

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

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

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Provider services included:	Sherwood Forest Hospitals NHS Foundation Trust Nottinghamshire Healthcare NHS Foundation Trust Nottingham University Hospitals NHS Trust Doncaster and Bassetlaw Hospitals NHS Foundation Trust
CCGs included:	NHS Mansfield & Ashfield CCG NHS Nottingham North & East CCG NHS Newark & Sherwood CCG NHS Rushcliffe CCG NHS Bassetlaw CCG NHS Nottingham West CCG
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Summary of the review

This report records the findings of the review of health services in safeguarding and looked after children services in Nottinghamshire. 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 Nottinghamshire, cross-boundary arrangements have been considered and commented on. Arrangements for the health-related needs and risks for children placed out of area are also included.

About the review

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

- The review explored the effectiveness of health services for looked after children and the effectiveness of safeguarding arrangements within health for all children.
- The focus was on the experiences of looked after children and children and their families who receive safeguarding services.
- We looked at:
 - the role of healthcare providers and commissioners.
 - the role of healthcare organisations in understanding risk factors, identifying needs, communicating effectively with children and families, liaising with other agencies, assessing needs and responding to those needs and contributing to multi-agency assessments and reviews.
 - the contribution of health services in promoting and improving the health and wellbeing of looked after children including carrying out health assessments and providing appropriate services.
- We also checked whether healthcare organisations were working in accordance with their responsibilities under Section 11 of the Children Act 2004. This includes the statutory guidance, *Working Together to Safeguard Children 2015*.
- Where we found areas for improvement in services provided by NHS but commissioned by the local authority then we will bring these issues to the attention of the local public health team in a separate letter.

How we carried out the review

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

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

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

In total, we took into account the experiences of 87 children and young people.

Context of the review

Children and young people under the age of 20 years make up 22.7% of the population of Nottinghamshire; 11.4% of school children are from an ethnic minority group.

The health and wellbeing of children in Nottinghamshire is generally better than the England average. The infant mortality rate is similar to and the child mortality rate is better than the England average.

Commissioning and planning of most health services for children and young people is the responsibility of Public Health and CCGs. To bring these two areas together, the work is carried out by the Nottinghamshire Children's Integrated Commissioning Hub hosted in Nottinghamshire County Council. Those services that remain the commissioning responsibility of the CCG for Bassetlaw are commissioned directly by Bassetlaw CCG.

Commissioning arrangements for looked after children's health are undertaken by the Nottinghamshire Children's Integrated Commissioning Hub and for Bassetlaw by Bassetlaw CCG. The looked-after children's nursing teams and designated nurse role are provided by Nottinghamshire Healthcare NHS Foundation Trust Health Partnership Division and Bassetlaw Health Partnerships. The looked after children's medical teams and designated doctor roles are provided by the following acute hospital trusts:

- Nottingham University Hospitals NHS Trust
- Sherwood Forest Hospital NHS Foundation Trust
- Doncaster and Bassetlaw Hospitals NHS Foundation Trust

Public Health Nursing Services (including Family Nurse Partnership, Health Visiting and School Nursing) are commissioned by the Children's Integrated Commissioning Hub and provided by Nottinghamshire Healthcare NHS Foundation Trust Health Partnership Division.

Maternity services in Bassetlaw and Doncaster are commissioned in partnership between Doncaster and Bassetlaw CCGs and provided by Doncaster and Bassetlaw Hospitals NHS Foundation Trust. Mansfield and Ashfield CCG's are the lead commissioners for midwifery services provided by Sherwood Forest Hospital NHS Foundation Trust. Nottingham West CCG commissions midwifery services from Nottingham University Hospitals NHS Trust.

Contraception and sexual health services (CASH) are commissioned by Public Health and provided by:

- Nottingham University Hospitals NHS Trust
- Sherwood Forest Hospital NHS Foundation Trust
- Bassetlaw Health Partnerships, Nottinghamshire Healthcare NHS Foundation Trust Health Partnership Division

GUM services are commissioned by Public Health and provided by:

- Nottingham University Hospitals NHS Trust
- Sherwood Forest Hospital NHS Foundation Trust
- Doncaster and Bassetlaw Hospitals NHS Foundation Trust

Child substance misuse services are commissioned by Children's Services and Public Health, Nottinghamshire County Council and provided by Nottinghamshire Healthcare NHS Foundation Trust.

Adult substance misuse services are commissioned by Public Health and provided by New Directions (previously CRI).

Child and Adolescent Mental Health Services (CAMHS) tiers 2 and 3 are commissioned by the CCGs and provided by Nottinghamshire Healthcare NHS Foundation Trust Health Partnership Division and Local Services.

CAMHS tier 4 is commissioned by NHS England and local inpatient facilities are Thorneywood. There are five other inpatient facilities across the East Midlands.

Adult mental health services are commissioned by Newark and Sherwood and Bassetlaw CCGs and provided by Nottinghamshire Healthcare NHS Foundation Trust

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

The report

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

What people told us

We heard from some parents accessing the 0-19 team:

"We know we can see and talk to the health visitor at the baby weighing session at the children's centre."

"I am confident I know what the health visiting service offers. When my children are school aged I would expect to get a pack to tell me about school nursing."

"We were visited by the school nurse after my daughter had an operation. The school nurse had also been the health visitor. This gave some continuity."

One young person in care told us:

"You can choose when and where you have the review health assessment. Usually they came to the house. They give you a chance to find out things about your health. They are really nice and you felt you could ask them things."

A care leaver told us:

"There was some preparation before leaving care, things you don't know about. I had a health history given to me, it's really nice to know these things, like details about being born, that was really important to me."

Foster carers told us:

“Our GP is good, as soon as we ring up we get an appointment straight away because they are looked after.”

“When he came into care he was terrified of any appointments, and had big issues with going to hospitals at all. He had never seen a dentist. Our dentist and GP have been great, really sensitive, despite the children’s fears.”

“They didn’t label him unnecessarily. The initial health assessment was fantastic, the paediatrician took their time at the child’s pace and was very careful throughout. Some special health issues were being considered including genetic tests and these were explained to him in a way that he could understand then the paediatrician also saw him with the results and discussed a home visit with him.”

“Our review check was very positive. The first two reviews were with paediatricians because of his initial needs but its planned the next one will be with a children in care nurse.”

“The health people were so accessible and the paediatrician even rang me back about my queries. It’s been a wraparound service.”

“Reviews take place at home and are very relaxed as a result. The LAC nurse who came to do the medicals picked up our concerns. There’s nothing negative to say about the process. However, we aren’t asked what we think about the IHAs or RHAs so we don’t have an opportunity to give feedback. We do now get copies of health plans and health assessments.”

“The biggest issue is needing to push to get any action once the needs have been identified. Sometimes, you have to be pushy to get services for the children, and you have to ask around to find out what’s available. As an example, we needed to learn Makaton to communicate with one of the children. We asked and asked and asked but got nowhere. In the end we had to take it on ourselves to sort something out.”

