

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

# Children Looked After and Safeguarding

## The role of health services in Sheffield

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<b>NHS England area:</b>	North
<b>CQC region:</b>	North (East)
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## Summary of the review

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

Where the findings relate to children and families in local authority areas other than Sheffield cross-boundary arrangements have been considered and commented on. Arrangements for the health-related needs and risks for children placed out of area are also included.

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## About the review

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The review was conducted under Section 48 of the Health and Social Care Act 2008 which permits CQC to review the provision of healthcare and the exercise of functions of NHS England and Clinical Commissioning Groups.

- The review explored the effectiveness of health services for looked after children and the effectiveness of safeguarding arrangements within health for all children.
- The focus was on the experiences of looked after children and children and their families who receive safeguarding services.
- We looked at:
  - the role of healthcare providers and commissioners.
  - the role of healthcare organisations in understanding risk factors, identifying needs, communicating effectively with children and families, liaising with other agencies, assessing needs and responding to those needs and contributing to multi-agency assessments and reviews.
  - the contribution of health services in promoting and improving the health and wellbeing of looked after children including carrying out health assessments and providing appropriate services.
- We also checked whether healthcare organisations were working in accordance with their responsibilities under Section 11 of the Children Act 2004. This includes the statutory guidance, *Working Together to Safeguard Children 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.

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## How we carried out the review

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We used a range of methods to gather information both during and before the visit. This included document reviews, interviews, focus groups and visits. Where possible we met and spoke with children and young people. This approach provided us with evidence that could be checked and confirmed in several ways.

We tracked a number of individual cases where there had been safeguarding concerns about children. This included some cases where children were referred to social care and also some cases where children and families were not referred, but where they were assessed as needing early help and received it from health services. We also sampled a spread of other such cases.

Our tracking and sampling also followed the experiences of looked after children to explore the effectiveness of health services in promoting their well-being.

In total, we took into account the experiences of 97 children and young people.

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## Context of the review

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Sheffield's population is diverse. There are areas of the city where new immigrant communities choose to settle and we heard how the situation creates pressures on already stretched services and challenges in respect of engagement and resource availability to meet need.

Children and young people under the age of 20 years make up 23.9% of the population of Sheffield. 30.5% of school children are from a minority ethnic group.

Children and young people from minority ethnic groups account for 29% of all children living in the area, compared with 21% in the country as a whole. The largest minority ethnic groups of children and young people in the area are Asian or Asian British, accounting for 11% of the population. The proportion of children and young people with English as an additional language in primary schools is 20% (the national average is 18%) and in secondary schools it is 15% (the national average is 14%)

The majority (98.9%) of Sheffield residents are registered with a GP practice that is a member of NHS Sheffield CCG. Three NHS trusts operate within the local authority of Sheffield of which the Sheffield Children's NHS Foundation Trust provides the most children's and adolescent services.

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

*Commissioning and planning of most health services for children are carried out by **NHS Sheffield CCG**, there are joint commissioning arrangements in place with **Sheffield City Council** and **NHSE** and a bi monthly **Children's Joint Commissioning Group** oversees these areas and priorities.*

*Commissioning arrangements for looked-after children's health are the responsibility of **NHSS CCG**, however there is a joint arrangement between **NHS** and **Sheffield City Council** for the provision of these services and the looked-after children's health team; designated roles and operational looked-after children's nurse/s, are provided by **Sheffield Children's Hospital NHS Foundation Trust (SCH NHS FT)**.*

***Acute hospital services** are provided by **Sheffield Children's NHS Foundation Trust (SCH NHS FT)**.*

***Health visitor services** are commissioned by **Sheffield City Council** and provided by **Sheffield Children's Hospital NHS Foundation Trust (SCH NHS FT)** in addition there is a small Health Inclusion Team (which are not exclusively HV's) and work with hard to reach families including asylum, homeless and travellers which is provided by Sheffield Health and Social Care NHS FT .*

***School nurse** services are commissioned by **Sheffield City Council** and provided by **Sheffield Children's NHS Foundation Trust (SCH NHS FT)**.*

***Contraception and sexual health services (CASH)** are commissioned by **Sheffield City Council** and provided by **Sheffield Teaching Hospitals NHS Foundation Trust (STH NHS FT)**.*

***Child substance misuse** services are commissioned by **Sheffield City Council** and provided by **The Corner***

***Adult substance misuse services** are commissioned by **Drug and Alcohol Coordination Team (DACT)** and provided by **Sheffield Health and Social Care Foundation Trust (SHSC NHS FT)**.*

***Child and Adolescent Mental Health Services (CAMHS)** are provided by Specialist facilities are provided by **Sheffield Children's NHS Foundation Trust***

*Adult mental health services are provided by **Sheffield Health and Social Care Foundation Trust (SHSC NHS FT)***

*The last inspection of safeguarding and looked after children's services for Sheffield's children took place in October 2010 as a joint inspection with Ofsted. Recommendations from that inspection are covered in this review.*

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## The report

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This report follows the child's journey reflecting the experiences of children and young people or parents/carers to whom we spoke, or whose experiences we tracked or checked. A number of recommendations for improvement are made at the end of the report.

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## What people told us

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In the children's emergency department parents of an 8 month baby said

*"The staff are all friendly, helpful and calming with our baby."*

Parents of a 2 year old child in the children's emergency department:

*"We can't fault the service, we have been seen quickly, they are thorough and caring."*

A foster carer told us:

*"The majority of health professionals have been exceptionally good. The consultants and the ward staff at Sheffield Children's Hospital, who are caring for my child, go above and beyond their roles".*

*"The care provided by the GP and practice staff is exceptional. The GP practice has never wavered at having any of the children that are placed in my care being registered at their practice. It doesn't matter how busy they are, they will always see my children. It might not be the same GP but the most I've ever had to wait for an appointment time is 2 hours. It's not just the GP that are exceptional – the practice staff are always quick at responding".*

A foster carer told us:

*"The health visitor who comes and does the review health assessments doesn't understand the impact of the health complexities of my child. I only see the health visitor once every 6 months for the review health assessments. She comes every 6 months, tick's some boxes and goes."*

Another carer told us about their health visitor

*“If I need anything from my health visitor they are always available at the end of the phone. My son has lots of allergies and the health visitor has given me lots of advice and support and are always brilliant”.*

*“I’ve been offered all the universal contacts and my health visitor will come out and see me at home most of the times, but I can always go to the drop-in clinic if I need to as well”.*

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## The child's journey

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

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### 1. Early help

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- 1.1 Children and young people benefit from having details of their attendance at SCH NHS FT emergency department (ED) shared with their GP and health visitor or school nurse. GP letters are also annotated with any safeguarding or child protection concerns or action taken.
- 1.2 Children and young people up to 18, if they are known to the hospital and receiving care, or 16 if they are not, are able to access emergency care at SCH NHS FT. Receptionists at the department record the details of the child and their next of kin and check the demographics on the Patient Administration System (PAS). However, only the name of the next of kin is recorded on the casualty record; there is no additional information detailing the relationship of the next of kin or who is accompanying the child. The failure to record and consider this detail is a feature of serious case reviews. We were told that other important information including ethnicity and religion is available to all staff on the Medway computer system although this was not evidenced in records seen. **(Recommendation 2.1)**
- 1.3 Children and young people are seen quickly by the triage nurse who establishes the reason for attendance and in all cases seen offers pain relief where this is necessary. The trust requires that all children are weighed at triage or as soon as possible after; we saw some cases where this did not happen. The recording of a child's weight is important, not only to ensure the correct dosage of medicine, but also to check correct growth. **(Recommendation 2.2)**
- 1.4 In the SCH NHS FT emergency department (ED) the child's record is flagged with an alert if there, or has been, any safeguarding or child protection concerns, including if a child is looked after. This enables ED practitioners to consider the social history in relation to the reason for attendance. Repeat attendances are also included on the casualty card and we saw how ED practitioners were using this information to inform their decision making when treating the child.



