlighted the case of a young person who was admitted to the CDU in acute mental health distress. A specialist bed placement could not be found anywhere in the UK to accommodate the young person and they were kept on the CDU for five days. As a result of their disruptive behaviour a four-bed bay in the unit had to be closed to other admissions during this time.

The case presented as a challenge to practitioners on the unit. Following a serious incident review of the circumstances in the case, significant learning points have been acknowledged and actions taken to mitigate the risk of this kind of incident re-occurring. These include; providing access to the trust's electronic medical records to CAMHS staff; implementing a pathway for managing children and young people in a similar position; and clear, documented management plans which include details of appropriate nursing interventions, therapeutic opportunities and review timescales. ([Recommendation 8.1](#)).

2.8 We learned that occasionally children have to be seen in the first instance by an adult psychiatrist who has access to remote advice from a paediatric psychiatrist. This is a knock-on effect of the significant capacity issues in CAMHS and has been introduced as an interim measure to enable CAMHS practitioners to make in-roads into their waiting lists. As we have described above in 'Early help' in relation to school nursing, this arrangement is not the only one where other parts of the health service have taken on additional work owing to the capacity of CAMHS to manage a service that they would ordinarily provide. ([Recommendation 5.1](#)).

2.9 The current arrangements to support children and young people who attend the emergency department at Hinchingbrooke hospital following an incident of self-harm or overdose are not compliant with NICE guidelines setting out special considerations for such patients. Those young people who attend the emergency department between 9am and 4pm, once medically fit, can access a CAMHS assessment, either in the emergency department or at the local CAMHS clinic. However, young people who attend out-of-hours where there is no medical need for admission can often face extended stays in the emergency department whilst practitioners from the three providers negotiate an appropriate care pathway. The paediatric ward does not admit young people to the ward where there is no medical need and where no CAMHS assessment has taken place. This is a long standing issue in Cambridgeshire and despite regular meetings taking place between all three providers the issue remains unresolved. This is not in the best interests of vulnerable young people who need support and care. ([Recommendation 7.1](#)).

2.10 At the Rosie maternity hospital, completion of a template under the safeguarding section of the expectant mother's record on the EPIC system helps to ensure staff are aware of recognised risks. This template prompts practitioners to record a brief summary of concerns, the status of the unborn child in relation to whether there is a CAF plan, a child in need plan or a child protection plan, as well as a list of professionals involved with the woman or family. When fully completed staff have clear and concise information and guidance on who should be contacted if circumstances change, or at delivery and discharge. This aids multi-agency communication, joint working and information sharing.

2.11 However, as we have reported above under 'Early help', there is an over reliance on staff to share information with the community teams, including health visitors, by way of email. The absence of formal monitoring of the effectiveness of this arrangement carries a risk of key information being overlooked. This is exacerbated by the often cancelled monthly meetings between the hospital midwifery service and the health visitors. This adds to the risk of health visitors being unaware of vulnerability or risk prior to scheduling antenatal visits. ([Recommendation 1.3](#)).

2.12 We found that health visitors are routinely invited to child in need and child protection meetings with children's social care and that they regularly attend and contribute. However, we were informed that sometimes staffing shortages within health visiting teams led to a lack of health visiting activity in some cases. In one of the cases we tracked, a child who was subject of a child in need plan, there had been a period of up to three months when there had been no contact from the health visiting team.

2.13 Each GP practice across Cambridgeshire has an allocated link health visitor. In some GP practices there are regular vulnerability meetings or opportunities for the health visitors to discuss any families of concern. We heard of particular good practice in one GP surgery where the primary care team, the health visitor, midwife and children's social care attend the meetings.

2.14 We were also told that some GP practices have not engaged with these meetings. In one particular GP practice the health visitor has not attended any meetings at all. This practice is too variable and means that some vulnerable and complex families may not be receiving a co-ordinated approach to their care. Effective communication is further inhibited due to the inconsistent use of the primary care patient record systems to mark particular issues (a process known as READ coding) by GP practices across the county.

2.15 In CAMHS, most records we examined and all of the more recent records include detailed risk assessments. Risk assessments are appropriately updated to reflect any changes. In turn, the risk assessments inform the crisis relapse care plan and the patient's general care plan. Young people are provided with a copy of their care plan and are asked to sign to say whether they agree or disagree with its contents. This is a dynamic approach to managing changing risk and patient involvement and we consider this to be good practice.

In one of the cases we were tracking across different services, we saw that a young person aged 17 had been discharged from CAMHs in March 2015, despite the young person still exhibiting risk taking behaviour. There was no explanation in the records why this had been the case, other than the fact that the practitioner responsible for their care had left the trust's employ.

Several entries in the records after this showed that the young person's behaviour at school was still a cause for concern but that there was a reluctance on the part of the CAMHs to become involved due to the case being 'closed'.

A later entry showed that the CAMHs had allocated a practitioner to attend a professionals meeting about the young person and that the service had begun to work with the person once more. Whilst we were assured that the young person was continuing to receive the service, it was not clear why the decision was made to discharge the patient or the decision to re-commence engagement. In this case there was an unnecessary gap in the continuity of the young person's care plan. ([Recommendation 3.6](#)).

2.16 School nurses in the county told us they have good access to all school academies including faith schools. Services offered include sexual health advice, condom provision via the C-card scheme and chlamydia testing. The service also provides emotional support, especially where CAMHS referrals have been unsuccessful.

2.17 Part of the service's role is to provide personal, social and health education training to children and young people. However, we were advised that this is becoming increasingly more difficult due their commitment to support children emotionally where they would otherwise be receiving such support from mental health services. Furthermore, staff told us they were challenged by this additional need as not all of the workforce were skilled or equipped to support children with more complex needs that would ordinarily require care at tier three of the CAMHS strategic framework. ([Recommendation 5.2](#)).

3. Child protection

3.1 All health staff refer to threshold guidance known as the 'Model of Staged Intervention' (MOSI) to help to decide the appropriate level of intervention to meet any child or young person's needs. This includes guidance on when to pass on concerns either within or outside the health services. We were told that health visitors found the threshold document easy to understand but that application of the thresholds when responding to child protection referrals could vary depending on the children's social care worker allocated. This had led to some areas of dissonance and, although we were not presented with any specific examples, some health practitioners told us that they were not confident that the MOSI had been effective in resolving professional disagreements about the level of intervention.

3.2 In the foregoing sections we described risks arising from the absence of a formal monitoring process for checking information about children and young people and their families in the Addenbrooke's hospital emergency department. There are similar issues with a lack of managerial oversight or audit of child protection referrals made to children's social care with an over reliance on individual staff members to inform the named safeguarding nurse of any safeguarding concerns or referrals. It should also be noted that there was no named safeguarding professional or deputy present on the day of our visit who could advise us as to the way monitoring might take place other than what was evident in the cases we sampled. Practitioners we spoke to were unaware of any other deputising arrangements

3.3 Although we saw that the named nurse is considered a valuable resource and contact point for advice and support, the nature of their role and their capacity to carry out regular monitoring means that there is a lack of consistency in the quality and detail of referrals. This was also the case for reports submitted to children's social care for child protection conferences where we noted variability in the detail of the content with some reports not articulating risk well.

3.4 The EPIC records system at Addenbrooke's hospital does not have a screening tool to prompt practitioners to ask questions relating to the risks of child sexual exploitation (CSE), unless they are directed to the statutory intervention or multi-agency referral form. There is an over reliance on practitioners in the emergency department to be aware of the types of questions they need to ask relating to CSE vulnerability and on their own professional curiosity. Opportunities for paediatric emergency department practitioners to identify children and young people at risk of CSE are therefore reduced. ([Recommendation 1.2](#)).