The child's journey

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

1. Early help

1.1 Women in Nottinghamshire accessing midwifery services have a good choice of locations for initial booking, including children's centres and GP settings for appointments. Both providers make good opportunities to see expectant women alone and at home for the 36 week birth plan visit, and cases sampled illustrated the benefits of home visiting in completing a thorough risk assessment to ensure families were supported.

1.2 Risk assessment throughout midwifery was comprehensive with clear onward referral to MASH when needed. Domestic violence is a routine enquiry and the electronic booking systems, used in both providers, support confidential alerts on any disclosure. There is good compliance with thorough recording of accompanying adults at appointments, partner details and in higher risk cases, exploration of social issues and history of police and/or probation involvement.

1.3 Opportunities to liaise with other disciplines are well embedded and agencies ensure succinct joined up working in maternity services. Following serious case review learning, regular links with health visitors in the 0-19 team are robust via the monthly health visitor liaison meeting and quarterly family nurse partnership meetings. This supports cohesive transitions and smooth information exchange between midwifery and health visitor services to ensure children's and family needs are being met in an increasingly timely manner.

1.4 The teen pregnancy support worker within the integrated child and family health 0-19 team effectively supports vulnerable young parents who are unable to access family nurse partnership. Young people we spoke to valued having a key professional who could provide continuity of support.

1.5 The maternity liaison meeting that takes place monthly between midwifery, social care and health visitors, is a good opportunity to discuss cases where there are lower levels of risk that need to be monitored but that did not meet threshold for children's social care intervention. Cases we sampled had benefitted from a multi-agency background check and early multi-agency discussion to facilitate early support to families to prevent needs escalating. This meeting also proved useful as an information flow back to GPs to highlight vulnerable families for follow up.

1.6 Following the impact of “call to action”, health visitors are now experiencing an increase in resources, leading to vulnerable children and families in Nottinghamshire having more access to a range of health services. Health visitor’s now offer universal ante natal visits, targeted work for families experiencing domestic violence and specialist services for travellers and families in the homeless hostels, which have resulted in those families who require additional support being identified at the earliest opportunity.

1.7 Health visiting teams across the county have the flexibility to respond to the local needs of their caseloads. The wide range of parent education classes on offer both ante and post nately such as couples classes, single parent, grandparent, daytime and weekend sessions allows more focus on particular needs. Teams can adapt the parent craft sessions to ensure it best fits their local population at different stages of early parenthood.

1.8 Integrated child and family health team case records reviewed were of a good quality using the assessment framework triangle model with some detailed information about intervention and liaison with other agencies. The use of chronologies is developing in more complex cases, however this is not standard across the team, therefore this inconsistency is not assisting practitioners to identify drift in cases at an early stage. Their use would allow practitioners to be more outcome focused, and clearer in their responsibilities to assess and review the service that families will find most beneficial. **(Recommendation 2.1)** *This information will also be brought to the attention of Public Health.*

1.9 Health visitor and school nursing files reviewed demonstrate that attendances of children at local emergency departments (ED) and minor injury units (MIU) are routinely copied and recorded in patient records with follow up support as appropriate. This consistency in practice was further supported by the recent commissioning for quality and innovation target (CQUIN) implemented to ensure families were visited as a minimum after any three ED attendances.

1.10 Health visitors are well linked with GP practices, with some attending GP practice “think family” meetings where they exist. Where there is regular liaison in place, information is being shared between professionals and children are being safeguarded more effectively. However these meetings are not routine in all practices across the county. **(Recommendation 4.1)**

1.11 We have seen good partnership working embedded between health visiting and children’s centres to support families holistically. This includes monthly liaison meetings to update all professionals on families who are receiving support and identify roles for professionals to prevent duplication of services and to ensure families receive targeted support from the most appropriate professional.

1.12 Professionals recognised gaps in the communication between children's social care (CSC) and clinicians in the 0-19 service receiving domestic violence notifications and are working to resolve these through the revised ENCOMPASS pathway within the multi-agency safeguarding hub (MASH). There are currently missed opportunities to capitalise on the high levels of multi-agency working within the MASH, which incorporates a health overview and health analysis of family need. Developing this would further ascertain what universal services can do to support families and address their needs at an early stage, outside of CSC involvement.

1.13 School nurses have a visible presence in both primary and secondary schools and also see children who are home educated. They provide 'drop in' services weekly at all secondary schools where children and young people can discuss by appointment or by calling in on the school nurse during a session, to discuss any issues that might be troubling them. Whilst this is a valued service, we did hear of young people being directed to school nurses for support with emotional health as there is a perception that they will not be accepted by or have timely access to CAMHs support. Not all school nurses have accessed ongoing specialist training in emotional health and wellbeing therefore may not be best equipped to take on this role.

1.14 Young people have access to contraception and sexual health services (CASH) both via school drop in, clinics and the Sexions service. Sexions is a well-established outreach service including in school and phone/text contact available for young people. The CASH and Sexions services use data to aid effective delivery of their services and have a good grasp of social demographic patterns in the county to help target services to best meet need.

1.15 Emergency department (ED) and minor injury unit (MIU) facilities for children are variable and in some settings, waiting rooms were unsighted by staff. Paediatric staffing and cover arrangements is an issue across all sites visited. There are no paediatric trained staff employed at the MIU and the extensive use of locum doctors and frequent use of bank or agency nurses means that children are not always seen by appropriately trained staff. We are aware of the pilot at Kingsmill between 3-9pm which is delivering more timely treatment for children and young people and await its evaluation in Spring 2016. We were not provided with any strategy to recruit and retain paediatric nursing expertise within the departments. **(Recommendation 1.4 and 3.4)**

1.16 Children and young people attending Kingsmill ED benefit from having differentiated paediatric ED records. This is especially important for those young people who are seen in the adult ED as their records are easily identified as belonging to a young person and this should inform any assessment of vulnerability.

1.17 At Kings Mill ED we saw case examples of good safeguarding risk assessment by clinicians. Clear processes are in place in all unplanned care settings visited for staff if they identify safeguarding concerns. However there is too much emphasis on the professional curiosity of the practitioner to do this without supportive prompts, therefore the trust cannot assume that this has been considered. Documentation used is not NICE compliant and does not include prompt questions to assess safeguarding risk. The current risk assessment process is therefore reliant on the experience of the clinician to fully risk assess children and young people. Likewise, Newark Minor injury unit (MIU) and Bassetlaw ED Assessment template does not cover some key areas of information and so consistency of safeguarding practice is not well supported. This is especially relevant given their high use of agency and bank staff. **(Recommendation 1.3 and 3.1)**

1.18 Children and young people booking into the ED's and MIU are first seen by the receptionists who take and record demographic details along with the child's next of kin. However, in the majority of records seen the next of kin was either not recorded or recorded inaccurately. This is not acceptable. Accurate recording of next of kin and who is accompanying the child to the ED is important and is a common feature of serious case reviews. **(Recommendation 1.1)**

1.19 The setup of the Symphony electronic system in use at Bassetlaw District General Hospital ED has limited safeguarding functionality. This results in inconsistent capture of key information as it is reliant on the expertise of each practitioner. This may mean that important information for risk assessment isn't gathered from reception through triage to treatment, particularly around detailed information on next of kin, parental responsibility and accompanying adult. There is a missed opportunity to identify adults clearly. Previous attendances also need to be manually checked and are not linked to any alert which weakens assessment and identification of risk. **(Recommendation 3.2)**

1.20 The use of Systm1 at Newark MIU enables staff to access wider information about children and families from this area and their past history of attendances as part of the triage. This aids risk assessment, is good practice and helps identify patterns of attendance.