- 1.5 Children's ED practitioners are not using any established safeguarding triage to identify any potential child protection concerns. This is a requirement of NICE CG89: When to suspect child maltreatment and also a requirement in Standards for Children and Young People in Emergency Care Settings (RCPCH 2012). There is an over reliance on professionals using their own judgement. In cases seen we could find no written evidence of a systematic assessment or consideration of the potential for non-accidental injury or other child protection concern. **(Recommendation 3.1)**
- 1.6 Arrangements to support adults attending the STH NHS FT ED with concerning presentations because of domestic abuse, mental health issues and substance misuse are assessed and treated in a co-ordinated and effective way. The department has a weekly visit from the local Independent Domestic Violence Advocacy Service (IDVAS) and an IDVAS is available for contact during normal working hours. A mental health liaison team is also present in the ED department to assess and treat any adult presenting with mental health issues, has self-harmed or taken an overdose. We saw evidence of good communication with midwifery services if an adult presented during pregnancy and good dialogue with the local adult substance misuse services. However, the arrangements to identify the hidden harm to children from adults who present with concerning behaviours, however, are less robust. A recent change in the adult ED paperwork has resulted in practitioners not always asking and recording the safeguarding triage questions. This means that there are potential missed opportunities to identify and support children at an early stage. **(Recommendation 3.1)**
- 1.7 Young people who attend STH NHS FT ED with risk taking behaviours, including assault, violence or substance misuse, are able to benefit from a referral to the community youth teams. Practitioners in ED should assess the young person and offer onward referral. Verbal consent is sufficient for the referral to be made; however, numbers through this route are relatively low. The paediatric liaison nurse also actively follows up any attendance where risk has been identified and will make retrospective referrals to the service where appropriate. This pathway is not supported by the same process for children and young people who attend the SCH NHS FT ED and this is a gap. **(Recommendation 2.3)**
- 1.8 The majority of expectant women book their pregnancy early and are seen for the initial booking appointment at either the GP surgery, the children's centre or at home. A recent audit has confirmed that not all expectant women are seen alone and the routine enquiry for domestic abuse is not always asked as required by the trust policy. Plans are well advanced to introduce a new pathway at booking and at the first scan to ensure that all expectant women will routinely be seen alone. **(Recommendation 7.1)**

- 1.9 Expectant women benefit from having bespoke digital maternity notes; this allows the midwife to complete the ante natal record and upload the content in real time to the main computer record. Lost hand held records are no longer a risk and midwives, based in the hospital, are able to access records immediately. In all records seen the details of the father were recorded along with other relevant history around potential risk and vulnerability. Midwives in Sheffield are high referrers for the Family Common Assessment Framework (FCAF) and to the local Multi Agency Support Teams (MAST) to elicit early support. Expectant women can access support from the local Doula service which is popular with women and supported by midwives who provide some of the initial training.
- 1.10 Midwives recognise that sometimes the booking process can be overwhelming for women with complex and chaotic lifestyles and sometimes stagger the information gathering over a number of appointments. This is a sensitive approach in supporting these women.
- 1.11 There is an expectation that midwives review the expectant woman's GP record as part of the initial risk assessment, however, it was not possible to establish if this had taken place in any of the records seen. Many midwives attend monthly meetings with GP practices and health visitors to discuss families of concern and share information. This helps to provide a co-ordinated approach to their care.
- 1.12 Health visitor/midwifery liaison meetings take place every 4-6 weeks and once pregnancy has been confirmed at the meeting, a letter is sent by the health visiting service to mothers requesting contact to arrange an antenatal visit. Where families are identified as vulnerable a letter is sent to parents with an appointment date and time. However, in records reviewed, we saw that health visitors were not always being notified of pregnancies at liaison meetings, and are therefore unable to offer antenatal contacts for vulnerable families. In one case the mother had disclosed domestic violence to the whilst on the labour ward, however, the health visitors only became aware following receipt of a mother and baby discharge summary from the hospital. This is a missed opportunity to ensure that professionals are sharing relevant information with each other in order to provide early support for families'.
- 1.13 These issues will be brought to the attention of Public Health England as commissioners for the health visiting service and school nursing services.  
**(Recommendation 7.2)**
- 1.14 New mothers in parts of Sheffield are offered shopping vouchers if they breastfeed their babies for up to six months. The vouchers are being offered in specific areas of Sheffield as part of the Nourishing Start for Health (NOSH) trial being conducted by researchers. It is acknowledged that breastfeeding has a wide range of benefits for both mothers and babies and can help to prevent illness in children.

- 1.15 Families of children under 5 living in Sheffield benefit from a good delivery of the Healthy Child Programme. All families with children under the age of 5 receive a new birth visit, a 6 week check, and a development review at 9-12 month and then again at 2-2 ½ years. Health visitors in Sheffield are not routinely contributing to any parenting programmes, due to capacity issues, which mean that they are not identifying opportunities to provide early intervention support to young families.
- 1.16 There is currently no additional offer of development reviews of babies and families over and above the delivery of the Healthy Child programme. This has been recognised as an area for development by managers from the trust. We heard that Sheffield have recently recruited a new cohort of nursery nurses and it is hoped that once they are fully trained they will be tasked to pick up this piece of work. Where nursery nurses are well established in teams they are supporting health visitors well, through delegated activities, in particular for universal development reviews, behaviour management and feeding support.
- 1.17 Health visitors told us that maternal mental health is explored at each contact and recorded in mother's records. In one case sampled, the health visitor had recorded in the children records that the mother had said that she was feeling under pressure and stressed but, this was not fully explored or documented in mother's records, therefore there is a risk that maternal mental health is not being fully assessed and reviewed. These issues will be brought to the attention of Public Health England as commissioners for the health visiting service and school nursing services.
- 1.18 Effective and flexible arrangements are in place to offer ongoing support when a child moves from the health visitor into the school nursing service. Where appropriate the health visitor involvement will continue until a suitable time to transfer and this is facilitated. This preserves relationships and means that families continue to work with a trusted practitioner at a time of transition.
- 1.19 School nurses work in school areas but where children in the family are attending different schools a one nurse service is provided. This means that the numbers of professionals going into families is minimised and avoids the need for duplication.
- 1.20 In school nursing services we heard about early help initiatives to engage and inform new emerging immigrant communities in response to identified need and in order to deliver public health services. Nurses were providing information cafes in schools, Youth Club drop-ins and corridor workshops. This means that children and families are provided with information and opportunities to engage with health care staff in familiar or non-threatening environments thus promoting early engagement with public health services.

**Case example:** *In response to lack of engagement in school drop in clinics and in an attempt to target those hard to reach children who are not attending regular school, school nurses worked with youth services to pilot a youth club drop in.*

*The programme was designed in conjunction with young people who identified topics that they would like to talk about. The sessions involved group learning and space separate for 1:1 chat. The pilot was evaluated by young people and outcomes measured and found an increase knowledge and awareness around sexual health and awareness, alcohol use and limits.*

- 1.21 Child and Adolescent Mental Health Services (CAMHS) are engaged with the provision of early help for young people with emotional difficulties. We saw examples of good joint working between CAMHS and adult mental health services although practitioners and managers acknowledged that this is variable and could be stronger. We saw evidence in records in both CAMHS and adult mental health services where the practitioners had relied upon parents to convey information rather than liaise directly between practitioners. This is not best practice. It is imperative that practitioners working with complex and vulnerable families establish good direct communication between professionals, outside of any formal CIN or child protection processes, to ensure that all professionals are clear on roles and responsibilities and that an effective team around the family is established. The lack of effective communication between professionals and services is a feature of SCRs. (**Recommendation 6.1**)
- 1.22 We heard about a potentially very beneficial pilot that CAMHS have set up based on what has been established and funded by one school. CAMHS have obtained funding from the Department of Health and Department of Education to pilot practitioners being based in 3 senior schools and their feeder primary schools. This means a CAMHS presence in 10 schools in total who train school staff to better understand how children who have attachment disorder or who have suffered early trauma may behave and to equip staff with strategies and methods of managing such behaviours. This is a good example of effectively supporting children at an early stage. If successful it is envisaged that this could result in a significant strengthening to Sheffield early help offer.
- 1.23 From reviewing records and through discussions with community workers in adult mental health services we saw evidence that safeguarding is embedded in practice and utilises a whole family approach to case work. We saw good record keeping in mental health services with clear references to safeguarding of children as a consideration.