3.5 Young patients' records on the EPIC system have a 'FYI' flag, highlighted in yellow to alert staff to any additional information that might have been added. There is no other specific, prominent flag dedicated to alerting staff to safeguarding information such as whether a child or young person is subject of a child protection or child in need plan or is looked after by the local authority. Therefore, all such information is included as part of the FYI tab. We were advised that all staff that use the EPIC system can add information to a FYI tab including any information of concern. Furthermore, if a child from Cambridgeshire who is subject of such a plan is notified to the trust and the child does not yet have a hospital record then a record is created to alert staff should the child present at hospital, although we did not see examples of such cases during or visit. Copies of minutes of meetings, plans and court orders are scanned into the child's record attached to the FYI tab so that staff are aware of any vulnerable children.

3.6 At Hinchingsbrooke hospital emergency department, the care pathway for children and young people attending through alcohol or substance misuse does not sufficiently explore vulnerability. As a result, we heard that referrals to the young people's alcohol and substance misuse service are infrequent. This is a missed opportunity for services to work collaboratively and respond early to any emerging need. The pathway has also not been updated to reflect guidance on screening for the risk of child sexual exploitation (CSE). ([Recommendation 2.4](#)).

3.7 All children aged one year and under are assessed by a senior clinician before being discharged from the emergency department at Addenbrooke's hospital and this is seen as good practice.

3.8 Health visitors told us that they welcomed the 'Signs of Safety' model introduced by children's social care and that this had resulted in more effective engagement and involvement of vulnerable families. We saw child protection plans arising from the Signs of Safety conference that are outcome focussed and time-bound. However, some health visitors do not create their own, time-bound, outcome focused care plans to underpin the child protection plan. Without this planning it is difficult to assess and evidence progress.

3.9 In some health visitors files we examined it was clear that there is good joint working with children's social care. Health visitors are aware of how to make referrals to children's social care over the telephone, followed up with a written referral within 24 hours. The referrals to children's social care we looked at were of a good standard and clearly articulated practitioners' concerns and the reason for referral. We also learned that joint visits between health visitors and social workers were common and this, too, is good practice.

3.10 However, we found that reports submitted by the health visiting service for child protection conferences are not routinely quality assured. Although referrals are copied to the named nurse there remains variability in the content where some referrals do not analyse or articulate the risk. This is important as it helps children's social care to understand the health professional's concerns and what actions they suggest social care might take. ([Recommendation 4.6](#)).

3.11 The specialist midwives at the Rosie hospital participate in structured, multi-agency monthly meetings with community colleagues, health visitors, a link social worker and an independent domestic violence advocate. These meetings discuss the cases of all women who are due to deliver in the coming month where there are safeguarding concerns or if there is no postnatal discharge plan. Thereafter, records of the discussion and any plans are shown in the mother's notes on the EPIC system although the community midwifery teams do not yet have access to EPIC. We saw evidence of good multi-agency collaboration in one of the cases we were tracking across services and we have reported on this at the end of this 'Child Protection' section. We have also learned that the health visitors sometimes do not attend these meetings; this was borne out in our discussions with the health visiting teams. The effectiveness of these meetings could be strengthened by ensuring that health visitors are present at each meeting. ([Recommendation 1.3](#)).

3.12 At both hospitals' midwifery departments, we saw that expectant mothers whose first language was not English have access to a telephone interpreting service. This means there is no need to rely on family members or friends to translate on their behalf. This is particularly important when sensitive questions are being asked, such as in relation to domestic abuse and paternal factors.

3.13 Although we were assured that questions in relation to domestic abuse were asked at least three times during pregnancy we did not see any routine recording of the process taking place in either the electronic records at the Rosie or the paper records at Hinchingsbrooke hospital. The recording of questioning about domestic violence and paternal factors in any format is important, especially when more than one health professional might work with the expectant mother. This means that the effective assessment of potential impact on the child of domestic abuse or of paternal health and lifestyle choices could not be demonstrated. ([Recommendation 1.4](#), [recommendation 2.3](#)).

3.14 We saw that the minor injuries units (MIU) often prescribe emergency contraception and we reviewed the template for this on the computerised records system known as 'SystmOne'. We saw that there is no risk assessment facility on the template for patients under 16 year of age and no readily accessible checklist for assessing the risk of CSE. Furthermore, the SystmOne template for paediatric attendances has a link to a safeguarding screen which is intended to prompt staff to consider risks. We saw that this is not always completed and that there is no mandatory prompt question to force the practitioner to consider safeguarding concerns. Instead, nurses rely on their own experience and professional curiosity to ask questions and this means that the potential for harm may be overlooked. ([Recommendation 3.4](#)).

3.15 Moreover, we saw that the MIU do not keep any record of safeguarding referrals to children's social care or safeguarding enquiries they make to the trust's safeguarding team. Staff we spoke with were not able to identify any referrals that had been made to children's social care or the safeguarding team. The absence of any paediatric liaison function meant that there is no supervisory oversight of children's attendances at the unit and no quality assurance of referrals made. This creates a potential for parents of abused children to exploit this possible weakness in the MIU's ability to identify such concerns. ([Recommendation 3.1](#)).

3.16 We also encountered a lack of awareness of the practical application of CSE policies and procedures in the minor injuries unit. Understanding of indicators of vulnerability and of the means to carry out CSE risk assessments were not evident and this, too, is despite the heightened profile afforded CSE over the course of the last year. ([Recommendation 3.8](#)).

3.17 In the adult substance misuse service we found that the 'think family' approach is well embedded within practice. Managers work closely with commissioners and have together developed highly effective records management methods. These include recording the details of children and young people with whom adult substance misusers have contact and ensuring that those details are routinely updated should the person's circumstances change, such as when entering into a new relationship. For example, the practitioners use child and family checklists to determine information such as, whether their clients have contact with children, whether the client is pregnant, whether the family is known to children's social care and what the arrangements are for secure storage of medicines at clients' homes.

3.18 We saw that practitioners make detailed records when concerns are identified using a bespoke document for that purpose. This is then used as the basis of a discussion with the practitioner's manager and the decision about what further action to take is logged. In some cases this results in a referral being made to children's social care. Referral forms we examined were comprehensive, detailed and clearly articulated the risk to the child or young person the client had access to.

3.19 We examined evidence that clearly demonstrated to us that safeguarding children plays a significant part of the recovery worker's relationship with their clients. There is significant effort being put into a continued assessment of risk both whilst the client is in treatment but also during the 'step-down' period once treatment is no longer required.

3.20 We saw that practitioners in the contraception and sexual health service, iCASH, are unclear about the existence of local groups set up to manage the response to CSE. Therefore, they are not currently represented at, or partners of any CSE operational or strategic management meetings. This means that iCASH cannot contribute views to the way CSE is managed locally. Moreover, this is a missed opportunity to gather or share meaningful information and intelligence to help decision making about potentially vulnerable young people in Cambridgeshire at risk of CSE. ([Recommendation 4.2](#)).

3.21 We found that, although the current 'Lillie' records system in use at the iCASH service has recall functionalities, practitioners are not utilising this to identify young people they might wish to monitor more closely. In addition, although there is a 'caution register' on the current Lillie system, there are no pop-up alerts on the system to identify additional vulnerabilities. For instance, whilst allergies, HIV patients and whether or not consent is given to share information with GPs are shown, there is no scope to show safeguarding concerns. This means practitioners do not have a complete picture of any risks when dealing with children and young people. ([Recommendation 4.3](#)).