1.21 Paediatric liaison arrangements across all three unplanned care settings we visited were under resourced. This means there is no system to check that any issues around children that should have been picked up by ED have been. The paediatric liaison role does not review all under 18 attendances and therefore there is no effective "safety net" to provide an oversight on any cases that may require further support. During the review we identified cases that would have benefited from paediatric liaison input that had gone unrecognised by ED practitioners. This means that the opportunity for early intervention and support had been missed. **(Recommendation 1.5 and 3.5)**

1.22 Assessment of older children and young people does not sufficiently explore risk and vulnerability, including potential for child sexual exploitation (CSE). ED is a point of access into health services that young people exposed to CSE use, and it is important that opportunities to support vulnerable young people are maximised. **(Recommendation 1.6 and 3.6)**

1.23 The children and young people of adults who attend the unplanned care settings with concerning or risk taking behaviours are not being routinely identified and the details are not recorded on the adult's ED record. In only one case we found the details of children in the family recorded and this was used to facilitate an appropriate referral to children's social care. This is important detail and can be used to share information with health and/or children's social care so that children in vulnerable families can be identified and opportunities to intervene early maximised. **(Recommendation 1.7 and 3.7)**

1.24 Opportunities are being missed to identify and offer help for drug and alcohol misuse to young people attending ED settings as there is no adolescent pathway or screening tool in place. Young people who attend Kingsmill ED following intoxication or under the influence of substances are referred to children's social care and the paediatric liaison nurse alerted so that they are able to inform the child's school nurse. However there is no direct liaison between the local substance misuse service and the EDs.

1.25 Dedicated professionals with a special interest from the acute and community providers attend weekly Multi Agency Risk Assessment Conference (MARAC) meetings. Any relevant information is shared with practitioners involved in the patients' care. We heard that this information is recorded on the electronic patient records and flagged to alert practitioners of additional vulnerabilities that need to be taken into consideration during ongoing assessments.

1.26 CRI adult substance misuse services in Nottinghamshire, in partnership with the charity Hetty's, are embedding the "Think Family" model and providing support to children, families and carers affected by parents or relatives with adult substance misuse. In records reviewed, we saw evidence of adult substance misuse practitioners referring families to support services to ensure children and young people's needs are being taken into consideration and support made available to them.

1.27 Good arrangements are in place to identify any clients who access CRI and might present a risk to children as a result of their substance misuse. A pro-forma risk assessment tool is completed for all service users, which includes assessing for children and young people with whom they may have access to. This is important information to help ensure that hidden children living in the homes of risk taking adults are better safeguarded. Routine home visits are offered to all service users who have children or access to children. Records reviewed showed evidence of joint visits being planned with children's social care and taking place with family support workers. There are also arrangements in place for joint working with midwifery services.

1.28 GP engagement and contribution to safeguarding is developing however multi-disciplinary liaison meetings are not routine in all GP practices. This means there is a lack of opportunity for information exchange to ensure the needs of the child and family are met in a co-ordinated manner and to contribute to keeping children and young people safe. In practices where this is taking place, these are proving to be effective in supporting families and identifying risks.

1.29 The use of system1 in some GP practices has provided opportunities for information sharing however we found its functionality was not being used to best effect to support consistent safeguarding practice. Aside from tasking, GPs were not always aware of important information on records, and safeguarding templates. This means that the GP may not be not fully informed of any risk or vulnerability when in consultation with their patient. There is not yet a consistent use of flagging within primary care and community health arrangements to ensure that practitioners are all alerted where additional risks have been identified for children or their families.
(Recommendation 4.4)

2. Children in need

2.1 Arrangements for access to specialist midwifery for women with mental health or substance misuse issues are good. Specialist practitioners and clinics ensure women are able to access the additional health support they need through enhanced visits. Formalised pathways are in place for joint working with the perinatal mental health team and adult substance misuse teams which further strengthens this work. Case review meetings for women with substance misuse issues including attendance from health visitors, midwife, family planning consultant and CRI drug workers is particularly effective in providing holistic support. Cases sampled highlighted the benefits of this forum in identifying families exhibiting disguised compliance with rapid pick up and identification of safeguarding issues.

2.2 Referrals to the MASH from health visitors were clear and articulated risk clearly, with appropriate professional challenge when necessary. The introduction of health staff into the MASH is a positive development and aims to ensure children's health needs and their impact are fully considered as part of the assessment process. However, we have identified gaps in processes particularly around domestic violence, early help, and health staff being informed that a MASH enquiry is underway.

2.3 Provision of CAMHS across the county is variable based on historic commissioning arrangements, which has created anomalies in a cumbersome and complex service. We are aware of the significant changes to early support for emotional health and wellbeing services alongside more specialist CAMHS services due to be implemented from January 2016. It is anticipated many of the current issues associated with inequity, processes and transition between tiers will be alleviated through its implementation.

2.4 We saw evidence of young people and their families/carers benefitting from the therapeutic interventions offered in CAMHS and persistence on the part of individual practitioners to keep cases open where young people have significant needs but were reluctant to engage. Some families were experiencing delays in accessing therapeutic care following the initial assessment and for other families there was also a delay in their child receiving a service when there was a lack in clarity around decision making about whether a child's needs should be met within early help Tier 2 services or by more specialist CAMHS. This has led to the unacceptable practice of children moving between informal, and T3 CAMHS services which wastes resources and delays access to services. (**Recommendation 2.2**)

2.5 Following referral to CAMHS we saw some good initial assessments, undertaken by practitioners that were comprehensive and clearly identified need and risk. In these cases there was good use of SDQs to inform the initial assessments.