- 1.24 In adult mental health electronic records show that parenting and caring responsibilities are established as part of the initial information gathering process and this is recorded on the first page of the file containing demographics. This is compliant with the recommendations of Think Family, Think Parent, Think Child. However, adult mental health staff do not carry out a home visit as standard where there are children in the household as a means of assessing what is happening in the home environment and to validate information. This is an important part of the mental health assessment to ensure that there is a protective adult in households where there are children or contact with children. Without a home visit the living environments cannot be assessed taking into account government indicators of risk including overcrowding, poor housing and supports the 'no wrong door' approach. Home visits allow staff to quickly identify the most vulnerable families, other members of the household including children who maybe young carers or affected by parental mental ill health. Practitioners should record whether parents live together and the degree of contact with children. This means that mental health staff assess the support needs of vulnerable adults and strengthen the ability of family members to provide care and support for each other and are in a position to potentially identify and respond in a timely manner in cases where children are suffering, or are likely to suffer, significant harm by linking with other services. **(Recommendation 4.1)**
- 1.25 Each GP practice in Sheffield has a linked health visitor attached to a surgery. We heard that there is good liaison between the GP and health visitor on an ad hoc basis and also regular monthly liaison meetings. This is a good way for ensuring that health visitors are able to update GPs on any safeguarding or vulnerable families that they are working with.
- 1.26 GPs told us that they value the information exchange meetings with liaison HVs, about families of concern. In the children electronic patient records reviewed, we saw evidence of the health visitor documenting that a case had been discussed at the GP liaison meeting; however, there was no evidence of any outcomes following the discussion and what the role of each individual practitioner would be in order to safeguard children. Actions and expected outcomes arising from the exchange of information were not evident in records. Although the meetings are an effective way for sharing information across disciplines and helping vulnerable families engage with appropriate support at an early stage, the arrangement would be strengthened by identifying plans or actions for either party by ensuring these are added to the record so that it is clear what the monitoring is aiming to achieve and when thresholds are breached. **(Recommendation 1.1)**

- 1.27 GPs can ask the liaison health visitor for general advice about school age children issues, but school nurses do not attend practice meetings and there is limited communication between school nurses and GPs. A lack of effective communication, direct liaison and information sharing between practitioners involved with a vulnerable child or family is a feature of SCRs. GPs are in a position to invite other professionals to the liaison meetings to facilitate information sharing. These issues will be brought to the attention of Public Health England as commissioners for the health visiting service and school nursing services. **(Recommendation 1.1)**
- 1.28 We saw variable practice within general practitioners. There is no agreed local policy on low level indicators of harm, for example, children who miss appointments, do not attend (DNA) or do not take up immunisations and that practice varies in terms of the triggers and the method of follow up. In one practice each incoming document we opened on SystmOne had been annotated with the name of the GP who had reviewed it and the date which is good practice. Where GP practices are not using SystmOne, there is no other information visible about what is going on for a child in community services. **(Recommendation 1.2)**
- 1.29 Domestic violence has been a topic in past GP practice learning events to help GPs to recognise the potential long term harm to children who witness domestic violence. However, we found that in GP practice there is variable confidence in READ coding domestic violence on systems as well as understanding the significance and implications of multi-agency risk assessment conference (MARAC). Although we saw use of alerts about adults at risk or at high risk of domestic violence, insufficient attention was paid to ensuring all children at risk of harm as a result of domestic violence within the household or family are consistently being identified in GP recording systems. **(Recommendation 1.2)**
- 1.30 One practice manager at a GP service told us that their practice does not see new children for a registration visit to benchmark their health. We were told that this is not part of the contractual arrangements. This is a missed safeguarding opportunity and a feature identified in serious case reviews as it misses an opportunity to identify concerns in children who are transient. **(Recommendation 1.3)**
- 1.31 The in house IT system currently used by the drug and alcohol team is stand alone from wider systems. It is not service wide, risking gaps in intelligence between service areas. There are no arrangements to flag adults or children in families who are particularly vulnerable or at risk, including families with children who are subject to child in need or child protection plans. **(Recommendation 5.1)**

- 1.32 There are strong multi-agency links between drug and alcohol and other services where there are potential risks to children. In drug and alcohol services the assessment tool includes a system link to check all new clients to identify any children and cross reference relevant history. The system triggers a letter to inform health visitors of children under 5 in the household and for whom there maybe impact of drug or alcohol use in the family home. However, the same process is not available to school nurses and this has been recognised as a gap.
- 1.33 The drug and alcohol service were not aware of the GP practice meetings where relevant information about vulnerable families can be shared. One alcohol liaison nurse covers all the hospitals; however, we were told that as a result of capacity the nurse is unable to make contact with all of the patients who are identified as needing advice or support. This means that some opportunities for early intervention or referral are missed.  
**(Recommendation 1.1)**

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## 2. Children in need

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- 2.1 All attendances of children in the SCH NHS FT Emergency Department (ED) are not subject to a 'second look'. When ED practitioners identify that there are concerns which do not meet the threshold for children's social care but indicate a family may need additional support they make an electronic referral to paediatric liaison. The paediatric liaison nurse will review the attendance and then discuss the need for any intervention with the family health visitor or school nurse. We found cases that would have benefited from paediatric liaison input and of opportunities missed to intervene early. **(Recommendation 2.4)**
- 2.2 Children and young people who attend SCH NHS FT following an episode of self-harm or overdose are not always being admitted to the paediatric ward in line with NICE guidance and trust protocol. In two cases seen the children's emotional health and wellbeing were not considered and there was insufficient attention paid to their social vulnerability including in one case potential child sexual exploitation (CSE). Detailed notes from the ambulance staff had not been transferred into the patient record and had not formed part of the assessment. **(Recommendation 2.5)**
- 2.3 Young people up to 18 years who attend the adult ED service should be assessed and treated according to the 16-18 year old pathway which tracks their journey through the department and supports decision making around vulnerability. It is important to note, however, that the ED card has not been differentiated to reflect a screening for vulnerability for young people and is dependent upon the ED practitioner identifying risk. However, notwithstanding this, we saw excellent examples of strong paediatric liaison. Where an ED practitioner has any concerns about the safety of a young person, they refer to children's social care. Practitioners also complete a paediatric liaison information form where concerns do not meet the threshold for children's social care.
- 2.4 In STH NHS FT ED the paediatric liaison nurse screens the attendance list of all young people under 19 and scrutinises the records of any attendance that may indicate vulnerability or risk taking behaviours, along with any completed paediatric liaison form. The paediatric liaison nurse is tenacious in following up and obtaining information from public health nurses, GPs and other agencies who may be involved with these young people to assess their risk and ensure the appropriate professionals are informed of the attendance.



**Case Example:** *Mother Z attended the Emergency Department with a panic attack. On arrival the ED receptionist noticed that she had 3 school age children with her who should have been at school. During the ED consultation, the practitioner recorded the names and ages of the children and also established that Z was new into the area.*

*A paediatric liaison information form was completed and the Paediatric Liaison Health Visitor reviewed the form and ED record but was unable to find the children on the Systm1 so contacted child health. She then liaised with child health and identified a previous address in a different city. The children had prior involvement with CAMHS and other health agencies, including continence services. The family were also known to their former authority's children's social care.*

*The details of the children were shared with the team "children missing from education" and when a school was allocated the Paediatric Liaison Health Visitor tasked the school nurses to review the children.*

*Details of this vulnerable family were also shared with local children's social care.*

- 2.5 Young people, who attend the STH NHS FT ED following an incident of self-harm, overdose or in mental health crises are assessed by the adult mental health liaison team once medically stable. There are no young people or paediatric wards on site and if admission is needed for observation, then the young person is transferred to a medical admission unit (MAU). The MAUs have been risk assessed to ensure the environment is appropriate and a young person kept safe. We saw evidence of good liaison between the mental health liaison team and CAMHS where this was appropriate, with mental health liaison making a direct referral to CAMHS.
- 2.6 Electronic flags are on the ED system to alert practitioners if there are, or have been, child protection or safeguarding concerns. However, ED practitioners spoken to were unaware if there was an alert to indicate if a young person is a looked after child (LAC). We were later advised that ED has a medium alert system in which LAC are included. In contrast, health visitors are using SystmOne where there are vulnerability flags to alert practitioners of any cases about which they need to be immediately aware. All child protection or safeguarding cases are given blue flags to identify them as a universal partnership plus or safeguarding case. This means that health visitors are being well alerted of the need to consider any additional vulnerability, which is important to help ensure that their assessments are robust. This is particularly relevant given that the health visitors in Sheffield are working a corporate caseload.
- 2.7 Expectant women with mental health concerns are well supported. All community midwives have attended training in mental health and there is a NICE compliant perinatal mental health pathway. The pathway is currently being revised to incorporate advice and support for lower levels of emotional health need.