3.22 Practitioners in the iCASH service clearly identify the pathways to follow if they have safeguarding concerns for a young person. However, they do not make referrals to children's social care. We were told this was because vulnerable young people who attend iCASH services are generally known to social care and already have a social worker allocated. This is a dangerous assumption to make and has the effect of abrogating responsibility to pass on concerns. This is compounded by the fact there is no supervisory oversight built into the process. ([Recommendation 4.4](#)).

3.23 Practitioners in the iCASH service are not invited to child protection conferences or to multi-agency safeguarding strategy meetings. This means that practitioners cannot contribute to the health and wellbeing of young people, with whom they have relevant involvement. Further, iCASH do not currently receive any child protection or child in need plans following core group meetings, largely as an effect of not making referrals. This means that iCASH practitioners may be seeing young people without knowing what issues might be relevant. This is a bigger issue for young people aged 17 to 18 who are not routinely assessed using the risk assessment tool in use for children 16 and under. This issue has been identified by the locality service manager who told us of plans to introduce a generic email addresses for the three iCASH hubs. This is intended to enable children's social care services to notify and share safeguarding information more easily with iCASH practitioners. ([Recommendation 4.5](#)).

At one of the GP practices we inspected we saw that the professional culture and practices in relation to identifying and responding to children at risk were under-developed, particularly in relation to the risks of CSE. This is despite the efforts of the CCG over the course of the last year to raise the awareness of CSE through training and communication delivered to GPs.

In one of our tracked cases and in another case that we sampled, we saw that the children had both exhibited a catalogue of risk taking behaviour in relation to sexual exploitation. In each case, we learned of reported incidences of sexual activity in circumstances that exposed the child to exploitation but these were not recorded in the electronic patient notes on SystmOne. Neither was there evidence of the system's vulnerability flags being used to alert practitioners to the risks to the children.

In both cases there was no effective risk assessment in relation to CSE and the widely established screening tool was not in use on SystmOne.

Neither child had been referred onwards to children's social care under child protection procedures whereas the significant vulnerabilities and risk evident at the time they presented indicated that this would have been the correct action to take. ([Recommendation 10.1](#)).

In the second of the two cases, the child had been assessed under the Fraser guidelines as being competent to be given contraceptive advice and this advice had been provided. However, the assessment of competence was carried out on one occasion only and there was no regard given to the potential for the child's capacity to consent to evolve over time. There was no inclination to re-consider the child's capacity to consent despite there being additional risk factors reported since the original assessment had been made. ([Recommendation 10.2](#)).

We have referred both of these cases back to the CCG for further exploration.

3.24 In the CAMHS service, we saw that referrals to children's social care are held within the RIO case records. These are comprehensive and show a clear analysis of the risk to the young person and the actions required by children's social care. We could see that the MOSI threshold document was used as a reference point in the cases we looked at. We saw that a corresponding Datix record is generated each time a referral to children's social care is made and this is copied to the trust's safeguarding team. This enables a good level of oversight and monitoring.

3.25 As we have reported above under 'Child in Need', the process for identifying risk and adapting care plans to take account of, or to manage risks is well developed in CAMHS. Most records we looked at include detailed risk assessments which in turn, inform the care plan and a crisis relapse care plan. The risk assessments are appropriately updated to reflect evolving risk. In one of the cases we were tracking, however, there was no clear evidence of CAMHS staff considering CSE or using any CSE tool to assess such risk. This was despite concerning disclosures made by the young person over a period of time. Staff told us that action taken in such cases would be reliant on professional judgements and dependent upon the individual case but this was not evident in the case notes. ([Recommendation 3.7](#)).

3.26 The CPFT Safeguarding Handbook is accessible to all staff across the trust at each computer terminal, including the CAMHS and adult mental health practitioners, by means of a desktop icon entitled 'Safeguarding Satchell'. Among other aspects of safeguarding children, the handbook prompts practitioners, particularly those in adult services, to 'think family' as part of their initial assessment of patients. For example, as reported above in 'Early Help', staff make use of this approach by completing an assessment tool known as 'Keeping Children Safe'. This is accessible as a prompt from the patient's records on the RIO system. The tool prompts practitioners to consider whether anyone with mental ill-health is a parent or has access to children. The tool has a series of questions about any identified child's developmental needs, parenting capacity and other family and environmental factors and is based on the 'Framework for the Assessment of Children in Need and their Families'. In each of the cases we sampled, we found that this tool was completed, although it was unclear in cases where the tool was not completed whether questions regarding children had been considered or asked.

3.27 We found that adult mental health practitioners effectively use the alert functionality on the trust's IT system to highlight safeguarding concerns. This is good practice as it helps to highlight concerns and risk in relation to safeguarding children and its use is routine across the service.

In the adult mental health service, we saw evidence that a perinatal mental health pathway is in place for clients who were expectant mothers. One of the cases we sampled demonstrated effective interagency collaboration between the adult mental health service, the specialist mental health midwife, the obstetric team and legal advisers. The services involved took a co-ordinated approach to the management of a particularly complex case over a protracted period of time, during which the changes to the risk of harm were considered in a dynamic and multi-disciplinary way leading to a positive outcome. In the adult mental health service for example, we saw that the service manager had arranged for some training by the midwifery team to help reduce any anxieties they had about caring for a pregnant woman who was mentally unwell. We consider this to be an example of good, innovative practice towards a good outcome for this patient and her unborn child.

4. Looked after children

4.1 We saw that the looked after children (LAC) service has recently introduced some changes in their approach to carrying out health assessments. These revised arrangements have resulted in more assessment activity being carried out by the LAC team. We also learned that there have been significant efforts by the LAC designated doctor, since coming into post in September 2014, to address quality and consistency issues across initial and review health assessments. For example, the designated doctor has promoted consistent use of strengths and difficulties questionnaires (SDQs) for looked after children and these were available in many files. However, the SDQs were often not available in time to be discussed in reviews and assessments. In one case we looked at the indicators for the risk of child sexual exploitation (CSE) that had been apparent in the SDQs had not been followed up with a CSE risk assessment.

4.2 In this standardised approach, initial health assessments (IHA) for children other than those aged 16 and over are largely undertaken by the designated doctor and community paediatricians. Previously, GPs carried out most assessments of children aged 10 and under, whereas this number has now significantly reduced with those GP led assessments now being quality checked by the designated doctor. Under the current arrangements review health assessments (RHA) are carried out by the LAC nurses, one of which specialises in children aged 16 and over with the other predominantly working with children under 16. Where the school nursing service is already involved with a child then we learned that the school nurses carry out RHAs.

4.3 The newer arrangement helps consistency as it allows the designated doctor to write all children's health plans arising from IHAs and RHAs using an enhanced template. We saw greater consistency and depth in many health plans we looked at compared to past examples although in some cases there was a lack of clarity about desired outcomes and a lack of information about whether the child's voice had been considered. We saw that the scale of this task is daunting with a corresponding risk of it being unsustainable due to the large number of plans and the multi-faceted role of the designated doctor. Furthermore, whilst there are benefits to consistency, the process actually distances young people and their carers from health action planning as many of the plans arising from RHAs are necessarily drafted some time after the assessment. ([Recommendation 4.7](#)).

4.4 We were made aware that the LAC nurses complete IHAs for children aged 16 and over who are new in care, as well as RHAs for this group of young people. This is not compliant with the statutory guidance on 'Promoting the health and well-being of looked-after children' (DfE and DH). An examination by a medical practitioner for children and young people new in care should be the normal offer, with nurse assessment only appropriate where there is a confirmed refusal to engage with medical practitioners. ([Recommendation 4.8](#)).