2.6 Record keeping processes in CAMHS are fragmented. In some case notes, minutes and plans from child protection and child in need meetings were not secured to electronic record. This leads to the risk that new practitioners would not be fully sighted on the needs and risks related to children and young people on their caseload. (**Recommendation 2.3**)

2.7 Care plans seen were SMART however they did not clearly articulate that children and young people were actively involved in the planning of their own care or in giving consent. (**Recommendation 2.4**)

2.8 Child sexual exploitation awareness and pathways for identification and action to take within CAMHS are under developed. The service is not represented at the multi-agency CSE hotspots meetings and we saw no clear evidence of the CSE pathway and use of risk assessment tool, or intelligence monitoring within the service. As children and young people may disclose current or historic abuse during therapy, this is a gap. (**Recommendation 2.6**)

2.9 Young people who need CAMHS specialist advice out of normal working hours do not benefit from an effective on-call system ensuring that there is access to CAMHS expertise, and we are aware that further exploration of out of hours provision is underway. Access to advice for responding to young people attending ED out of hours is predominantly through adult liaison who are able to contact an on-call CAMHS registrar. However, we were informed that there is no on call CAMHS consultant for the county and this is not best practice. (**Recommendation 2.8**)

2.10 Children and young people who attend ED with mental health needs following self-harm or in mental health crises benefit from a period of admission to the paediatric ward for observation and this reflects NICE guidance. Early care planning and risk assessments do not currently routinely ensure a child or young person is allocated a one to one worker to keep them safe. At Kingsmill, a paediatric nurse with a special interest in caring for adolescents with emotional health needs is working hard to improve the experience of these young people on the ward and to ensure their physical and emotional needs are met. However, not all paediatric nurses across settings have accessed training in assessing the risk for these vulnerable children and how to effectively meet their emotional health needs. (**Recommendation 2.5**)

2.11 Additional nursing staff to support particularly challenging young people on the paediatric ward can only be authorised once it has been established who is to fund the additional resource needed. This can be problematic where there is a difference in opinion between professionals as to whether the cause of the presentation is psychiatric illness or behavioural/social. We saw evidence in one record of a young vulnerable person who had taken an overdose and although her physical needs were being met, CAMHS did not provide any support to the patient or to the nursing staff to meet her emotional needs.

2.12 Despite a risk assessment of the Kingsmill paediatric ward environment being carried out in July 2015, the recommendations identified to make the ward area safe have not been implemented. Currently the risk assessment used to determine direct observation for enhanced support is based on a dementia tool introduced following an incident where a vulnerable child absconded from the ward. This is not acceptable. (**Recommendation 1.8**)

2.13 Discharge letters from EDs and MIUs which are generated automatically and sent to GPs and community health teams to inform them of a child's attendance are variable in quality and often give inadequate information. Although staff can add free text additional information, cases sampled indicated this is rare. In two cases seen at the MIU, records were poorly written with minimal recording and failure to record the account of the child. This means it is difficult to ensure thorough follow up by primary care and community health colleagues to ensure the child is receiving appropriate support. (**Recommendation 1.9 and 3.8**)

2.14 Young people who are engaged with CAMHS and may need to transfer into adult mental health services are not supported by clear and timely arrangements. The interface between the adult mental health team (AMH) with CAMHS is not robust and we did not see evidence of joint working to facilitate the preparation of case transfers. This is a vital process in enabling young people to adjust to the different style of support offered by adult services in comparison to the Family Systems models that are generally offered by CAMHS. The transitional protocol from CAMHS to AMH services is not fully embedded in practice. There is no regular forum to discuss transition as this is assessed on a case by case base. (**Recommendation 2.9**)

2.15 The "Think Family" model and principles are underpinning the development of child safeguarding practice in AMH, however this is not fully embedded and recognised by the team as a gap. We saw evidence that a children's safeguarding risk assessment tool is completed as part of the initial and routine risk assessments. Practitioners understand the need to prioritise the safeguarding of children while working with the adult. Risk assessment documentation include identifying children with whom the client has contact as well as those for whom they have parental responsibility.

2.16 Joint visits between AMH and other disciplines are not routine practice. Relapse indicators and mental health contingency plans to highlight emerging or escalating needs are not routinely shared. Direct liaison between adult mental health professionals and other practitioners working with the family could be strengthened to ensure best support for families with mental health needs.

2.17 Adult mental health services are currently using both paper and electronic patient records. We heard that the electronic patient record system being set up within RIO is relatively new and therefore practitioners still have to document risk assessments and care plans within the paper held records. This means that the patient records are fragmented and that practitioners do not always have full access to records. (**Recommendation 2.17**)

2.18 Adult substance misuse service users that have children or access to children are offered a routine home visit by CRI. This is a good opportunity for practitioners to assess the home environment and for any additional vulnerability particularly when children and young people are concerned.

2.19 In records reviewed, we saw evidence of joint visits being planned with children's social care and taking place with substance misuse family support workers. This is particularly important as multiagency working can address the needs of all family members which can result in improved outcomes. It also means that professionals are working together to inform joint decision making and co-ordination of care for families.

2.20 The monthly multi-agency pregnancy liaison group meetings are a useful forum to ensure all pregnant services users benefit from a co-ordinated approach to their care. This is a good opportunity to ensure that appropriate professionals are involved and risk to unborn babies is taken into consideration when formulating action plans.

2.21 Young people who access CASH services do not benefit from a comprehensive risk assessment. Exploration of a young person's sexual history, potential signs of CSE and female genital mutilation (FGM) have limited prompts to aid identification of risks. Given that there will be young people at risk of CSE accessing sexual health services, this is a gap. Whilst staff are said to be aware of risk indicators, there was no readily accessible prompt list in use and we saw some cases where vulnerabilities had not been explored fully. In several cases we saw involving very young girls, practitioners had recorded no safeguarding concerns despite indicators of concern. The assessment template also lacks evidence that Fraser competence is sufficiently considered in each consultation.

(Recommendation 1.2)

2.22 Safeguarding practice in primary care across Nottinghamshire is variable. We saw good practice with some GPs rigorously following up children who had not attended medical appointments. However, there is a lack of consistency in how safeguarding information is being recorded and shared between health visitors and primary care. ***(Recommendation 4.2)***

2.23 Awareness of CSE in primary care is underdeveloped. GP practices we visited were not using any recognised or locally approved assessment process to identify or exclude risks of CSE when they were in consultation with a child or young person who may be exhibiting concerning or risk taking behaviours.

(Recommendation 4.3)

3. Child protection

3.1 Children and young people who have identified vulnerability and attend Kingsmill ED benefit from having electronic alerts on their patient record. This helps the ED practitioners to consider the reason for their attendance in conjunction with other information known about the child and ensure that information is shared with a child's social worker where necessary.

3.2 At Bassetlaw ED, there are no arrangements for ED staff or the trust safeguarding team to receive details of children who are in care or on a child protection plan. This means that patients are seen, assessed, treated and discharged in isolation from other information that may usefully inform a risk assessment. (**Recommendation 3.3**)

3.3 Referrals to children's social care by ED practitioners were completed fully, and care had been taken to identify siblings and details of other adults living in the family. However, the referrals did not routinely analyse or articulate risk. Responses to referrals from CSC did not detail the reasons for the decisions taken. This is not helpful as it does not provide a learning opportunity for practitioners to ensure the appropriateness of any future referral.

3.4 MASH accept referrals to children's social care from ED practitioners up to 4pm, Monday to Friday. Outside of these hours, the emergency duty team will only accept referrals that require immediate intervention. All other referrals have to be held until the following working day, when they will be accepted by the MASH. This may mean that the ED practitioner with the initial concern is often not available and the practitioner tasked with making this call is often not in possession of the finer detail.

3.5 We saw clear evidence in CAMHS of an effective escalation policy to support practitioners to escalate safeguarding concerns, in particular around professional disagreements. In one case sampled, records showed that CAMHS continued to keep a case open until they were assured that their concerns about lack of service provision to the young person had been escalated and resolved. Records evidenced the escalation of concerns by practitioners and their team leader through the policy, culminating in a multi-agency meeting with senior management and the young person being appropriately supported.