- 2.8 Expectant teenagers are supported by a teenage pregnancy midwife who works closely with the vulnerabilities specialist midwifery team. The teenage pregnancy midwife holds the cases of all under 16 year olds. Care leavers and children in care who are pregnant are prioritised by the family nurse partnership (FNP).
- 2.9 Following learning from a serious case review, health visitors are routinely recording groups and relationships on the patient IT record. This is good, as it shows that health visitors are safeguarding children by identifying significant others whom children maybe in contact with children.
- 2.10 There is a pathway to transfer care between health visiting teams in Sheffield. When a child transfers to the health visiting team from out of area, the health visitors will arrange to see families at home to assess any health needs or vulnerabilities. However, where cases are transferred from health visiting teams within Sheffield, the health visitor will risk assess the records and decide whether a transfer in visit is required. We were told that dependent upon the individual family situation, this review of records may generate a letter to share information regarding local services conversely, it may warrant a formal transfer-in visit.
- 2.11 SCH NHS FT currently has specialist health visitor roles in early intervention prevention, breastfeeding, substance misuse, and domestic violence. We heard that the specialist health visitors for homeless and travelling families and asylum seekers are employed by SHSC NHS FT. Despite being employed by different trusts we were informed that working relationship are good.
- 2.12 There is a clear pathway and policy for health visitors to follow-up accident and emergency attendances, in particular for accidental injuries or overdose, fractures, bruises, parental mental health or substance misuse and attendance by children under the age of one year. We were informed that there is good liaison and communication with the paediatric liaison nurse, and no concerns were identified in relation to receiving timely notifications.
- 2.13 Children that are identified by health visitors as needing additional support as they enter school age are discussed by telephone or, where necessary, a joint visit is arranged between health visitor and school nurse. The details of the children who are in receipt of universal services are transferred electronically via SystemOne patient records. There is a template on SystemOne which prompts practitioners to ask about any domestic violence concerns. If the question about domestic violence has not been asked, then a flag is added to the patient records to remind practitioners to ask question at next visit. This demonstrates that practitioners are identifying vulnerabilities at all possible opportunities.

- 2.14 In CAMHS, as part of the assessment process, young people are routinely seen alone by practitioners and this is good practice, giving the young person the opportunity to share difficult information or disclose any safeguarding issues without their parent or carer being present. It is routine for the young person to be seen by two CAMHS practitioners from different disciplines within the team to ensure a comprehensive assessment of the young person's emotional health and wellbeing is undertaken.
- 2.15 When an assessment pro forma was used in CAMHS we saw good use of genograms to set out complex relationships in families. This is a valuable tool in helping to identify key relationships but also potential risks in families. We did not see all CAMHS services using the pro forma, although all assessments followed a standard pattern. Where long letter assessments were developed, there was no genogram included and this may have enhanced the assessment in the safeguarding context.
- 2.16 Once engaged with the service, we saw case evidence of children benefiting from the therapeutic intervention of CAMHS practitioners with resultant good outcomes. Young people engaged with CAMHS set the agenda for therapy sessions, putting the issues they want to work on at the forefront. The young person rates each session as to how helpful it has been in a sensitive, young person centred approach which was well evidenced in case records.
- 2.17 When young people with mental health difficulties require tier 4 in-patient treatment, this is mainly provided in the SCH NHS FT own local in-patient unit, although this does not provide for intensive care (PICU). Local placement facilitates continued engagement with a young person's family and CAMHS case workers which supports good recovery. However, the lack of provision of an intensive home treatment team in Sheffield, may not best support early discharge or prevent the need for admission. We were told that if individual risk assessment dictates, staff from the in-patient mental health unit are able to work temporarily on the paediatric ward to best support care of mentally unwell young people whilst on the ward.
- 2.18 If a child is placed into Tier 4 in-patient unit at a distance from their home, the CAMHS practitioners are creative in how they maintain contact and ensure their engagement in discharge and treatment planning meetings. Optional use of teleconferencing, video conferencing or Skype is considered. This helps to ensure effective discharge pathways back into Sheffield CAMHS and is particularly important in the absence of a local home treatment team.

- 2.19 The move to treat young people within an age appropriate mental health service has been exercising local commissioners and providers for some time and there remain considerable challenges to an effective CAMHS service to support young people; not withstanding capacity and arrangements to transition into adult mental health services for those young people who will need further help post eighteen years. As part of the transformation of services a new 13 point transition protocol is in place to steer effective transitions for young people from CAMHS into adult mental health and we saw its use in a case example. We heard that transitions can vary in effectiveness. For example, as part of a project some young people aged between 16 and up to 18 that need support for their mental health have been supported by local CAMHS as opposed to adult mental health service.
- 2.20 Adult mental health services track and appropriately escalate concerns where children are involved. When actively involved, staff attend and provide reports for protection and child in need meetings. Where there has been historic or brief involvement, if requested, the team will provide information for the meetings.
- 2.21 Parents with drug or alcohol issues have ready access to a range of services to help them, including psycho social interventions and the Triple P parenting programme. In the drug and alcohol service there are good multi agency arrangements including a dedicated pregnancy team to identify and support women who are dependent upon drugs or alcohol and who become pregnant. GP feedback is that the service works well.

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### 3. Child protection

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- 3.1 Children and young people who need a child protection medical or a specialist medical to establish sexual abuse are seen quickly in the children's assessment unit which is on site at the SCH NHS FT. The sexual abuse referral unit (SARC) operates across seven days and offers a service to families across South Yorkshire. Work is ongoing to establish care pathways to provide ongoing support to vulnerable children and young people in their local area which is more appropriate.
- 3.2 Referrals to children's social care from practitioners working in acute services provided by SCH NHS FT are usually telephoned through to the prevention and assessment teams (PAT). We were not assured that practitioners were always following up telephone referrals with a written form. We were not able to review any referrals to children's social care made by ED staff. This means that there is an over reliance on the notes taken by children's social care and their interpretation of the conversation. This is not safe. **(Recommendation 5.2)**
- 3.3 Adult ED staff do not follow up referrals to children's social care in writing; instead there is an over reliance on the initial telephone call and a note on the ED record. This is unsatisfactory as it leaves records incomplete. **(Recommendation 5.2)**
- 3.4 The majority of vulnerable expectant women continue to receive their midwifery care from their community midwife. The vulnerabilities specialist midwifery team has specialist midwives with additional training in perinatal mental health, substance misuse and there are case holders for homeless women and pregnant asylum seekers. A midwife from the vulnerabilities specialist midwifery team supports and co-ordinates the care of the more complex women. We saw evidence of how this shared care approach worked well and provided continuity of care with specialist input and support as needed.
- 3.5 In midwifery services we saw examples of how unborn babies were being protected through effective child protection processes within midwifery services. Referrals to children's social care were comprehensive and clearly articulated risk.
- 3.6 An integrated care pathway between midwifery and children's social care ensures that referrals and assessments are timely. Reports for conference were prepared jointly between the woman's community midwife and the allocated vulnerabilities specialist midwifery team midwife using the "signs of safety" report template. All reports seen were detailed and, as far as possible, kept the focus on the impact of parental behaviour on the unborn baby and on its early life. All reports are routinely shared with the parents prior to the conference and this is good practice.