4.5 We saw that the service use the standard British Adoption and Fostering Agency (BAAF) documents to record assessments of looked after children. It is generally the practice looked after children services to share the third part of these forms, the part C summary, with the local authority in order to form part of the child or young person's care plan. Part B of the form is ordinarily held as confidential between the health service and the young person. It is unusual to find looked after children services that share the complete health assessment with the local authority. The records we sampled records do not indicate if consent is being obtained from competent young people under the age of 16 to share their confidential health information with social care and there is a risk that this breaches their confidentiality. ([Recommendation 4.9](#)).

4.6 We saw that the capacity of the LAC team, including the designated doctor, has been severely stretched due to an increase in the volume of work. The recent appointment of an interim team leader is yet to show a positive effect on this capacity. This has been brought about, in part, by an extension of the geographical area of responsibility of the LAC team to children who are placed up to 20 miles beyond the county border. For example, we learned that the number of children and young people in care for one year or more at the time of our review was 365, an increase over the 309 from the previous year, with 15 children and young people who were new in care in the previous week alone. In addition to the designated doctor, the service's clinical work is carried out by just 1.8 whole-time-equivalent nurses.

4.7 This increase in workload has an impact on the quality of record keeping, particularly since there is still a dual, paper and electronic records system in place which creates demands on practitioners' time. Moreover, the capacity pressures have an adverse impact on the ability to keep an effective oversight of the waiting list. In one case, a carer told us that they had sometimes had to wait up to six to eight weeks for the child in their care to be seen. These extended timescales were evident in many of the records we sampled where we noted delays in timescales throughout the process. These include delays between referral to IHA, delays in production of a health action plan, delays in RHAs being carried out by the due date and delays in being referred to other services. There is a risk that such delays may leave looked after children and young people having to wait an unacceptable time with unmet health needs. ([Recommendation 9.1](#)).

The looked after children service demonstrates good practice by extending their contact with young people into the first year after they leave care. However, care leavers placed out-of-county do not receive the same level of service due to the increased demands on the team's capacity. For example, one of our sampled cases, a young person placed out of county, has not benefitted from a sufficiently detailed health plan. Health issues have drifted in the years preceding leaving care. As they are out-of-county, there will be no health follow up as a care leaver. Their last formal review was in 2013 aged 15 and there have been only limited efforts to engage them since. ([Recommendation 9.1](#)).

4.8 Leadership by the LAC designated doctor is helping to enhance knowledge among the team about LAC health histories. The expected outcome of this would be more detailed ongoing health assessment and the production of relevant care leavers' health summaries. There are, however, no current arrangements to provide care leavers with a health summary document or passport which would ordinarily be good practice. Although their use has been discussed in the past, no process has been established for producing such summaries and this is now long outstanding.

4.9 We were concerned to learn that the service was experiencing a problem of foster carers failing to bring young children to health assessment appointments. This might suggest that carers have not been prepared properly about what is expected of them although we also acknowledge that the capacity issues reported above have created difficulties in the availability of appointments with the service.

4.10 We learned that locally collected data shows that looked after children and care leavers in Cambridgeshire experience high rates of pregnancy including repeat pregnancy. We have been made aware that children's social care are seeking to address this with some personal safety education targeted at this group of young people. We also understand that the LAC nurse who specialises in children aged 16 and over has been engaging with the service commissioners to seek options to increase the outreach access to contraception and sexual health services for hard to reach young people in care. In the meantime we found a flexible and sensitive approach was taken by the LAC service to meet this need. We saw a good practice example of this flexible, child-focused and innovative work for one particularly vulnerable young person offered by the LAC nurse who specialises in children aged 16 and over.

5. 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 Historically there has been a high turnover of paediatric trained staff in the emergency department at Addenbrooke's hospital. However, we were assured that staffing levels are currently at prescribed levels and that there is always a paediatric trained nurse on duty on the unit at all times of the day and night. These staff are supported by adult trained staff who are rostered to work on the paediatric unit to gain experience.

5.1.2 At Hinchingsbrooke hospital most children and young people visiting the emergency department are cared for by appropriately trained sick children's nurses. The trust are making good progress in recruiting to paediatric posts and are on trajectory to ensure that a registered sick children's nurse is on duty within the emergency department at all times. Interim arrangements ensure that a sick children's nurse is always on duty from 7.00am to midnight, seven days-a-week which is their busiest times. Adult emergency department practitioners have received some training in caring for the sick child. In this way we saw that the HHCT had responded positively to our regulatory inspections in 2014 and earlier in 2015 when this was identified as an area for attention.

5.1.3 We have reported above on the limited management oversight or audit of safeguarding processes within the Addenbrooke's hospital emergency department, including referrals to children's social care. We have largely attributed this to the extent and scope of the named safeguarding nurse's role and their capacity to carry out their role to its fullest extent. We have been made aware that the CUHFT have responded to this and that steps are in train to provide adequate deputy named nurse coverage although there were no safeguarding professionals from the trust present on the day of our visit. It is hoped that the additional team members will enable the trust to provide proper oversight of records about children so that risks and concerns are consistently managed. ([Recommendation 1.1](#)).

5.1.4 At Hinchingsbrooke hospital emergency department, all referrals to children's social care are copied to the trust's named nurse. These are entered onto a database and when children's social care advise on outcomes these are then communicated to the individual who made the referral. Staff told us that they appreciated this feedback as it reminded them of the value of focussing on children's needs and taking action to protect children and young people.

5.1.5 At both the Rosie and Hinchingsbrooke hospitals we were advised that midwives have good working relationships with children's social care. Vulnerable expectant mothers can be referred at any time during pregnancy, if concerns emerge about the protection of their unborn child, even from the time of booking. Midwives regularly attend child protection meetings and prepare written reports whether they attend or not, if given sufficient time to do so. This is good practice.

5.1.6 At Hinchingsbrooke hospital maternity unit we were advised that regular, routine monthly meetings are scheduled with health visitors. We were further advised that these meetings are dependent on staff availability and do not always take place. This means that health visitors are sometimes not aware of any vulnerability before scheduling an antenatal visit. We acknowledge, though, that the impact of this is outweighed by the joint antenatal visits carried out by health visitors and midwives, which we consider to be an example of good service co-ordination.

5.1.7 The school nursing team provide an all year round service to the five to 19 population. Resources are significantly reduced during school holidays, however, as a large majority of the workforce work term time only with only two nurses covering the county during the holidays. The reliance on the school nursing service to provide support to young people who would ordinarily have access to longer term mental health support from the CAMHS service means that those children are at greater risk during school holidays. We learned of an arrangement to alert young people's GPs to any risks so that they could support patients if required but we were not assured that these arrangements were robust. As we have stated elsewhere in this report, the inability of the health services to deal adequately with this current unmet need is a significant risk to vulnerable young people. ([Recommendation 5.2](#)).

5.1.8 The local ambulance service share information with health visitors and school nurses about any safeguarding or health concerns that do not meet the threshold for child protection but where they feel the family may benefit from extra support. This is good practice as ambulance staff have a unique opportunity to enter the family home and observe relationships.

5.1.9 In one of the GP practices we reviewed we found that there were no multi-disciplinary team meetings with the health visiting service for the purpose of sharing information about particular families or children of concern. Instead, information is exchanged informally with the health visitor at fortnightly baby clinics. There is no record of any such discussions and so it is not possible to determine whether information sharing was meaningful or led to better outcomes for children. The scope of our review meant that our sample size of GPs was low and so we are not able to state whether this practice is common across the county's GPs.