3.6 Records we reviewed in midwifery had clearly identified safeguarding markers on both the Orion and K2 systems however the lack of use chronologies of significant events as a standard does not support midwives to identify drift in cases. We did however see good operational management oversight of cases with additional vulnerabilities. (**Recommendation 1.10 and 3.9**)

3.7 Comprehensive individualised birth plans are routinely in place to protect the unborn child where additional vulnerability has been identified, with oversight by the named midwife. Plans we saw were of an extremely high quality with clear actions, and used a standard format to support staff in identifying who needs to be informed about the delivery of the baby and any specific action to take place.

3.8 Clear processes are in place to ensure midwives attend CP conferences and we saw good compliance with this, with oversight by the named midwife and quarterly reporting of attendance to trust boards.

3.9 County wide maternity services have clear departmental guidance for frontline practitioners working with families at risk of FGM. This includes automatic referral to children's social care for new born females to ensure they are safeguarded.

3.10 The importance and relevance of CASH services potential contribution in safeguarding arrangements is not well understood by partners. CASH does not routinely receive information about young people with child protection or child in need plans and so are unable to contribute to monitoring of the plan and identify if they have information about the plans effectiveness. CASH systems, with the exception of Bassetlaw, do not have any alerts to indicate to staff that a young person may be especially vulnerable or that there is safeguarding information, and has no links to external alerts. This will be brought to the attention of public health.

3.11 Adult mental health service users caring for or with access to children with identified vulnerability are not always having the appropriate alert placed on their record. We were informed that AMH practitioners can flag vulnerabilities on patient electronic records however we did not see evidence of this in records reviewed. For example, in one case reviewed the patient had three children on a child protection plan, however this was not flagged as an alert on the electronic patient records. This is a missed opportunity to ensure practitioners remain vigilant to additional vulnerabilities that need to be considered during assessments. (**Recommendation 2.9**)

3.12 We saw evidence of the clear expectation that adult mental health staff are engaged with the formal CP process, with attendance at meetings, contribution or engagement within the case notes, and filing of CP Plans. However, reports for conference are not routinely produced. This is important as when concerns about the safety of children or young people have been identified, and adult mental health practitioners are involved they may hold important information in order to help facilitate decision making to safeguarding children and young people.

3.13 Adult mental health practitioners are receiving minutes following child protection conferences; however minutes for core group meetings are not always received. This means that practitioners do not always have access to child protection action plans, which may go on to help them inform their practice. Therefore, AMH practitioners are not able to develop a more detailed service care plan, with the client, to underpin the child protection plan.

3.14 Adult mental health practitioners routinely see patients at home which is a good opportunity to assess the home environment and validate information, particularly when there are children concerned. In one record reviewed, we saw evidence that the practitioner had identified the children in the house during an assessment, and this was clearly documented within the records reviewed, making reference to how the children presented during the visit.

3.15 Parenting needs assessments are being completed for all AMH service users who are actively looking after children and young people. This includes details of any risk and impact of parental illness on children and young people. However, the action plans formulated as a result of the risk assessment were not SMART.

3.16 CRI practitioners are effectively engaged in formal child protection arrangements, including attendance and contributions to CP and core group meetings. Practitioners are using a standardised CP report form, which enables them to clearly share important information and provide analysis of any concerns they have for children and young people of their service users. This is important as these practitioners may have more regular contact with adults who have risk taking behaviour, compared to other multi-agency professionals. They are therefore well placed to help ensure that children and young people are safeguarded.

3.17 Although we saw evidence of CP plans and minutes being consistently filed within paper records in CRI, these were not underpinning individual service plans. For example, in one case reviewed the child protection plan included fortnightly contact with the adult substance misuse worker; however this was not reflected within the individual action plan and the service user was not being seen as agreed. This will be brought to the attention of public health.

3.18 When adult substance misuse practitioners have any safeguarding concerns, they are appropriately completing a children's safeguarding referral form, which prompts them to provide as much information as possible regarding the reason for referral. We saw variation in the quality of referrals to children's social care, where some practitioners were clearly articulating risk to children and young people whilst others were not. There is a clear pathway for practitioners to follow in supporting them to make a referral to children's social care and we were informed that all referrals are overseen by more senior practitioners and copied to the safeguarding lead. However this quality assurance process is currently not sufficiently robust to consistently impact on the quality of all referrals.

3.19 Adult substance misuse practitioners are appropriately flagging electronic patient records to alert practitioners to consider safeguarding vulnerabilities, including clients who have children on CP plans or have previously been subject of a CP plan. This means that practitioners are being well informed of the need to consider any additional vulnerability, which will in turn help ensure that their assessment is robust.

A is a 16 year old female known to CAMHs who booked for ante natal care. Exploration of partner details highlighted that her partner was more than 20 years older and it was a relatively new relationship. The CAMHs worker immediately rang the named midwife to highlight concerns that the young person minimised risk in the relationship and an ICPC was held very quickly with a support plan put in place. The young person subsequently attended a neighbouring county ED department with bruising and diligent follow up by the ED practitioner alerted them that the young person was not accessing maternity services in that county. The named midwife from the neighbouring county then contacted the named midwife in Nottinghamshire to check if the young person was known and to share information on the risk they had assessed. This joined up working both within county health teams and cross border colleagues ensured that a vulnerable young person and unborn were tracked between areas and that the right levels of support were put in place to ensure their safety.

4. Looked after children

4.1 Children and young people in care receive variable health input depending on where they are placed. Initial and review health assessment health (RHA) assessments are undertaken by appropriately qualified clinicians, however there are issues with the timeliness of assessments and the subsequent report writing and health plan formulation.

4.2 In one team we were told that all initial health assessments (IHA) are undertaken by a paediatrician in the team, however if the child had been seen by another paediatric service within the preceding two months then the information from that appointment would be used to inform the health care plan. In one case seen the child had not been seen by the children in care team and the initial health assessment and plan developed from existing information. Information had been collated from all available records to develop a chronology. This was recorded as an initial health assessment and based on a paper review. There is no policy in place to support the practice of a paper review in place of a comprehensive health assessment. This is a missed opportunity to ensure that looked after children have their health needs fully assessed. (**Recommendation 2.10**)

4.3 Overall the quality of IHAs and RHAs sampled was hugely variable across the county, with some exemplary work carried out by the children in care (CIC) nursing team. Arrangements in the north of the county utilising a team of three paediatricians to undertake all IHA's and in keeping consistency with the same CIC nurse completing the RHA on an annual basis has clear benefits in preventing the RHA's becoming episodic.