- 3.7 Midwives are expected to attend all child protection conferences and as a minimum must submit a report. Figures seen confirmed that 100% of case conferences, where midwifery were involved, were informed by a conference report completed by their service.
- 3.8 Close working relationships and good information sharing ensures that expectant women who misuse substances or whose partners are receiving treatment from the local substance misuse agency receive a co-ordinated approach during their pregnancy, intra and postpartum.
- 3.9 Birth plans created by children's social care and also by midwives help inform care of expectant women in labour and postnatally. Although these were sufficient to ensure the woman was supported and the baby appropriately protected, the named midwife recognises that the plans could be more SMART and shared with families. **(Recommendation 7.3)**
- 3.10 Comprehensive discharge summaries and updates are routinely sent to the mother's GP by the vulnerabilities specialist midwifery team. This ensures that the GP, as primary record holder, is fully up to date with all information surrounding the pregnancy and birth, including action taken to protect the unborn child.
- 3.11 Midwives are asked to complete observations on parenting by children's social care. These observations are shared with parents who are able to add their own comments on the record. Further work on recording support and competency in early parenting skills such as feeding is being introduced as part of the universal service postnatally. This is a good development as it will help minimise the stigma of only carrying out parenting observations on new parents at the request of children's social care. It will also help identify early any emerging concerns that may have been missed in the ante natal period.
- 3.12 Health visitors in Sheffield are using chronologies in SystemOne records well. This means that practitioners who may be accessing the records for the first time will have all the relevant information they need in the significant events tab without having to identify vulnerabilities by looking through the entire health records.
- 3.13 Health visitors are aware of the process to follow when making referrals to children's social care. In records reviewed we saw evidence of cases been referred verbally by telephone, which is then followed up in writing within 24 hours. However, practitioners do not have a standard referral form to complete, which means that they are not appropriately supported to analyse or articulate risks or concerns. This is important as it helps social care to understand the health visitors concerns and what action they are requesting from social care to take. **(Recommendation 5.2)**

- 3.14 Following referral to social care health visitors are being verbally notified of the outcome, and where they are not satisfied with the outcome they are appropriately escalating cases. In records reviewed, we saw evidence of health visitors being invited to and attending child protection and safeguarding meetings. We saw evidence of reports being routinely produced and presented at meetings. Reports seen were of a good quality and based on the signs of safety model.
- 3.15 The specialist safeguarding children team attend multi agency risk assessment conference (MARAC) and all actions are discussed with health visitors by telephone, followed by a task on SystmOne. Health visitors are also asked to send information for MARAC meetings, and we saw evidence of this in records reviewed.
- 3.16 CAMHS practitioners are expected to attend child protection conferences and core groups and submit a written report but this is not monitored. There is no centrally operated and agreed pathway with children's social care to ensure that invitations to child in need and child protection case conferences and core groups are promptly and efficiently directed to the appropriate CAMHS worker. This is a gap as it means that practitioners do not have up to date information that will inform risk assessments and ongoing work with children and young people. A lack of effective communication, direct liaison and information sharing between practitioners involved with a vulnerable child or family is a feature of serious case reviews. (**Recommendation 2.6**)
- 3.17 We saw child protection plans on individual case records in CAMHS. The practitioners we spoke with were clear that they would be proactive in chasing these up if they did not come through from children's social care. In some records we saw tenacious efforts by practitioners to liaise effectively with social workers but in others we could not find evidence of the outcomes from child in need and child protection plans or the minutes and decisions from child protection meetings and conferences. CAMHS managers acknowledged that this practice is inconsistent in the service and not all practitioners would be proactive in ensuring child protection conference minutes, decisions and plans are received and put into the case record. We did see one case example where the minutes of the initial child protection conference and decision not to put a child on a child protection plan was not on the case record and the practitioner recognised that they needed to obtain this from children's social care to ensure the decision was clear and there was no ambiguity about the child's status. It is beholden on health practitioners to ensure that these key child protection documents are obtained and contained within the child's case record. (**Recommendation 2.6**)

**Case example:** A young person with a history of very serious abuse, ADHD, self-harm and substance misuse. The CAMHS practitioner was concerned that the young person's boyfriend may be grooming her. The CAMHS practitioner discussed the concerns with the CSE team but CSE team has not taken up the case to date

The CAMHS practitioner is liaising closely with children's youth team who has good relationship with the young person. The youth worker is providing psychosocial education to the young person about drug use and has engaged a peer mentor to befriend the young person to help to see options for change. The young person is able to identify with the peer mentor.

The young person attends specialist college and the CAMHS practitioner meets regularly with the young person and their mother and the college staff. Young person has been referred to additional alternative support.

*Outcomes to date:*

The young person is engaged with CAMHS and the youth worker and doing well in college. As a result of the CAMHS therapeutic work, the young person is more reflective on her behaviour and less impulsive or quick to engage in risky behaviours and the Mother and daughter relationship is improving.

- 3.18 CAMHS has a robust did not attend (DNA) policy in place. Each case of DNA is discussed with a manager and decisions on appropriate action decided on a risk assessment basis. This includes consideration of the status of the child for example, child in need or child protection.
- 3.19 Although there is an escalation policy in place, CAMHS practitioners may not be invoking this to best effect when they have ongoing concerns about potential risk to a child or young person. We saw and heard examples where CAMHS practitioners continued to refer the same case onto other services but the case continued to be declined as not meeting the threshold. In one case seen the practitioner had been concerned about child sexual exploitation (CSE) but had not escalated the case through the trust's safeguarding team or their line manager despite this appearing to have been warranted. In other examples CAMHS practitioners have raised concerns about cases where they think there is risk of CSE with the CSE team but cases have not been taken up by the CSE team.  
**(Recommendation 2.7)**
- 3.20 The expectation is that drug and alcohol staff attend all child protection meetings and provide reports; attendance is monitored and there is a high level of compliance. Where certain risks factors are present, drug and alcohol workers services make home visits as part of the initial an ongoing assessment process.



**Case example:** *The drug and alcohol assessment tool includes a system, working with the LSCB link to check all new clients to identify any children and relevant history.*

*The tool includes wide questions about others and any children linked to the client. The LSCB safeguarding link is contacted to make checks on all new clients who appear to have links to children. This provides a history and the practitioner looks for support options that might be relevant and refers to children's social care if risks are identified that cannot be supported.*

*Immediately a child is identified as linked to a drug or alcohol service client in any way, the on-site liaison health visitor is notified and the assessment tool triggers a letter to the child's social worker.*

- 3.21 CASH services, provided by Sexual Health Sheffield and part of STH NHS FT were able to refer directly to the CSE team but arrangements recently changed and the agreed pathway is that all assessments for child sexual abuse now go to Children's Social Care first who then decide if the referral should be forwarded onto the CSE service. The concerns from staff are therefore that this may prevent a timely support and create barriers to access appropriate services for young people at risk of CSE.

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## 4. Looked after children

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- 4.1 Sensitive, thoughtful arrangements are in place to support women whose babies are to be removed into foster care. A photographer takes professional photographs that are included in a pack for both the mother and baby to keep. This includes a copy of foot and hand prints and a diary for the mother to complete and hand over to the foster carer. We hear from young people how important this early life story work is.
- 4.2 Children and young people are given choice of venue for review health assessments. This is good practice as it enables young people to be seen in a venue in which they are comfortable.
- 4.3 Sheffield has adapted the British Agency for Adoption and Fostering (BAAF) paperwork to prompt and ensure a more holistic health assessment for looked after children (LAC). In all records seen the issue of consent by the young person had been considered and where age appropriate and Fraser competent had been signed by the young person. This is good practice and ensures that children are able to engage in their own health care assessment planning.
- 4.4 The paper forms used for health assessments of looked after children are colour coded to separate those children under 5 years and those over five years. There is a section used for self-assessment of emotional well-being in the form of smiley or sad faces. This was seen on records to be used every time and as a tool for further exploration of how children are feeling. However, there is no separation of the forms for young people who are approaching adolescence and therefore some of the questions and prompts on the forms for those who are five years and upwards are not age appropriate. For example, those pertaining to drug and alcohol use or sexual activity.
- 4.5 The forms did not contain detail of the reasons for the child/young person becoming looked after. This is important information, although present in other areas of the file, may not be readily seen and considered as part of the initial or review health assessments. **(Recommendation 2.8)**
- 4.6 Whilst height /weight ratios are recorded in review health assessments and in several we saw, obesity was flagged, in some of these the issue was not mentioned in the subsequent health plan or was addressed vaguely. More attention is needed to ensure that health issues from assessments are comprehensively addressed in health care plans with appropriate timescales and monitoring of progress tracked and recorded so that the health care plan is a working document. **(Recommendation 2.9)**