5.1.10 We saw that there are two dedicated safeguarding professionals who perform the primary care safeguarding leadership function ordinarily carried out by a named GP. Part of their role is to assist GPs in undertaking audits of their effectiveness in discharging their safeguarding function as set out by section 11 of the Children Act 2004; a programme of these audits is in progress at the time of this review. As part of this audit, GPs are specifically asked about formal multi-disciplinary arrangements for discussing vulnerable families. It is hoped that this audit will enable primary care providers to develop their safeguarding practice. ([Recommendation 10.3](#)).

5.1.11 The use of alerts for vulnerable children and families on the patient records systems in use in primary care is not well developed or consistent. This makes it difficult for effective oversight of safeguarding needs and risk assessment. However, we acknowledge that the CCG are taking steps to address this through a cross-service IT working group to examine more effective ways of integrating the electronic systems in use in different providers.

5.1.12 We were informed that all iCASH services across Cambridgeshire are using the Lillie computer system. This has had a positive impact as it has strengthened communication and helped to create good links with genito-urinary medicine (GUM) services. The system has also had time-saving benefits, as practitioners are able to access information about any GUM screening or assessments carried out for young people or service users. This means that practitioners have complete access to all important sexual health related information about a young person, a clear benefit to young people of this integrated working.

5.1.13 We found that adult mental health practitioners generally have good partnership relationships with maternity services, children's social care, and community mental health teams. As reported on in 'Child protection' above, we learned of a particular case of a pregnant woman with significant long-term mental illness where exemplary practice arising out of strong partnership working between the mental health and maternity services had led to positive outcomes for both mother and baby.

5.1.14 As reported above under 'Early help' the most significant issue we encountered is the effect that the capacity of the CAMHS service to manage its waiting lists has had on the experience of children in Cambridgeshire and also on other health professionals. We acknowledge that there is considerable transformation work being undertaken by the joint commissioners and the CPFT in order to improve the way the service for children and young people with mental ill-health is delivered. In particular we have been assured that November 2015 is a realistic timescale for the trust to re-establish the waiting lists for ADHD and ASD. It is important to note at this point that any further delays in doing so will pose a further unacceptable risk to young people who are in this vulnerable group. ([Recommendation 5.1](#), [recommendation 5.2](#)).

5.1.15 Since taking up post in 2014 we saw that, with oversight from the joint commissioners, the designated doctor for the looked after children service has been working with children's social care to develop a whole systems approach to resolve issues about quality and timeliness of health support for looked after children. For example, we saw that a comprehensive and ambitious audit plan was due to commence later in 2015. This was intended to identify quality issues across the looked after children service but it is acknowledged that this has programme has yet to begin.

5.1.16 We reviewed an options paper for the looked after children service from July 2015 as part of a service review. This paper confirms the current challenges for looked after children services across the CCG and helpfully starts to discuss options to increase compliance with statutory guidance, such as the leadership roles of the designated doctor and designated nurse. However, the funding, capacity and training requirements are not fully gauged and the implications of the resource requirements for assessing children placed out-of-county or for children from elsewhere placed within Cambridgeshire are not fully understood. ([Recommendation 9.1](#)).

5.1.17 We found that the CCG have a clear picture of their priorities for safeguarding children and for the looked after children service despite the relatively complex healthcare provider landscape. For instance, the CCG covers two separate local authority areas and, as a result, two separate local safeguarding children's boards (LSCB), both of whom have recently required the CCG to carry out audits under section 11 of the Children Act 2004. In the county of Cambridgeshire alone, the acute, community and mental health services are provided by five separate trusts. Some of those services have been recently re-commissioned, moving from one trust to another. In some cases, different trusts occupy the same hospital premises and provide separate stages of patients' continuing care and this has led to historical issues that affect that care. For example, in 'Children in need' above, we have reported on the long standing, unresolved issue between three trusts affecting the care of young people experiencing mental health distress and admitted through the emergency department at Hinchingbrooke hospital.

5.1.18 Nonetheless, we found that the CCG's designated nurse and doctor provide highly visible and proactive leadership aimed at improving the safeguarding arrangements in the county. For example, we saw that the designated clinicians have been proactive in the ongoing work aimed at understanding the requirements of the looked after children service. Further, we acknowledge the work that the CCG has undertaken with the local medical council and NHS England to provide an alternative means of resourcing a named safeguarding role for primary care in the absence of a suitable medical candidate. This includes the support offered to the dedicated safeguarding professionals for primary care in carrying out section 11 Children Act audits as reported above and the provision of an information resource pack for GPs and primary care staff.

5.1.19 Some of the more significant activity of the designated professionals is the collaborative work with providers that has an impact on operational effectiveness. For example, we saw that the CCG has begun a project to improve the safeguarding capability of the many different electronic (and in some cases paper-based) patient records systems in use across the different providers. As the current systems are not well interfaced, this project is intended to significantly improve the way information about children in need or at risk is transferred and interpreted across providers.

We noted one particularly noteworthy example of collaborative work led by the designated professionals through a 'task and finish' group. This was set up to consider the 'whole service' approach to children for whom there are perplexing presentations. This resulted in the development of a cross-health protocol for managing concerns of fabricated or induced illness (FII). In this way, potential FII cases are considered by a group representing all health providers involved in a child's care in order to focus on the needs of the child and resolve difficulties in interpreting findings. Thereafter, FII referrals would be made as a whole health community as opposed to by a single provider. We saw that this had already been effective in three cases, one of which had led to a referral being made to children's social care and a resulting child in need plan.

5.2 Governance

5.2.1 As shown above, the CCG have designated safeguarding professionals in post with clear roles and responsibilities, accountable to the Director of Quality, Safety and Patient Experience. Both post holders provide leadership and direction to the named safeguarding professionals in the health network and are in a position of influence within the local health economy. For example, both designated professional sit on the quarterly Health Executive Strategic Group which includes key executive members from each of the acute providers, the CCG and NHS England.

5.2.2 In addition, the designated doctor and nurse manage a bi-monthly health safeguarding group for named safeguarding professionals in their area which is used as the basis for their communication and work-plan. For example, we saw that the group had provided direction on supporting GPs with section 11 audits and monitoring of the implementation of actions arising from serious case reviews.

5.2.3 The designated professionals told us that one of the strengths of their work had been the recent re-structuring of the reporting mechanisms on safeguarding children by the providers' named safeguarding professionals on a quarterly basis. We saw that the better quality of information enabled the CCG to challenge providers, through clinical quality review meetings, about their safeguarding performance where this was necessary. For example, we saw that the Patient Safety and Quality directorate of the CCG had been able to issue a performance notice and remedial action plan to one of the providers requiring them to meet a safeguarding training shortfall by June 2015; this had been achieved.

5.2.4 The designated professionals are also part of additional strategic processes in the area and this enabled the CCG to have an influence in the development of safeguarding practice on both a multi-agency basis and within the health sector. For instance, the designated nurse is a member of the multi-agency referral unit project board. One of the benefits of this has been greater recognition and understanding of the issues associated with disparate computer systems across the health services and has led to the initial steps being taken to taking steps to address the issues through the previously mentioned cross-service IT working group.

5.2.5 We saw that the CCG designated team were also members of both the strategic implementation group and operational groups dealing with child sexual exploitation (CSE). This led to the development of a CSE resource pack and screening tool by the LSCB for use in all multi-agency services across the county and the implementation of the LSCB CSE policy in health services. However, as previously reported above, the capability to screen for, record and take action about CSE was underdeveloped in some providers and we have made several recommendations about this.