4.4 Some records sampled did not highlight a good sense of the child as an individual. The voice of the child was not evident in all files seen. In most cases there was no evidence of the child being asked to sign consent to being seen nor was there any evidence of explanation of the process and reason for the health assessment. Some young people told us it feels they are being "done to" and do not have processes explained to them. Children and young people should be given time and the opportunity to actively engage in the health assessment and planning process. This encourages personal responsibility for their health care as they transition into adulthood. (**Recommendation 2.11**)

4.5 Involvement of birth parents and inclusion of family history was variable on records. This is a missed opportunity to obtain valuable personal information for children and young people. Care leavers routinely tell us how important this information is to them as they enter into adulthood. (**Recommendation 2.12**)

4.6 Health outcome plans were not always SMART with recommendations not specifically time limited or outcome focussed, and an over reliance upon others to complete. This means that plans are not able to be used as a tool for monitoring progress and to ensure accountability, leading to the risk that young people's needs are not fully being met. (**Recommendation 2.13**)

4.7 On some assessments undertaken by the CIC nurses, we saw good transfer of targets and checks on previous actions from one plan to the next, to ensure follow up of actions were monitored. This included attendance by the school nurse as a health representative at the LAC review to ensure health recommendations were considered on an ongoing basis and being implemented in a timely way.

4.8 In the North of the county, young people have more choices about where they have their RHA and the CIC nurses are able to offer some flexibility about location and time of day to suit the needs and wishes of the young person. In the south of the county, cases sampled showed more health assessments undertaken in clinic settings. This leads to a variability in the overall experience and opportunities of young people across Nottinghamshire to influence and take responsibility for their health reviews.

4.9 Quality assurance processes are underdeveloped. The in-house quality assurance tool in use is not consistently improving quality and practice on either in-county or out of area assessments. Files seen that had been quality assured and referred back to the assessing clinician resulted in clear actions being put in place. In one case, we saw a more comprehensive follow up of outstanding health needs being addressed for example monitoring the progress of an urgent CAMHS referral. However we saw other records which had been quality assured and gaps identified which had not been referred back. The lack of effective QA process means there is an ongoing and unresolved inconsistency in the quality of assessment children both in and out of area are receiving. (**Recommendation 2.14**)

4.10 There is no dedicated commissioned resource for care leavers however some CIC nurses who have a special interest in care leavers and the designated doctor offer support post 18 as an informal arrangement. Care leavers are provided with “important health information” and a “care leaver bag” containing essential health items has been developed in consultation with young people. We saw some exemplary evidence of this, however there was considerable variation in the quality of these in different teams. Further exploration and audit to ensure consistency of the quality of this across the county would strengthen the offer. (**Recommendation 2.18**)

4.11 An effective specialist CAMHS service for looked-after children is in place. Part of the offer includes a consultation model for carers to develop their engagement and understanding of emotional and mental health difficulties in the young people they are caring for. Whilst this facilitates rapid access to intervention, we were told that thresholds can be high to qualify for support from this team and that stability of placement is a key factor.

4.12 Children and young people who are looked after have access to enhanced services for sexual health, including the provision of longer appointment allocation in teenage CASH and GUM clinics and direct referral access for young people via CIC nurses to Sexions service for additional support. This is positive and recognises the additional vulnerability of children who are looked after.

4.13 Information for IHAs and RHAs is requested from the GP to inform health assessments although this is not consistently recognised in all practices as often it is conducted as an information trawl from system1 records. As only 50% of GP practices are using System1, information from GPs is therefore not always available to inform the Initial and review health assessments. In files reviewed, we saw evidence of GP information taken from System1 but we saw no evidence of separate information reports from GPs. This means that vital health information may be overlooked. In one practice we visited, the safeguarding lead GP was well sighted on the health vulnerabilities of children and young people in care and completed a quarterly records check on all looked after children registered with the practice. This included oversight on any outstanding health needs or referrals, with tasking of GP's to ensure actions were followed up. This is good practice to ensure the health needs of children in care are monitored on an ongoing basis and not only as part of statutory health reviews. Some GPs we met with recognised that they would benefit from a greater understanding of looked after children arrangements and their roles in the health of children in care. (**Recommendation 4.5**)

One case sampled highlighted the benefits of having the same CIC nurse undertaking review health assessments each year. The previous RHA had been noted as difficult due to the setting of the appointment but the young person did not have the confidence to request a change for the following year. The CIC nurse had noted observations about the RHA and the young person's ability to discuss his health needs openly in the environment, therefore was able to advocate for the young man and arrange his RHA in a different location, which led to a more positive experience for the young person.

Management

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

5.1 Leadership and management

5.1.1 We saw some strong collaborative working at both an individual and organisational level. The Nottinghamshire and Bassetlaw CCGs memorandum of understanding in place between partners helps cohesive joint working and provides clarity on agencies roles and responsibilities. This has led to a shared understanding of the safeguarding agenda, and actions to be undertaken across CSC, health and police.

5.1.2 Strong safeguarding leadership, advice and guidance across the county is provided by the two designated nurses however capacity in a county of this size means they are not a highly visible presence in all providers due to current levels of resourcing.

5.1.3 In addition, capacity issues in the named GP roles in some of the Nottinghamshire CCGs mean GPs lack leadership on child safeguarding. This hampers progress in ensuring consistent and effective primary care safeguarding arrangements. All practices are linked into a safeguarding network which is helping to promote practice and awareness though there remains a significant development agenda across the county.

5.1.4 In order to ensure services learn from serious incidents, and that practice is subject to continuous improvement, learning events and updated training have been developed. However in some services across the health community we were not able to see the impact of this during our visits.

5.1.5 The interface between health and CSC is working well. The soon to be implemented pilot for developing the MASH and the early help unit involving health staff should aid collaboration and cohesive working to achieve best outcomes for children and families. However we understand this pilot is mostly focused on bridging the information exchange gap with DV notifications and this is a missed opportunity to identify patterns and provide more universal health support to families at an early stage.

5.1.6 There is more to do across the county, to develop staff awareness on their role and process of escalation on cases where there is professional disagreement. Further work is needed to clarify and embed new initiatives to ensure staff are confident and competent in their use. This was a common theme on initiatives such as the CSE identification tool and GP coding. Sharing this with all frontline practitioners to ensure they are incorporating this routinely in their risk assessments and everyday practice is an area of development.

5.1.7 Commissioners and health providers were seen to be responsive to emerging patterns in local needs, such as the additional resources provided to CAMHS for the eating disorders service and to help support the acute trust with CAMHS admissions to the paediatric wards when more young people presented with these difficulties. This should lead to children and young people being supported more effectively.

5.1.8 The use of a single patient information system across many health disciplines is an effective information sharing tool about children and young people accessing a range of services. The ability to capture safeguarding information along with the use of “tasking” other professionals for follow-up ensures that practitioners who can access this system do not miss any actions they are required to do.

5.1.9 For services using the RIO system such as AMH and CAMHS, client information and risk assessment is fragmented between both paper and electronic records leading to the risk that staff are not fully sighted on the individual needs and vulnerabilities of their client group.

5.1.10 Caseloads are well managed and monitored within the 0-19 team. The ability to co-work families of preschool and school age children makes best use of resources. The use of a public health demographic profiling tool shares workloads and ensures staff are allocated accordingly to areas with high levels of safeguarding need.