- 4.7 In all LAC files seen the front sheets were completed with demographics. Attendances at ED were noted as well as the number of attendances in the last 12 months. This is good practice as it ensures a cross referencing of important information in respect of children and young people. Although documents did capture ethnicity and religion, we did not see evidence that any cultural implications were considered by the assessor or addressed in the assessment or plan. Lack of acknowledgement of faith and culture is not only a feature of serious case reviews but also essential for person centred planning. **(Recommendation 2.9)**
- 4.8 Although in the majority of cases birth parents should be able to attend their child's health assessment, we saw no evidence of birth parents inclusion in the process. Parents are the holders of vital health information for their children and this is a missed opportunity to gather relevant histories from parents and promote their involvement in their children's health care plans. **(Recommendation 2.10)**
- 4.9 In general practice, we found that awareness about, and knowledge of, the requirements and arrangements for meeting the health needs of LAC were under developed. Any looked after child living in Sheffield will have a health assessment undertaken, regardless of originating authority, as long as they are registered with a Sheffield GP. However, GPs are not routinely being asked to contribute to initial and review health assessments for looked after children. This is a missed opportunity to include vital information from a primary record holder and to promote an understanding of the additional needs of looked after children and young people. **(Recommendation 2.11)**
- 4.10 Strength and difficulties questionnaires (SDQ) are being sent out by social care and we were told that the completion and return rates are high. However, health care staff told us that SDQs are not being used to inform health assessments for children. This is because the returned SDQs are not being shared with health staff by social care. Looked after children are five times more likely to have a mental health disorder than all children. The use of SDQs contains essential detail and should be part of the health care assessments in order to identify risks and ensure appropriate support plans are developed. This area has been identified as requiring improvement and plans are in place to strengthen the use of SDQs to inform health assessments from April 2016.
- 4.11 In CAMHS we heard about good outcomes for looked-after children through support given to social workers, foster carers and young people from the multi-agency psychological support (MAPS) team. Examples included securing a change of placement promptly when a looked-after child disclosed abuse from another foster child in the placement.

- 4.12 MAPS are effective in helping foster carers to understand the developmental trauma that looked-after children can experience and which may result in disruptive or difficult to understand behaviour that can put the placement at risk. As a result of MAPS support foster carers are better able to understand and manage situations and we heard a number of examples where this engagement had helped to sustain fragile placements.

**Case Example:** *MAPS worked to support new foster parents who were caring for two siblings who had been victims of sexual abuse. The level of inappropriate sexual interaction between the siblings was such that the foster carers were unable to leave the children alone with each other. Both children were moved into separate new foster placements. MAPS continued to meet with and support the original foster carers so that they could deal with the impact the situation had had on them. As a result the foster carers felt able to care for other children. Another set of siblings were placed with them and disclosed past sexual abuse and again behaviour between them was sexualised. However, the foster carers, having felt well supported in the past, promptly asked for MAPS support as the new situation emerged and are currently benefitting from MAPS support in how to manage the placement. This demonstrates the positive impact of MAPS and how foster carers value their input and support.*

- 4.13 We were told that feedback from foster carers and young people who have had input from Multi-Agency Psychological Support (MAPS) is very positive. The MAPS lead clinical psychologist currently gets the SDQs data from children's social care and is working with children's social care to put in place effective processes whereby SDQs will routinely inform review health assessments. This does not currently happen. Whereas MAPS routinely input into statutory looked-after child reviews and attend as required, they do not input into the looked-after child review health assessments and this is a gap (**Recommendation 2.11**)
- 4.14 Appropriate arrangements are in place to ensure that looked after children and young people placed out of Sheffield benefit from initial health assessments and health reviews. A good tracking system is in place to monitor timeliness of initial and review health assessments. However, in some cases seen the assessments were out of date due to difficulties in securing consent. This has been previously highlighted as problematic but requires resolution to ensure that health assessments of children are not unnecessarily delayed. Once completed most cases seen showed comprehensive assessments that clearly outlined the health needs of the child or young person.

- 4.15 Not all young people leaving care are receiving health summaries: This was an area identified as requiring development in an earlier inspection. The specialist nurse for looked after children undertakes all review health assessments for young people in residential care. Where the nurse undertakes the final health care assessment a health care summary is provided. However, resource shortfall means that some young people are not able to be provided with a timely health care summary but it is provided within six months of them leaving care. For those young people whose final health assessment is undertaken by school nurses they do not receive a health summary. This means that some young people will not have easy access to their health histories and important information as they transition into independent living. (**Recommendation 2.12**)

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# Management

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

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## 5.1 Leadership and management

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- 5.1.1 The named professional team within the SCH NHS FT is well resourced and is compliant with Working Together 2015 and the Intercollegiate Guidance. Named professionals have access to good local and county wide support networks for peer and individual supervision. The named nurse also attends a tertiary specialist named professional groups that meets three times a year. The named nurse is directly line managed by the Director of Nursing which reflects recommendations in Working Together 2015.
- 5.1.2 At STH NHS FT the named nurse post is shared between two named professionals for safeguarding who report to the lead nurse for children and young people. There is no direct accountability to the board of directors lead for safeguarding; instead they are three management tiers down. The arrangements are not compliant with arrangements for Working Together 2015 or the Intercollegiate Guidance Safeguarding Children & Young People: Roles & Competencies for healthcare staff. Intercollegiate Document (section 13) in relation to accountability which states that safeguarding child protection professionals should be a) accountable to the chief executive of the employing body and b) report to the medical director, nurse director or board lead with primary responsibility for children's services and safeguarding within the organisation. However, we were told that access to the board of directors by named professionals at STH NHS FT was unimpeded by these management arrangements.
- 5.1.3 The STH NHS FT uses a network of managers as safeguarding lead staff to promote safeguarding practice within their directorates. However, there is no formal role description to support the post holders and their performance is not linked to the performance appraisal process. **(Recommendation 5.3)**
- 5.1.4 Capacity for the post holder to fulfil the role of named midwife has been stretched. The trust has recognised this and recently approved the recruitment of a deputy named midwife. The named midwife is a member of the health reference group and the trust's safeguarding committee and attends supervision with the designated nurse.

- 5.1.5 There is currently good management oversight of the number of families and children that are receiving the universal core health visiting offer within the recommended timeframes. Health visitor team leads in Sheffield receive a monthly key performance indicator report, which includes information of missing data that is collated from SystmOne patient health records. Health visitor team leads are reviewing all records to exception report and to ascertain why information is missing. Learning from this is then shared with individual health visitors.
- 5.1.6 Each health visiting team in Sheffield keeps a manual record of all cases that have been referred for safeguarding supervision. This includes information on how often the health visitor is visiting the family, when they were last seen and when supervision was last accessed. This information is then submitted to the safeguarding named nurse, who is able to keep a log of all safeguarding cases in health visiting teams. The trust recognise that the current safeguarding supervision model needs strengthening, particularly in respect to outcomes being SMART, and timeframes for when practitioners should be accessing safeguarding supervision. We were told that there are plans in place to strengthen the current model.
- 5.1.7 There has been a long standing historical problem in Sheffield of young people with mental health problems being treated by adult services and also a lack of clear transitional arrangements for those who are 16 plus with enduring mental health problems that are likely to need adult services. To this end we were told that there have been lengthy discussions between adult and children's services in trying to reach resolution. The situation has been compounded by austerity measures and therefore lack of capacity and potential loss of funding. A high level strategy is now in place between the CCG and local authority to identify priorities for emotional wellbeing and mental health in children and young people including arrangements for transitions between CAMHS and adult services. The strategy encompasses an evaluation process.
- 5.1.8 Although there have been some operational difficulties following the transfer in January 2015 of 16-17 years' service from adult mental health to CAMHS, this transfer is expected to be permanent pending final recommendation to the CCG Clinical Executive Board (CEB) in October 2015. Detailed plans to underpin this to improve the eating disorders services, support a roll-out of the children and young people IAPT service and provide joint training in schools in line with national guidance.
- 5.1.9 The re-organisation of CAMHS and new commissioning arrangements for young people aged 16-17 with mental health problems to receive support from CAMHS rather than the adult mental health service, is a positive development. CAMHS told us of the good relationship between themselves and NHS England in Rotherham which supports efficient and prompt identification of appropriate in-patient beds through special commissioning for Tier 4

- 5.1.10 The recent provision of a named nurse for safeguarding based in the local SCH NHS FT CAMH in-patient unit (Becton) is a positive development, given the vulnerability of this cohort of young people and the increased likelihood of disclosures of experiences that may have significant implications for their current mental health. This additional named nurse role is able to give focused attention, support and advice to young people and practitioners in the unit.
- 5.1.11 In adult mental health services, care plans were dated but not always SMART with a clear contingency. Electronic records only were seen but there was no evidence to demonstrate that plans had been signed by practitioner and parent. Although reports were provided for initial child protection conferences and completed using the new strengths based template, in records seen they were not always countersigned by a manager or supervisor. Managers work on the assumption that experienced practitioners will provide quality reports. Management oversight and counter signature of reports provides a framework for operational governance and an opportunity for managers to monitor safeguarding and child protection practices as well as a process to ensure compliance with operational expectation. (**Recommendation 4.2**)