5.2.6 We also noted an exemplary piece of work that demonstrated that the CCG were accountable to young people. We saw that the designated doctor had led a multi-agency group to consider female genital mutilation (FGM) that had representatives from the police, children's social care and health. This had resulted in the development of a pathway for children at risk of FGM including the LSCB-wide policy, and accompanying guidance. However, a significant influence on this project had been that of the children from two local primary schools who been consulted on the effectiveness of a leaflet warning of the risks of FGM for distribution to other schools in the area.

5.2.7 In most of the providers we looked at during this review, the named safeguarding nurses are clearly identified and held in high regard by their respective providers' executives. They have clearly defined roles and are accountable to their heads of nursing or appropriate lead professionals at executive level. This meets with the role descriptions as set out in the intercollegiate guidance on safeguarding roles and competences issued by the RCPCH on behalf of the other Royal Colleges. For example, the named nurse for CCST is accountable to the Chief Nurse and line managed by the children's service manager.

5.2.8 Governance arrangements within CCST have recently been strengthened. The safeguarding committee now has executive oversight and the trust board has strategic responsibility for all safeguarding matters. The named nurse is supported by a team of specialist nurses for safeguarding children, though one team member is on secondment to the MASH and one post is vacant.

5.2.9 The named nurse for HHCT is an interim post, however, recent changes to the governance structure across the trust have led to increased accountability and reporting to the trust board on safeguarding. The safeguarding committee is now chaired by a trust executive and is a formal sub-committee of the trust board.

5.2.10 The practice of carrying out and responding to safeguarding audits is well established across the health services. For example, since 2013, the adult substance misuse service has carried out an annual children's safeguarding audit where an average of 70 cases are examined to check the effectiveness of child safeguarding measures. Where necessary action plans are developed, staff training is implemented and required improvements reported to the LSCB. We looked at reports submitted to the CCG by the major providers since 2014 and have seen that this is a typical and well embedded approach.

5.2.11 The current arrangements for the provision of an out-of-hours (between 3pm and 9am) CAMHS service to the emergency departments at Addenbrooke's and Hinchingbrooke hospitals rely upon a CAMHS psychiatrist being available to provide advice to the trust-wide (CPFT) psychiatrist who is called to assess a young patient in the first instance. Between 9am and 3pm the service is provided by an on-call clinician and consultant for each hospital. The CAMHS service initiates a telephone conference every morning with the emergency departments and the duty psychiatrist to hand over management of the patients' care. This arrangement is supported by an on-call non-clinical general manager from CPFT whose role is to manage any escalation, such as finding a bed for a young person who requires admission.

5.2.12 The effectiveness of these arrangements is monitored by a cross organisational mechanism involving operational managers from the relevant trusts; six-weekly in the case of Hinchingsbrooke hospital and bi-monthly for Addenbrooke's hospital. This is further monitored by a six monthly strategic liaison meeting. We were advised that this model has been operating for the past eight months and that it has so far been effective. However, as we have reported above in the case of a young person admitted on to the CDU at Hinchingsbrooke hospital, the arrangements have been tested on one occasion that was escalated as a serious incident. ([Recommendation 8.1](#)).

5.2.13 We looked at evidence that showed that the looked after children service has been reviewed and audited periodically, including a recent service review. There have been very recent improvements in the performance data, due in large part to the leadership of the designated doctor for the looked after children service. However, the lack of clarity about the leadership role of the designated doctor and the absence of a designated nurse has meant that the pace of change against recommendations from audits has been slow whilst demand volume has increased. This is a priority piece of work for the CCG. ([Recommendation 9.1](#)).

5.3 Training and supervision

5.3.1 The take up of safeguarding training at levels one, two and three currently stand in excess of 90% across CUHFT. We were advised that training is LSCB approved but that individual practitioners have a choice as to whether they access their training, even at level three, by way of face-to-face sessions or by using an online package that was available. We were further advised that level three training is not provided on an inter-agency basis although we note that other agencies and specialist workers are often called in to deliver bespoke sessions on topics such as CSE, domestic abuse and the roles of police and social care. This is not in line with the previously mentioned intercollegiate guidance on roles and competences and it is not regarded as best practice. ([Recommendation 1.5](#)).

5.3.2 We saw that the interim named nurse for HHCT had not yet received level four training, however, they had already identified that this was a requirement for their role and steps were in train to organise that.

5.3.3 Hinchingsbrooke hospital emergency department staff attend level three safeguarding training. We were told that the HHCT is now on trajectory to become compliant with their level three requirement. However, we were not assured that training fully meets the requirements of the intercollegiate guidance in terms of number of hours and the inter-agency component. ([Recommendation 2.5](#)).

5.3.4 Hinchingsbrooke hospital emergency department staff do not access any formal safeguarding supervision. Newly qualified health visitors are supported through a buddy system with increased supervision and peer group meetings. However, the preceptorship does not contain clear safeguarding competences to help practitioners understand and demonstrate good safeguarding and child protection practice. ([Recommendation 2.6](#)).

5.3.5 The named safeguarding nurse for HHCT has recently produced a paediatric newsletter that gives an overview of safeguarding children activity, including good practice and any learning arising from significant events or serious case reviews and this is a good practice.

5.3.6 Supervision in CCST, in both the health visiting service and the paediatric wards at Hinchingsbrooke hospital, is not sufficiently robust. Some practitioners are routinely recording the outcomes and plans arising from supervision on the client record but some others are not and this does not support auditable decision making. ([Recommendation 4.10](#)).

5.3.7 The cascade model of supervision in use in CCST is not suitable for health visitors who are holding cases. Some practitioners told us that the current supervision record template does not meet their needs. The named nurse told us that they had recently carried out an audit on supervision, identifying some areas for action and acknowledged that the recent move to group supervision had been driven by capacity issues. ([Recommendation 4.11](#)).

5.3.8 We were advised that school nurses are provided with structured and regular peer group safeguarding supervision where practitioners take cases of concern to discuss with their safeguarding supervisor and colleagues. We saw that actions arising from safeguarding supervision discussions are recorded in client notes and inform the care planning process. Children and young people are made aware if their case is to be discussed at supervision and we see this level of involvement in their own care planning as good practice.

5.3.9 Across both Addenbrooke's and Hinchingsbrooke hospitals midwifery services we saw that safeguarding supervision does not meet current requirements in that it is not offered separately to clinical supervision and takes the form of advice and guidance rather than individual structured safeguarding supervision. When advice and guidance is sought and provided we saw that the outcomes of those discussions are not routinely recorded on client notes along with actions and responsibilities of any individual health professional. This means that health plans might not always contain up-to-date plans for expectant and vulnerable mothers-to-be and clear timelines for actions might not be implemented. ([Recommendation 1.6, recommendation 2.7](#))

5.3.10 In the CPFT, a recent 'safeguarding surgery' programme of link worker study days across the county were facilitated by the safeguarding children team and link workers from the Trust's teams were invited to attend. In addition staff could book 'slots' with them to discuss anything about safeguarding children including how to make a detailed and accurate referral to children's social care. We consider this to be an example of good practice as it enables staff from a number of different locations to access up-to-date safeguarding knowledge. A recent file audit suggested that all staff are now well aware of best safeguarding practice and are confident in asking sometimes difficult questions of clients to ensure child safety. In files we looked at we saw that practitioners were routinely asking clients about any changes in circumstances that might mean they have different access to children and young people. This then resulted in further risk assessments and plans adjusted if considered necessary.