5.1.11 The current capacity of the named nurse in Sherwood Forest Hospitals NHS foundation trust is insufficient to fulfil the duties as outlined in Working Together. The named nurse is currently line managed by the trust’s divisional matron for planned care and surgery. This arrangement does not reflect Working Together or the Intercollegiate Guidance. (**Recommendation 1.11**)

5.1.12 Current arrangements for the seconded designated CIC nurse role, alongside capacity issues of the designated doctor role are not supporting strong strategic oversight for the CIC team. Despite the very committed and focused operational team, the service lacks strategic direction and the ability to develop and consolidate consistent practices that will drive up standards for children and young people in care. (**Recommendation 2.15**)

5.2 Governance

5.2.1 The bi-monthly joint Nottinghamshire and Bassetlaw CCGs safeguarding committee is an effective platform to mitigate risk between the CCGs and ensures all policies across the county are aligned. It reports directly to CCG boards and provides an upward assurance and oversight of providers.

5.2.2 Regular scrutiny panels held in each CCG focus on quality outcomes and frameworks. Key issues related to safeguarding are raised at this panel and there is good connectivity between the safeguarding committee and quality panels. An additional more regular quality contract review meeting with Nottinghamshire Healthcare trust is in place due to the size and scope of this large provider.

5.2.3 The quarterly health and social care liaison meeting is a positive forum for sharing learning across the county and keeps inter agency challenge to find solutions to recurring problems high on the agenda. Representation includes MASH, specialist safeguarding practitioners, early help unit, children's centres, health visiting, paediatric liaison and midwifery. Many staff reported how valuable this has been recently, particularly in resolving issues with child protection conference invitations and in refining the pre-birth planning processes to ensure more rapid plans and support are put in place.

5.2.4 Regular audits in midwifery services such as the completion of Whooley mental health questions and domestic violence checks are defining training priorities for the team. Re-audit following training has shown a significant improvement in ensuring these important areas are asked routinely as part of ongoing risk assessment.

5.2.5 We were informed that quarterly audits in CRI are completed, with a specific audit for children's safeguarding. Lessons from this have been implemented in practice and shared with practitioners. For example, a recent audit identified that the current risk assessment being used by adult substance misuse practitioners, did not enable them to effectively integrate risks into care plans. As a result a new risk assessment tool is being launched imminently to address this deficit.

5.2.6 The introduction of an automatic electronic alert of pregnancy to GP's is positive and ensures GPs are informed at an early stage. Cases sampled highlighted the benefits of these requests for safeguarding or family information being considered as part of ongoing risk assessment.

5.2.7 The quarterly network meeting of named midwives across the county is driving forward changes to better support families. Examples include the development of the pre-birth planning template guidance that is now in place to aid consistency in information capture between children's social care and health teams.

5.2.8 Across teams, we have seen a range of referrals which clearly articulate the risk to children and young people but this is not consistent. Arrangements to quality assure referrals in all providers is not sufficiently robust to ensure that practitioners are consistently demonstrating best practice in making referrals to children's social care. (**Recommendation 5.1**)

5.3 Training and supervision

5.3.1 Recent multi agency training on sexual abuse run by the designated doctor along with three young people who were victims of CSE or abuse was well valued. We heard this has developed practitioner's awareness of CSE, and their risk assessment to include analysis of triggers such as behavioural changes in a young person.

5.3.2 Midwives in both providers have access to training via the "midwifery issues" annual study day, run by the named midwives. This is in addition to ongoing level three training and has included national themes on CSE, DV, FGM, in addition to local training disseminated from the local children's safeguarding board on domestic violence in the traveller community. All community midwives are now trained to complete domestic abuse, stalking and honour based violence (DASH) forms for domestic violence and link with the trust DV nurse who attends MARAC.

5.3.3 Action has been taken to strengthen supervision arrangements across health services however there is more to do across all services to ensure increased operational oversight on cases to prevent drift. This is particularly evident on cases where practitioners may not have identified a need to request supervision on a case. The use of chronologies is not standard practice in most services; the use of these would support practitioners in their risk assessment and ability to identify drift more readily. Lack of chronologies is a feature in serious case reviews.

5.3.4 Supervision arrangements where they exist, are clear, and in many services we did see this documented on notes, however in others where this was not the case, there is a risk that important information is not readily accessible or actions not followed up. Within CAMHs we were not able to see the effectiveness of this in most cases. In some records the practitioner had recorded a reference to a discussion with a manager but there was no detail of the discussion or actions to be taken. Despite practitioners diligence in ensuring cases were brought to supervision, this was not effective in moving the case forward in a timely manner to ensure children were well supported. (**Recommendation 2.16**)

5.3.5 Whilst all providers we visited had clear expectations for training, current arrangement and compliance is not meeting intercollegiate guidelines. Much of the training is delivered on an in house basis and despite multi agency content, is not delivered to a multi-agency audience. Some staff we spoke with had not accessed or embedded training into practice at a level commensurate with their roles and responsibilities. (**Recommendation 5.2**)

5.3.6 We could not be assured that adult substance misuse practitioners have been appropriately trained to level 3 in safeguarding as there is currently no management oversight of who has attended from adult substance misuse services. This was recognised as a gap by management. This will be brought to the attention of public health.

5.3.7 CRI Practitioners have access to internal CSE training; however this is not currently mandatory. We were informed that practitioners all have access to the CSE toolkit which is available on the intranet, but management recognised that CSE awareness is currently underdeveloped in adult substance misuse services. This will be brought to the attention of public health.

5.3.8 AMH practitioners are not trained in line with intercollegiate level 3 safeguarding training. There is lack of clarity on what safeguarding training should be accessed. However, we heard that there are plans to introduce a 'think family' training package which will fulfil the function of level 3 training. (**Recommendation 2.19**)

5.3.9 Good supervision opportunities exist for designated professionals with opportunity for peer review and challenge. Appropriate arrangements are also in place for the named professionals to access safeguarding supervision and training.

5.3.10 Kingsmill ED practitioners benefit from regular access to supervision at pre-arranged drop in clinics held fortnightly. In addition, peer supervision is available at consultant led peer review meetings, although these are usually attended by paediatric ward staff.

5.3.11 All midwives have rapid access to ad hoc safeguarding advice and support with formal supervision arrangements in place with the opportunity for practitioners to reflect on their cases. We saw evidence of safeguarding supervision or action plans being recorded in notes, and monthly monitoring to ensure staff are regularly accessing supervision.

5.3.12 Formal supervision in 0-19 services is frequent and comprehensively recorded using the system1 template, however there is scope for more oversight from the safeguarding team for example to request practitioners to bring certain cases for discussion. There is an over reliance on clinicians to recognise the cases to bring for supervision discussions and we saw some evidence of cases where an overview discussion had not been sought, particularly with parents who are difficult to engage, which is a risk.

5.3.13 Within CASH, supervision of complex cases is under developed and cases examined indicate a need for greater access to safeguarding expertise. Clinical staff are required to attend two supervision sessions in any year though there are no methods to monitor this to ensure that it happens, and supervision isn't recorded on patient notes.