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## 5.2 Governance

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- 5.2.1 The governance structure for safeguarding within SCH NHS FT is appropriate. However, there is an over reliance on reporting on safeguarding activity only from the Sheffield Children's Safeguarding Board. The trust board's current key performance indicators, although useful, do not include activity around referrals to children's social care, attendance at conference or reports submitted.
- 5.2.2 SCH NHS FT holds a bi-monthly meeting chaired by the Director of Nursing and attended by management representatives for all areas in the Trust including ED. The Designated Nurse and Designated Doctor both attend this meeting. Minutes of the healthcare governance arrangements were provided by STH NHS FT and demonstrated that their healthcare governance committee continues to function as a committee to the Board of Directors overseeing the Trust arrangements for quality, healthcare related governance and healthcare related risk management. The committee has continued to strengthen and broaden its activities to develop the way it leads healthcare governance activities and ensure compliance with national standards. As well as the papers specifically included on the work plan such as the annual safeguarding children report, a number of other papers have been reviewed by exception by the committee and this included domestic homicide, maternal deaths and child sexual exploitation.
- 5.2.3 Governance arrangements for safeguarding children within the STH NHS FT are co-ordinated by the healthcare governance committee which is a formal sub-committee of the Board of Directors. The trust wide children and young people's meeting is chaired by the deputy chief nurse and this meeting reports to the health care governance committee.
- 5.2.4 In addition to the children and young people's meeting STH NHS FT, there is a joint adult and children safeguarding leads meeting where representatives from the various care groups across the trust meet with named professional and discuss safeguarding practice. The governance arrangements for safeguarding children, however, in STH NHS FT Emergency Department are much more effective. There is a regular safeguarding meeting for the department where children, vulnerable adults and domestic violence are standing agenda items. The paediatric liaison health visitor attends the meeting and external agencies are invited to attend as and when the planned discussion necessitates this. Outcomes from this are reported to the ED Governance meeting.

- 5.2.5 The governance structure for safeguarding within SCH NHS is appropriate. However, there is an over reliance on reporting on safeguarding activity from the Sheffield Children's Safeguarding Board. The trust board's current key performance indicators, although useful, do not include activity around referrals to children's social care, attendance at conference or reports submitted. Peer review is well established within the SCH NHS emergency department and is used to discuss cases of concern or where there are learning opportunities.
- 5.2.6 Health Visitors in Sheffield are currently offering universal antenatal contacts to all mothers to be. However, we heard that this has been difficult to implement in some areas due to capacity issues in teams, in particular where staff are on long-term sick. We also heard that although Sheffield has successfully trained a new cohort of health visitors, they have lost a number of them to neighbouring areas. Therefore, the workforce strategy has not been effective. There are concerns that these vacant posts may not be recruited to following the recent move to the local authority and due to the impending funding cuts. In school nursing there are also some challenges in recruiting new staff. Staff told us that they feel valued and supported by commissioners but there are some concerns that projected cuts due to financial constraints will impact upon service delivery in the longer term.
- 5.2.7 School nursing services have over the last year begun to transfer records to SystmOne. This means that children's early birth history and health records are available for school nursing staff to view. This means that parents do not have to repeat information assuming that practitioners use the system to familiarise themselves with children's histories. However, not all records are available on SystmOne and therefore there are gaps in important information pertaining to children. In addition there are presently limitations to the use of SystmOne. We were told that full use and implementation is planned for next year following procurement.
- 5.2.8 There continue to be significant challenges in improving young people's access to CAMHS support and some young people wait too long to receive therapeutic support. SCH NHS FT states that it is undertaking a lot of work to review and improve waiting list management processes and promote consistent clinical decision making regarding thresholds which have prompted a reduction in waiting times.
- 5.2.9 The CAMHS performance monitoring framework is under re-negotiation with the provider (SCH NHS FT). Performance monitoring is being developed on a clinical pathway basis in line with the new national data collection systems.
- 5.2.10 The CCG has increased CAMHS investment as part of the 2015/16 contract in recognition of the increased activity over the past few years. There is more to do to ensure the transition of young people with mental health problems from CAMHS into adult mental health works consistently well, although we did hear case examples where this had happened.

- 5.2.11 Work has been on-going in developing a pathway for the CAMHS transition service. We were told that the services are working together to try and improve transitions for young people into adult service provision. Some children are being provided with services from adult community mental health teams as well as well as tier 4 provision. Adult mental health staff do not undergo any additional training to prepare them for direct work with children and young people. However, records demonstrated good cross team liaison and information sharing with CAHMS staff.
- 5.2.12 Senior managers in CAMHS have recognised that there is a need to strengthen operational governance across CAMHS services to ensure best practice is embedded and that there is a drive for continuous improvement. To that end, team leader meetings have recently been established to facilitate this.
- 5.2.13 We heard about mixed messages and differences of understanding between health providers and children's social care regarding whether or not information about specific cases can be shared and in using the encryption protocol for NHS.net. This can inhibit effective communication about children and young people known to be vulnerable. This is not an issue we commonly find elsewhere. **(Recommendation 5.4)**
- 5.2.14 In adult mental health services, as part of a pilot programme with the home treatment team, discharges from in-patient services are planned in conjunction with other professionals as part of a multi-agency discussion and take into account the safeguarding of children. This ensures formulation and control over the discharge process that includes any on-going treatment regimens and ensures that other relevant professionals are aware of the service involvement.
- 5.2.15 In CASH services systems are not supporting robust assessments or assisting in identifying concerning patterns of behaviour in service users. Although the services are integrated, the IT systems are separate on each site and no arrangements have been made to cross check or share information between the sites. **(Recommendation 5.5)**
- 5.2.16 There are only limited arrangements for management oversight and quality assurance of safeguarding practice and risk assessment within the CASH services. The CASH service has not kept copies of referrals to children's social care therefore it has not been possible to quality assure content or to be clear about which referrals have actually been made or to ascertain outcomes. **(Recommendation 5.2)**

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## 5.3 Training and supervision

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- 5.3.1 It is important that staff working with children and families are effectively supervised to support them and to promote good standards of practice in safeguarding children. Most clinical staff who are employed by SCH NHS FT attend Level 3 safeguarding training. The trust recognise that multi agency training as required in the intercollegiate guidance is the preferred option and those staff who hold specialist roles are encouraged to attend the Sheffield LSCB training. The remainder of staff attend the trust's local training; the content of which has been shared with the LSCB as part of the Section 11 audit.
- 5.3.2 Supervision in safeguarding children within acute services provided by SCH NHS FT is an area for development. Ad-hoc advice and guidance is readily available to staff and peer review is well established, however, supervision is not yet a mandatory requirement. **(Recommendation 5.6)**
- 5.3.3 The training needs analysis for STH NHS FTH does not accurately identify ED practitioners as needing Level 3 safeguarding children training. Instead, the recommendation is for practitioners to attend Level 2 training with only senior nurses attending Level 3. This is not acceptable as all practitioners working in the department have frequent contact with young people. **(Recommendation 7.4)**
- 5.3.4 Peer review is well established within the SCH NHS FT Emergency department and is used to discuss cases of concern or where there are learning opportunities. Currently ED staff do not access individual or group supervision in safeguarding children. There is good access to ad-hoc advice and guidance, however, this is not reflective and is a gap. **(Recommendation 5.6)**
- 5.3.5 Appropriate arrangements are in place for community midwives and the vulnerabilities specialist midwifery team to access Level 3 safeguarding training. The vulnerabilities specialist midwifery team midwives attend the LSCB training and some team members have also obtained the diploma in child protection.
- 5.3.6 Preceptorship for new midwives contains competencies around safeguarding and child protection practice. In addition, the vulnerabilities specialist midwifery team access support from a clinical psychologist to address risk from vicarious trauma. This is in recognition of the impact of working continuously with such complex and high risk clients. Community midwives attend one to one supervision and group supervision at regular intervals.