5.3.11 Generally the training and supervision of CAMHS staff has improved significantly over the last year due to the efforts of the CPFT safeguarding team. This was bolstered by the introduction of a structured supervision model and the establishing of safeguarding link workers in each team to support clinicians with any difficult situations or areas of uncertainty. These improvements were most apparent in the detailed risk assessments and care plans we saw. We also saw that the supervision model had given rise to an operational decision making tool that supported staff with complex issues and enabled them to prepare better to make reports for child protection or child in need meetings.

5.3.12 Safeguarding supervision in CAMHS service and the adult mental health service is relevant, meaningful and consistent. We saw a number of very good examples of support offered to staff with detailed supervision discussions documented in the patient's notes that set out very clearly why particular actions had been taken. This is good practice and supports auditable decision making.

5.3.13 Staff from both children's and adult services provided by the CPFT told us they benefitted from a computer desktop tool developed by the safeguarding team called a 'safeguarding satchel'. This tool, containing policies, guidance, templates and tools is a one-stop reference point. Safeguarding link workers, staff with an enhanced level of safeguarding knowledge who are available for advice, have recently been introduced as part of the workforce in each team. Both of these initiatives mean that CPFT staff have additional support over and above their own level of knowledge and understanding.

5.3.14 Similarly, staff in both the children's and the adult's substance misuse service benefit from a newly published safeguarding children manual safeguarding manual. The document includes a description of roles and responsibilities, contact points for identified staff who can act as a reference people for safeguarding information, best safeguarding practice, safeguarding referral pathways and a 'do's and don'ts' section. The manual gives clear guidance and support to adult substance misuse recovery practitioners as to their responsibilities in protecting vulnerable and potentially vulnerable children and young people.

5.3.15 Staff in the iCASH service attend level three safeguarding training and we were told that compliance is good. The lead nurse in the iCASH service is notified when practitioners are three months away from becoming non-compliant with their level three training. The nurse then follows this up with individual practitioners to ensure that training has been booked and this ensures that this good level of compliance is maintained.

5.3.16 We were also advised that the level three training is approved by the LSCB and that the content complies with the intercollegiate guidance. We learned that practitioners can access training online or face-to-face and we have since been assured that training fully meets the requirements of the intercollegiate guidance in terms of the number of hours and the extent of the inter-agency input. ([Recommendation 4.12](#)).

5.3.17 We were told that practitioners have access to additional training through annual study days, including recent training on CSE. Female Genital Mutilation has been identified as a subject for the next study day. The iCASH team themselves take an active part in organising this training. We see this level of staff involvement as good practice as it ensures that any training procured meets their needs.

5.3.18 We were informed that iCASH practitioners have monthly nurses meetings, which includes an element of supervision; however practitioners are not currently attending any formal supervision on safeguarding children practice. This is a missed opportunity for practitioners to discuss vulnerable young people they are working with. This has been recognised as an area for improvement by the locality manager, and work is currently underway to develop a safeguarding supervision process for this group of staff. ([Recommendation 4.12](#)).

5.3.19 We learned that the CCG, in partnership with LSCB partners have developed level three training for all GPs. This comprises a half-day package involving scenario and case discussion with part of the scenarios covering the work of other agencies, albeit without a specific input from staff in other agencies such as police, social care and the voluntary sector. To date, the designated doctor and nurse have reached 250 out of 800 GPs with this training and work continues to complete the remainder in this year.

5.3.20 The CCG have also required each provider to supply a training needs analysis to say how many staff at each level described by the intercollegiate guidance on roles and competences require training at each of those relevant levels. At the time of our review this was yet to be completed, however, the CCG have required providers to meet a target of 90% of staff trained across all levels. In one instance, they had issued a performance notice and a remedial action plan to one provider to make sure that they reached this target by June 2015 and we saw that this was achieved.

5.3.21 We saw that the CCG had taken the lead in disseminating the findings for three recent serious case reviews to all health staff through their bi-monthly health safeguarding group meetings with named safeguarding professionals from each of the providers. We noted that the CCG's Quality Directorate risk register and action plan for safeguarding showed particular action and progress to meet certain risks, one of which was the oversight of actions arising from serious case reviews. In any event, there was a broad culture among all health staff to consider learning for serious case reviews and in our conversations with practitioners these were referred to frequently. For example, we saw that learning had been disseminated in relation to staff considering 'disguised compliance' in parents and carers of children at risk arising from one of the reviews. In our discussions with staff in the adult services in particular we found that practitioners were attuned to this phenomenon and were aware of what to look out for.

Recommendations

1. **Cambridge University Hospitals NHS Foundation Trust (CUHFT) should:**
 - 1.1. Implement arrangements for providing management oversight of children's records in the emergency department and those records of adult patients with access to children who attend with presenting risk factors. This should include a review of the named safeguarding nurse's role. This is so that the trust can be assured that effective liaison with other services takes place for children who would benefit from early help, that all children about whom there are concerns are highlighted appropriately to the local authority and that appropriate organisational learning takes place to improve quality and consistency of safeguarding information.
 - 1.2. Ensure that emergency department staff are supported to consider the risks of child sexual exploitation by including a screening tool as part of the patient records.
 - 1.3. Ensure the arrangements for antenatal communication and collaboration between the midwifery team at the hospital, the community based midwifery teams and the health visiting service are strengthened. This should include the involvement of the health visiting teams at multi-disciplinary meetings and the means of monitoring whether the email communication with community teams and health visitors is effective in the absence of full access to the EPIC system.
 - 1.4. Implement a process for capturing family and social information in the EPIC records system. This is to enable staff to consistently record risks and vulnerabilities and to take actions to ensure women and their new-born children can engage with relevant services in a timely way.
 - 1.5. Ensure that the delivery of level three training for all relevant staff is provided on an inter-agency basis and using scenario based discussion as recommended by the intercollegiate guidance on roles and competences issued by the Royal College of Paediatrics and Child Health (RCPCH).
 - 1.6. Implement arrangements for safeguarding supervision in the maternity department so that it is individual practitioner based, is separate from clinical supervision and that a record is made in the patient record about the outcomes of supervision discussions in order to support auditable decision making.

2. Hinchingsbrooke Health Care NHS Trust (HHCT) should:

- 2.1 Develop facilities for the reception, assessment and treatment of children and young people in the emergency department at Hinchingsbrooke hospital so that they meet the needs of different aged children and are arranged to maintain their privacy, dignity and safety.
- 2.2 Ensure an audit is carried out to assess compliance against the 'Standards for Children and Young People in Emergency Care Settings' issued by the Royal College of Paediatrics and Child Health (RCPCH). This is so that impetus towards improvement derived from previous CQC inspections can be maintained.
- 2.3 Implement a standardised process for clearly identifying in the maternity hand-held notes and in the patient records where additional information about concerns or vulnerabilities is held, such as the 'Service Planning and Care Pathway' V3 form. Ensure that compliance with this is audited to provide assurance that risks and vulnerabilities are consistently recorded and taken account of.
- 2.4 Revise the emergency department pathway for assessing and responding to children and young people who have attended as a result of alcohol or substance misuse to ensure that it explores vulnerability to sexual exploitation.
- 2.5 Ensure that level three training for all relevant staff is provided in accordance with the intercollegiate guidance on roles and competences issued by the Royal College of Paediatrics and Child Health (RCPCH).
- 2.6 Ensure that formal safeguarding supervision is introduced for emergency department staff that is separate to general supervision and related to cases of concern handled by staff so that practitioners are supported to understand and demonstrate good safeguarding and child protection practice.
- 2.7 Implement arrangements for safeguarding supervision in the maternity department so that it is individual practitioner based, is separate from clinical supervision and that a record is made in the patient record about the outcomes of supervision discussions in order to support auditable decision making.