5.3.14 AMH Practitioners have access to individual case management supervision every 4 weeks with their line manager, which includes an element of safeguarding supervision. There is also an opportunity to discuss cases at a weekly multidisciplinary meeting and we saw evidence of discussions and outcomes being clearly recorded in the patients electronic records. However, this is reliant on individual practitioners identifying cases for discussion. There is currently limited management oversight to ensure that all safeguarding issues are being considered.

5.3.15 Adult substance misuse practitioners have access to monthly group safeguarding supervision, where attendance is a mandatory requirement for all practitioners. Cases for discussion are being identified by individual practitioners, however we were informed that the safeguarding lead who chairs the session, will also randomly sample cases to ensure that safeguarding has been appropriately considered at all times by the practitioner.

5.3.16 A safeguarding supervision proforma is completed at the CRI monthly group supervision session, which is currently being filed in paper records. There is also an expectation that individual practitioners will enter onto the electronic patient records any action following case discussions. However, we saw that this is not consistently happening, and where practitioners are making reference to action plans, it is not being related back to the safeguarding supervision sessions. This will be brought to the attention of public health.

5.3.17 GPs are complying with the minimum requirement for level 3 training although some cases highlighted gaps in awareness of their role and pathways for example DV and CSE. This indicates that further training is needed to ensure they are sufficiently aware of local and national themes. In some practices, e learning was the only mechanism accessed. We found significant variation in practice and awareness in the sample of surgeries we visited which needs to be a priority area of focus. The current differing roles and capacity of the named GPs across the county is significantly impacting on safeguarding training and practice being consistently embedded across the county. (**Recommendation 4.3**)

Recommendations

1. **Nottinghamshire CCGs, in partnership with Sherwood Forest Hospitals NHS Foundation Trust should ensure that:**
 - 1.1 next of kin and accompanying adult details are recorded consistently in ED and MIU settings
 - 1.2 Risk assessment documentation in the CASH service is reviewed to ensure it includes specific prompts for Fraser competence and key safeguarding risks
 - 1.3 Documentation for ED and MIU is redesigned to meet NICE standards
 - 1.4 Paediatric staffing and specialist training in ED and MIU is reviewed to ensure children and young people are assessed by appropriately trained staff
 - 1.5 Arrangements for the paediatric liaison role is reviewed to strengthen safeguarding arrangements in EDs and MIU
 - 1.6 a risk assessment for children at risk of sexual exploitation is developed for ED and MIU settings
 - 1.7 the details of children at home are routinely captured as part of ED and MIU attendance paperwork for adults
 - 1.8 a risk assessment for children and young people with mental health needs who are admitted to wards is developed to ensure their needs are appropriately met
 - 1.9 Discharge letter formats from ED and MIU settings are audited to ensure appropriate information is shared with primary care and community health teams
 - 1.10 The use of chronologies is developed in maternity services to identify drift in cases
 - 1.11 The capacity of the named nurse is reviewed in line with Working Together.

- 2. Nottinghamshire and Bassetlaw CCGs , working in partnership with the lead commissioning CCGs, Local Authority Public Health commissioners, Nottinghamshire Healthcare NHSFT, Bassetlaw Health Partnerships, Sherwood Forest Hospitals NHSFT and Doncaster and Bassetlaw Hospitals NHSFT should gain assurance that:**
- 2.1 A standard operating procedure is developed for the 0-19 team regarding the use of chronologies
 - 2.2 Pathways and thresholds into tier 2 and tier 3 services are clarified for referrers to enhance rapid access to services for children and young people
 - 2.3 Record keeping systems in CAMHS are reviewed to ensure all information is readily accessible on 1 system
 - 2.4 Children and young people are involved in the development and review of smart care plans with consent clearly recorded
 - 2.5 CAMHS training is developed for paediatric ward staff
 - 2.6 CAMHS pathways and risk assessment for child sexual exploitation are developed
 - 2.7 That CAMHs and Adult mental health teams work together to develop and embed a transition protocol between services.
 - 2.8 Arrangements for on call CAMHs consultant cover are reviewed
 - 2.9 Electronic alerts are used consistently in adult mental health team to highlight vulnerable families including those with children on child protection plans
 - 2.10 Initial health assessment processes are clarified and audited in relation to the use of paper reviews
 - 2.11 The voice of the child is developed in initial and review health assessments and children and young people are given the opportunity to actively engage in the health assessment process.
 - 2.12 Family history information where available, is consistently included in statutory health assessments
 - 2.13 Healthcare plans for children in care are made SMART
 - 2.14 A quality assurance process is consistently used in children in care assessments

- 2.15 Arrangements are put in place to develop the strategic role of the designated nurse for looked after children
 - 2.16 Notes and action plans of safeguarding supervision discussions within CAMHS are recorded
 - 2.17 Timescales for the complete implementation of the transfer to RIO records system are put in place to support comprehensive risk assessment
 - 2.18 Information provided to care leavers is of a consistently high standard across the county
 - 2.19 Safeguarding training requirements for the AMH team are clarified and implemented
- 3. Bassetlaw CCG, in partnership with Doncaster and Bassetlaw Hospitals NHS FT should ensure that:**
- 3.1 Documentation for ED is redesigned to meet NICE standards including next of kin and accompanying adult details.
 - 3.2 The ability to retrieve and highlight previous ED attendances is explored on the symphony system as part of risk assessment
 - 3.3 Arrangements are reviewed to explore information sharing for ED to alert staff to children with vulnerabilities.
 - 3.4 Paediatric staffing and specialist training in ED is reviewed
 - 3.5 Arrangements for the paediatric liaison role is reviewed to strengthen safeguarding arrangements
 - 3.6 That a risk assessment for children at risk of sexual exploitation is developed for ED
 - 3.7 That the details of children at home are routinely captured as part of ED and attendance paperwork for adults
 - 3.8 Discharge letter formats from ED is audited to ensure appropriate information is shared with primary care and community health teams
 - 3.9 The use of chronologies is developed in maternity services

4. **Nottinghamshire and Bassetlaw CCGs working with their providers including General Practice, should ensure that:**
 - 4.1 They engage with all GP practices to influence them to adopt the think family principles that are reflected in the development of multi-disciplinary family liaison meetings
 - 4.2 Assurances are gained that recording processes for practice liaison meetings are in place on GP and community health team case notes
 - 4.3 GP training on child sexual exploitation and domestic violence is developed
 - 4.4 They promote the current guidance on issuing safeguarding alerts on electronic records across primary care recording systems in Nottinghamshire
 - 4.5 links between GP's and the children in care health team are established to develop understanding and communication around the health of children in care

5. **Nottinghamshire and Bassetlaw CCGs, in partnership with Sherwood Forest Hospitals NHS FT , Nottinghamshire Healthcare NHSFT and Doncaster and Bassetlaw Hospitals NHS FT gain assurances that**
 - 5.1 mechanisms are developed to ensure oversight of safeguarding referrals
 - 5.2 level 3 training arrangements are further developed in line with intercollegiate guidance

Next steps

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

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