- 5.3.7 In Sheffield, health visitors have access to 1:1 safeguarding supervision at a minimum every 3 months which is provided by a Band 7 early interventions prevention health visitor. In records reviewed, we saw evidence of cases being referred for safeguarding supervision, which is then actioned by the safeguarding administration team: however, this does not mean that all cases are being discussed at safeguarding supervision. Where cases were being discussed at safeguarding supervision, plans were not always outcomes focused. These issues will be brought to the attention of Public Health England as commissioners for the health visiting service and school nursing services. **(Recommendation 5.6)**
- 5.3.8 Health visitors who are newly qualified or have been in post for 2 years will have access to additional group supervision. Newly qualified health visitors working in Sheffield are supported through a 6-12 month preceptorship period which is based on the national health visiting preceptorship programme which is assessed and competency based. They are also allocated a mentor, who is based in the same office as them for additional support and guidance. Mentors will support newly qualified health visitors at child protection conferences and ensure that reports produced for conference are of a good standard. Formally documenting safeguarding competences can help practitioners understand and demonstrate their knowledge and awareness of good safeguarding practice.
- 5.3.9 All Band 5 and Band 6 school nursing staff have 3 monthly supervision in mixed styles which include group supervision with peers involving either case discussion or lessons from SCRs or lessons learned. At other times staff are offered 1:1 supervision with a member of the community safeguarding team. However, the frequency of 1:1 supervision is not structured or robust. In records seen it was noted that child protection or safeguarding concerns were “referred to safeguarding supervision” but there was no evidence to show that a case discussion and outcome plan and review or follow up had been agreed. In some cases the referral had been made but there was no evidence that a subsequent supervision case discussion had taken place. This is a gap. **(Recommendation 5.6)**

- 5.3.10 An effective safeguarding supervision framework is not in place across CAMHS. We were told that there is good access to the safeguarding advisory line operated by the LSCB which currently has a health presence and this is often the first place CAMHS practitioners go to for safeguarding advice and guidance. Practitioners also value the guidance they get from the SCH NHS FT safeguarding named nurses although this can take more time to get a response. All practitioners receive clinical supervision which is expected to have a safeguarding element. However, whilst ad hoc safeguarding supervision is a valuable thread in supervision arrangements it is essential that all practitioners have planned, recorded and regular safeguarding supervision from an appropriately trained supervisor. It was not clear that clinical supervisors have been trained to deliver effective safeguarding supervision. Managers in CAMHS were clear that they would expect that any discussion about an individual case in supervision would be recorded in the case record. They acknowledged that this does not always happen and we did not see any examples in records reviewed. **(Recommendation 5.6)**
- 5.3.11 In LAC services safeguarding supervision is not structured and has been recently reviewed. We were told that 1:1 supervision is available on an ad hoc basis and that a new safeguarding supervision policy has been written and is due to be implemented in November 2015. It will centre on action learning sets based upon learning from SCRs and lessons learned this will need to be considered against guidance and the requirement for 1:1 safeguarding supervision for staff.
- 5.3.12 There is no formal supervision structure within drug and alcohol services and this is not compliant with guidance. Sheffield acknowledged that the provision of safeguarding supervision in line with Working Together to safeguard Children 2015 is an area for development. **(Recommendation 5.6)**

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## Recommendations

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- 1. NHS Sheffield Clinical Commissioning Group and NHS England should ensure that:**
  - 1.1 GPs and health visitors are supported in developing the liaison meetings to include school nurses and drug and alcohol services and to establish a clear method of record keeping, action planning and a system of monitoring practice resulting from these meetings.
  - 1.2 support is given to Primary Care in standardising user codes to identify vulnerability and ensure that all health professionals are aware of and adhere to the DNA policy.
  - 1.3 all children newly registered with GP practices are seen and basic measurements of health and weight are undertaken to benchmark their health and development.
  
- 2. NHS Sheffield Clinical Commissioning Group and Sheffield Children's NHS Trust should ensure that:**
  - 2.1 health practitioners when information gathering accurately record in detail and include questions about relationships and caring responsibilities as part of the information gathering process.
  - 2.2 children who attend ED are routinely weighed as part of a base line observation.
  - 2.3 the Sheffield Hospitals Foundation Trust ED community youth team referral protocol is adopted that will ensure that young people with risk taking behaviours are referred onto community youth teams for support.
  - 2.4 all cases of children and young people who attend ED are reviewed by paediatric liaison.
  - 2.5 a NICE compliant care pathway is developed to ensure that children and young people who have mental health problems are assessed for admission to the paediatric ward have a comprehensive assessment of their needs, to include all available information including that from ambulance services.
  - 2.6 there is a centrally agreed pathway with social care to ensure that invitations to, and outcomes from, safeguarding and child protection meetings are expedited.
  - 2.7 all staff are aware of the escalation policy and how to use it.

- 2.8 the health assessment forms used for children and young people include the reason for them becoming looked after and their legal status.
  - 2.9 all looked after children have timely and high quality holistic assessments of their physical, emotional and mental health needs that are informed by SMART health plans to continuity of health care and consideration of any cultural needs.
  - 2.10 work is undertaken with the local authority to ensure that parental health information is recorded as part of the initial and review health assessments of looked after children.
  - 2.11 GPs and MAPS are asked to contribute to initial and review health assessments for children in their practice and that family health information is transferred onto health assessment documentation as part of the process.
  - 2.12 all young people who leave care are provided with a comprehensive health passport.
- 3. NHS Sheffield Clinical Commissioning Group and Sheffield Children's NHS Trust and Sheffield Teaching Hospitals NHS Foundation Trust should ensure that:**
- 3.1 registration and risk assessment documentation which includes consideration of risk taking behaviours and potential for hidden harm is in place in the ED for both adults and children, and that completion by clinical and non-clinical staff is subject to effective monitoring arrangements.
- 4. NHS Sheffield Clinical Commissioning Group and Sheffield Health and Social Care Foundation Trust should ensure that:**
- 4.1 mental health staff undertake a home visit as part of their assessment of adults who are identified as having contact with children.
  - 4.2 all reports for child protection conferences are countersigned by supervisors.
- 5. NHS Sheffield Clinical Commissioning Group and Sheffield Children's NHS Trust and Sheffield Teaching Hospitals NHS Foundation Trust and Sheffield Health and Social Care Foundation Trust should ensure that:**
- 5.1 a review of all recording systems and record keeping is undertaken and that a plan to develop the electronic record system is in place to include family inclusive practice and ease of information sharing between service areas to include where necessary prompts for practitioners to check other services or systems.



- 5.2 all referrals to children's social care are followed up in writing by using a standardised referral form and outcomes are recorded on the patient record.
  - 5.3 all staff in safeguarding posts have formal role descriptors linked to the annual performance appraisal processes.
  - 5.4 there are clear information sharing protocols and that staff are familiarised with the encryption protocol for use with nhs.net.
  - 5.5 where there are separate or stand alone IT systems, there are prompts in place to cross reference data so that files are complete, information is shared appropriately to update risk assessments and that plans for children and their families are accessible.
  - 5.6 all health care staff who case hold are provided with regular planned 1:1 safeguarding supervision with a suitably trained supervisor that reflects involvement in complex casework and ensure that discussions and action plans from supervision are clearly documented in the patient records.
- 6. Sheffield Clinical Commissioning Group and Sheffield Children's NHS Trust and Sheffield Health and Social Care Foundation Trust should ensure that:**
- 6.1 the information sharing pathway between CAMHS and adult mental health services is implemented within a clear planned timeframe.
- 7. Sheffield Clinical Commissioning Group and Sheffield Teaching Hospitals NHS Foundation Trust should ensure that:**
- 7.1 the new pathway for pregnant women is implemented to ensure that women are seen alone and includes a question about domestic violence to provide a comprehensive assessment of risk to assess all pregnant women to safeguard unborn babies.
  - 7.2 health visitors are notified by midwifery staff of all pregnancies that will ensure that all families, irrespective of identified vulnerabilities, are offered and receive antenatal visits by health visitors in line with best practice.
  - 7.3 all birth plans are SMART and shared with families.
  - 7.4 the safeguarding training arrangements are standardised to comply with the intercollegiate guidance for healthcare staff 2014 to ensure that staff are undertaking training at a level commensurate with their role and accurate records.

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## Next steps

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

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