3. Cambridgeshire and Peterborough NHS Foundation Trust should:

- 3.1 Implement arrangements for providing management oversight of children's records in the minor injuries units. This is so that the trust can be assured that effective liaison with other services takes place for children who would benefit from early help and that all children about whom there are concerns are highlighted appropriately.

- 3.2 Ensure an audit is carried out of paediatric attendances and staffing arrangements at the three minor injuries units across the county which may treat a significant number of children as well as adults to assess how paediatric expertise among staff might be increased. This should contribute to a more global piece of work in conjunction with the Cambridgeshire and Peterborough CCG and other emergency care providers as set out in recommendation 6.1 below.
- 3.3 Develop its paediatric facilities in the minor injuries units across the county to ensure they are compliant with 'Standards for Children and Young People in Emergency Care Settings' issued by the Royal College of Paediatrics and Child Health (RCPCH).
- 3.4 Formalise the arrangements for capturing information about risk for children and young people attending minor injuries units, particularly risks in relation to child sexual exploitation and where young people receive contraceptive services.
- 3.5 Ensure CAMHS practitioners are aware of the importance of capturing information about key relationships as prompted by the RIO records system. This is to enable practitioners to understand and assess the impact of family life on the child, the impact of the child's mental health on family members and the other services that might benefit the child and their family.
- 3.6 Ensure that CAMHS practitioners are aware of the importance of documenting a plan for handing over the responsibility for managing ongoing risks to individual clients when a staff member leaves the employ of the service. This is to ensure that children and young people are kept safe by a continuity of their care plan.
- 3.7 Implement a formal method for assessing risk of child sexual exploitation of CAMHS clients and provide practitioners with a screening tool within the RIO system to enable them to assess such risk effectively.
- 3.8 Implement a formal method for assessing risk of child sexual exploitation by practitioners in the minor injuries units and provide them with additional training if required, together with a screening tool to enable them to assess such risk effectively.

4. Cambridgeshire Community Services NHS Trust should:

- 4.1 Develop a protocol for capturing key information about the vulnerabilities to iCASH clients aged 17 to 18, such as those arising from sexual history or domestic violence, and the means by which compliance with this protocol can be monitored by managers. This is to ensure that the risk of exploitation is thoroughly assessed and opportunities to refer onwards for early help are taken.

- 4.2 Explore ways in which the iCASH service can be represented at local strategic and operational groups for child sexual exploitation. This is so that they can contribute their expertise and provide information and intelligence about individual cases.
- 4.3 Develop the Lillie records system in the iCASH service to enable it to store information about vulnerabilities and concerns and alert practitioners to such concerns to ensure they have a complete picture of the risks to children and young people.
- 4.4 Implement a formal process in the iCASH service for making safeguarding referrals to children's social care and for providing management oversight of these. This is to ensure that children and young people identified by the service to be at risk are properly highlighted and to assure the quality and standard of information shared.
- 4.5 Formalise the arrangements in the iCASH service for receiving, recording and making use of information from safeguarding processes to ensure that practitioners can take account of current and evolving risks to their young clients.
- 4.6 Implement a process for quality assuring referrals to children's social care and reports for conferences emanating from the health visiting service to ensure that risk is clearly articulated.
- 4.7 Ensure the separation between health assessments and health planning in the looked after children service is reduced to enable children and young people and their carers are fully involved in the process.
- 4.8 Ensure the protocols for carrying out health assessments of children new in care comply with statutory guidance on 'Promoting the health and well-being of looked-after children' (DfE and DH) that require those health assessments to be carried out by medical practitioners.
- 4.9 Clarify, through the trust's information governance team, the practice of sharing all parts of the health assessment forms of competent children under the age of 16 with the local authority without their consent and ensure this clarity is communicated to all relevant staff and to the local authority.
- 4.10 Ensure that practitioners in the health visiting service and school nursing service record outcomes and plans arising from safeguarding supervision on the client records in order to support auditable decision making.
- 4.11 Implement a safeguarding supervision template for use in the school nursing and health visiting services to ensure that it excludes group supervision, thereby ensuring that it meets the individual supervision needs of practitioners and their clients.
- 4.12 Ensure the impetus towards introducing formal safeguarding supervision for practitioners in the iCASH service is maintained.

5. The Cambridgeshire and Peterborough CCG and Cambridgeshire and Peterborough NHS Foundation Trust should:

- 5.1 Continue to work together in a planned way to implement solutions to the problems of access and waiting times for core mental health services for children and young people and to bring the waiting times for those services down to acceptable levels. In particular the CCG and the trust should maintain the work in place to reinstate the waiting lists for children and young people awaiting assessment for Autistic Spectrum Disorder and Attention Deficit Hyperactivity Disorder so that the service is fully functional by the date stipulated in the CCG improvement plan.
- 5.2 Urgently explore and implement ways to support the community and primary care services in delivering emotional support to children who are currently in need and until the improved access arrangements for core mental health services are implemented.

6. The Cambridgeshire and Peterborough CCG, Cambridge University Hospitals NHS Foundation Trust, Cambridgeshire and Peterborough NHS Foundation Trust and Hinchingsbrooke Health Care NHS Trust should:

- 6.1 Work together to ensure the paediatric emergency and urgent care need across the county complies with the 'Standards for Children and Young People in Emergency Care Settings' issued by the Royal College of Paediatrics and Child Health (RCPCH). This should include clarity on the roles of different access points to urgent paediatric care; the definition of those patients who might access urgent care from those locations; and identify an appropriate staff and skill mix across those locations. This is to ensure that children and young people of all ages have access to standardised urgent care close to their home and can benefit from meaningful referral onwards to local community services where the need for early help is identified.

7. Cambridgeshire Community Services NHS Trust, Cambridgeshire and Peterborough NHS Foundation Trust and Hinchingsbrooke Health Care NHS Trust should:

- 7.1 Work together to define an appropriate, generic pathway for the CAMHS assessment of young people who attend the emergency department out-of-hours following incidents of self-harm or substance misuse. This is to ensure that young people do not face extended stays in the emergency department whilst awaiting such an assessment.

8. The Cambridgeshire and Peterborough CCG, Cambridge University Hospitals NHS Foundation Trust, Cambridgeshire and Peterborough NHS Foundation Trust should:

- 8.1 Implement changes arising from a serious incident investigation (STEIS reference: 2015/7706) into the inappropriate placement of an adolescent male in the critical dependency unit.

9. The Cambridgeshire and Peterborough CCG and Cambridgeshire Community Services NHS Trust should:

- 9.1 Implement changes arising from the findings of the ongoing review of the current resourcing of the looked after children service to examine whether capacity meets demand including the leadership roles. This is to ensure that the team are properly staffed to provide an effective service, that there is equality of access and improved health outcomes for children placed within and outside of the county and to ensure the service complies with the statutory guidance on 'Promoting the health and well-being of looked-after children' (DfE and DH).

10. The Cambridgeshire and Peterborough CCG should:

- 10.1 Ensure that recently implemented training to GPs on the risks to children of sexual exploitation is effectively embedded into practice. This should include an assessment of the level of awareness of GPs about identifying and managing risks, effective record keeping and management of referrals to children's social care.
- 10.2 Issue guidance to GPs about the use of the Fraser guidelines to establish the capacity of children and young people to receive contraceptive advice when that capacity might be affected by evolving risk taking behaviour.
- 10.3 Analyse the findings from section 11 Children Act audits to determine the efficacy of regular multi-disciplinary management of the care of vulnerable families and implement any changes required to develop the practice across the county's primary care providers.

Next steps

An action plan addressing the recommendations above is required from NHS Cambridgeshire and Peterborough 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.